PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2024-D30

PROVIDER–
Kindred 2006-2014 LTCH/SNF Bad Debts CIRP Groups

Provider No.: Appendix A

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service

DATE OF RECORD HEARING -
December 18, 2023

Cost Reporting Periods Ended -
2006-2014

CASE NOs.: 08-0585GC; 09-1589GC; 10-0090GC; 11-0028GC; 12-0147GC; 13-2822GC; 14-1622GC; 15-3239GC and 16-1252GC

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ISSUE STATEMENT:

Whether the Providers may be reimbursed for bad debts incurred by patients who were dually eligible for Medicare and Medicaid.[1]

DECISION:

After considering the law and program instructions, the evidence presented, and the parties' contentions, the Provider Reimbursement Review Board ("Board") affirms: (1) the Medicare Contractor's dual eligible bad debt adjustments for the Providers that chose not to enroll in the Medicaid programs in Massachusetts, Tennessee, and, beginning in 2012, Pennsylvania; and (2) the Medicare Contractor's dual eligible bad debt adjustments where the state's Medicaid program (Pennsylvania - prior to 2012) would not enroll an LTCH.

INTRODUCTION:

These appeals involve nine (9) Long Term Care Hospitals ("LTCHs") in Massachusetts and Pennsylvania, and one (1) Skilled Nursing Facility ("SNF") located in Tennessee (collectively referred to as "Providers") affiliated with Kindred Healthcare, Inc. ("Kindred") for various cost reporting years between 2006 and 2014.[2] Significantly, ***none*** of the Providers were enrolled as Medicaid providers in their respective states during the cost reporting periods at issue.[3]

The Providers' assigned Medicare contractor[4] is Wisconsin Physicians Service ("Medicare Contractor"). The Medicare Contractor denied Kindred's bad debt claims for individuals who were eligible for both Medicare and Medicaid services (referred to as "dual eligibles") based on the "must bill" policy of the Centers for Medicare & Medicaid Services ("CMS"). This policy required providers to bill the relevant state Medicaid program for Medicare deductibles and copayments and receive a remittance advice ("RA") denying payment (in whole or in part) before the uncollectable amount can be reimbursed as a Medicare bad debt.[5]

The Providers timely appealed the denial of their bad debt reimbursement to the Board and met the jurisdictional requirements for a hearing. The Board conducted a hearing on the record. Glenn P. Hendrix, Esq., of Arnall Golden Gregory, LLP represented the Providers. Jerrod Olszewski, Esq. of the Federal Specialized Services represented the Medicare Contractor.

The Board issued a decision for these nine cases on November 20, 2017.[6] The Board ultimately affirmed the Medicare Contractor's denials for Providers who ***chose*** *not to enroll* in the Medicaid programs in Massachusetts, Tennessee, and beginning in 2012 Pennsylvania. The

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[1] *See* Ex. P-12, Providers' Consolidated Final Position Paper at 1 (Aug. 5, 2016).
[2] *Id. See* Appendix A for Schedules of Providers. Note: Case # 16-1252GC for 2014 was added to the record hearing by letter dated March 16, 2016.
[3] Ex. A, Stipulations of Fact at ¶ 4 (Jan. 15, 2016).
[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs, as appropriate.
[5] Medicare Contractor's Post-Remand Consolidated Final Position Paper at 9 (Aug. 10, 2016); Ex. A, Stipulations of Fact at ¶ 8.
[6] *Kindred 2006-2014 LTCH/SNF Bad Debts CIRP Groups v. Wisconsin Phys. Servs.*, PRRB Decision 2018-D5 (Nov. 20, 2017) ("*Kindred*, 2018-D05").

Board, however, reversed the Medicare Contractor's denials where the Kindred LTCHs were ***unable*** *to enroll* in their state's Medicaid program as an LTCH (for Pennsylvania - prior to 2012). Following an appeal of that decision, these cases were remanded to the Board, which issued a Notice of Record Hearing on December 18, 2023 and officially closed the record on January 18, 2024.

STATEMENT OF FACTS:

A. Procedural History Following PRRB Decision 2018-D15

Following the Board's decision, the Providers appealed to the U.S. District Court for the District of Columbia (the "District Court"), which later issued a Memorandum Opinion and Order remanding these cases to the Secretary. After summarizing the relevant law and the Board's decision, the District Court noted that the Administrator reversed the Board's decision on January 17, 2018, reinstating the Medicare Contractor's full denial of reimbursement based on a failure to obtain state-issued RAs.[7] The Administrator argued that, since 1987, Medicare has required a provider to bill the State *and* receive an RA, relying on a number of sources including provisions in the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"). Without an RA, the Administrator claimed a provider could not demonstrate "reasonable collection efforts."[8] Even if a state did not permit an LTCH or other entity to enroll as a Medicaid provider, the Administrator argued it "could have sued the state for noncompliance with federal law."[9]

The Providers filed a request, which was granted, to strike certain exhibits filed by the Secretary because they were not included in the administrative record.[10] The Providers argued the decision to deny their reimbursement was improper for five reasons:

> (1) [T]he decision is inconsistent with CMS' past application of the must-bill policy, which permitted exceptions;
> (2) The decision failed to adequately address the Providers' inability to obtain state-issued RAs;
> (3) The Administrator relied on prior agency decisions where the providers did participate in Medicaid, all of which are inapplicable [to the instant cases];
> (4) CMS did not apply the RA requirement to the Providers before 2006; and
> (5) CMS's imposition of an RA requirement is a change in policy that violates the 1987 Bad Debt Moratorium.[11]

The Secretary countered that its "must-bill" policy "is longstanding and has been applied to all providers consistently, with no exceptions, since before the 1987 Bad Debt Moratorium."[12] The

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[7] *Kindred Healthcare, Inc. v. Azar*, No. 18-650, 2020 WL 3574614 at *4 (D.D.C. July 1, 2020).
[8] *Id.*
[9] *Id.*
[10] *Id.* *5-6.
[11] *Id.* at *6.
[12] *Id.*.

District Court disagreed with the Secretary and, as a result, did not reach the remainder of the Providers' arguments.[13]

The District Court noted that the Bad Debt Moratorium "prohibits the Secretary from 'mak[ing] any change in the policy in effect on August 1, 1987, with respect to' bad debt reimbursement to Medicare providers, 'including criteria for what constitutes a reasonable collection effort.'"[14] The District Court found that the record did not "demonstrate[] that CMS's must bill policy required providers to obtain a state-issued RA before 2004, let alone when the Bad Debt Moratorium was passed in 1987."[15] While certain sources established that providers were required to *bill* the individual States for dual-eligible co-pays and deductibles before claiming Medicare bad debts, they made "no mention of an RA requirement."[16]

There was some dispute as to whether the Providers in these cases actually *billed* the states, based on the administrative record. The District Court found, however, that the reason for the bad debts' disallowance was because no RA had been submitted, *not* because the Providers had failed to bill the states.[17]

Finally, the District Court remanded the case to the Secretary who was "directed to reconsider whether, absent the RA Requirement, the Providers are entitled to bad debt reimbursement."[18]

B. Medicare Bad Debts Associated with State Cost Sharing Obligations for Dual Eligibles

State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost-sharing (Medicare deductibles and copayments) on behalf of poor and low-income Medicare-eligible individuals. While a state may limit payment of cost sharing amounts for most dual eligible patients,[19] a state may be obligated to pay full cost sharing amounts for patients who qualify for Medicaid as Qualified Medicare Beneficiaries ("QMBs").[20]

In general, to receive Medicaid reimbursement, a provider must enroll as a Medicaid provider. Some state Medicaid agencies do not allow enrollment of certain providers (*e.g*., long term care hospitals, inpatient rehabilitation facilities) and, in those situations, the providers are unable to bill the state Medicaid program for Medicare cost sharing amounts. The Kindred Providers were not enrolled as Medicaid providers (participating or nonparticipating) during the time periods at issue.[21]

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[13] *Id.* at *8.
[14] *Id.* at *6 (citing OBRA, Pub. L. No. 100-203, tit. IV, § 4008(c), 101 Stat. 1330-55).
[15] *Id.*. In support, the District Court cites to PRM 15-1 §§ 310, 322 as well as to case law such as *Select Specialty Hospital-Denver v. Azar*, 391 F. Supp. 3d 53, 59-60 (D.D.C. 2019). *Id*. at *7.
[16] *Id.* at *7.
[17] *Id.* at *8.
[18] *Id.*.
[19] 42 U.S.C. § 1396a(n)(2) allows states to limit the cost-sharing amount to the Medicaid rate and essentially pay nothing toward the dual eligibles' cost sharing if the Medicaid rate is lower than what Medicare would pay for the service.
[20] However, 42 U.S.C. §1396d(p)(3), at least for a period of time, required state Medicaid programs to pay cost-sharing amounts for QMBs.
[21] Ex. A; Stipulations of Fact at ¶ 4.

C. Medicare's Bad Debt Policy

Medicare regulations governing bad debts are located at 42 C.F.R. § 413.89.[22] Subsection (a) establishes the general rule that bad debts "are deductions from revenue and are not to be included in allowable costs." However, in order to ensure that Medicare-covered costs are not shifted to individuals who are not covered by the Medicare program, subsection (d) specifies that bad debts attributable to Medicare deductibles and coinsurance are reimbursable as allowable costs. Prior to the Board's initial decision, 42 C.F.R. § 413.89 (2004) specified that bad debts must meet the following criteria specified in subsection (e) to be considered allowable:

> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
>
> (2) The provider must be able to establish that reasonable collection efforts were made.
>
> (3) The debt was actually uncollectible when claimed as worthless.
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> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

CMS has provided extensive guidance on its bad debt policy in PRM 15-1 §§ 308, 310, 312 and 322. PRM 15-1 § 308 requires that the provider make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible. PRM 15-1 § 310 states that a "reasonable collection effort" involves the issuance of a bill on or shortly after discharge or death…." However, this section by its own terms, is inapplicable to indigent patients and specifically refers to § 312 which allows providers to "deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively." While this language absolves the providers from taking further steps to prove the dual eligible patient indigent, subsection C of § 312 requires providers to "determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., ***title XIX***, local welfare agency and guardian..."[23]

Finally, PRM 15-1 § 322 states that a provider may not claim Medicare bad debt reimbursement for that portion of the deductible and copayment amounts that "*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*" but may claim "[*a*]*ny* ***portion*** of such deductible or coinsurance amounts that the State is not obligated to pay. . . provided that the requirements of § 312 or, if applicable

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[22] Redesignated from 42 C.F.R. § 413.80 pursuant to 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).
[23] (Emphasis added.)

§ 310 are met."[24] Significantly, § 322 predates[25] and complies[26] with the "Bad Debt Moratorium" which prohibited the Secretary from making certain changes to bad debt policies in effect as of August 1, 1987.[27]

On September 18, 2020, the Secretary promulgated amendments to add certain subsections to the criteria at 42 C.F.R. § 413.89(e)(2): "[t]he provider must be able to establish that reasonable collection efforts were made." With regard to the issue in these cases, 42 C.F.R. § 413.89(e)(2)(iii) (2020), related to reasonable collection efforts for indigent dual eligible beneficiaries, now reads:

> (iii) *Indigent dual-eligible beneficiaries (including qualified Medicare beneficiaries).* Providers may deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid under a State's Title XIX Medicaid program as either categorically needy individuals or medically needy individuals. To be considered a reasonable collection effort for dual-eligible beneficiaries:
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> (A) When a State permits a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, to determine the State's liability for the beneficiary's Medicare cost sharing, the provider—

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[24] (Emphasis added.)

[25] PRM 15-1 § 322 was last revised January 1, 1983 via Transmittal 279 as documented within the manual. The current version of PRM 15-1 is available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021929 (last accessed Sept. 22, 2024). *See also* Ex. C-7 (copy of PRM Rev. 3, Aug. 1968).

[26] In support of its position, the Board notes the following examples of pre-1987 agency statements and Board cases applying CMS' bad debt policy: HCFA Action No. HCFA-AT-77-73 (MMB) (July 5, 1977) (responding to questions about a change in federal law in January, 1968 which made payment of Medicare deductible and copayments by the state Medicaid program optional); Medicare Intermediary Manual, CMS Pub. 13-4, Part 4, § 4499 at Ex. 15 (Transmittal 16, Dec. 1985) (copy at Ex. C-8); *Geriatric and Med'l Ctrs., Inc. v. Blue Cross Ass'n,* PRRB Dec. No. 82-D62 (Mar. 3, 1982) (finding that "the cost of these services were not included in payments for services covered by the State of Pennsylvania"), *decl'd* review, HCFA Adm'r (Apr. 23, 1982); *Concourse Nursing Home Grp. Appeal v. Travelers Ins. Co.*, PRRB Dec. No. 1983-D152 (Sept. 27, 1983) (finding that "the Provider has furnished no documentation which would support its contentions that it had established collection policies and procedures or that actual collection efforts were made to obtain payments from the patients or the Medicaid authorities before an account balance was considered . . . bad debt"), *decl'd review*, HCFA Adm'r (Nov. 4, 1983); *St. Joseph Hospital v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 84-D109 (Apr. 16, 1984) (finding that "the Provider did not attempt to bill the State of Georgia for its Medicaid patients"), *decl'd review*, HCFA Adm'r (May 14, 1984).

[27] There are essentially two prongs to the Bad Debt Moratorium: (1) the first prong prohibits CMS from changing its bad debt policy in effect on August 1, 1987; and (2) the second prong is a hold harmless provision that prohibits CMS from requiring a provider to change its bad debt collection policy when the intermediary had accepted that policy prior to August 1, 1987. Only the first prong is relevant to this appeal as the Providers have not presented any evidence to establish that the second prong is relevant. OBRA 1987, Pub. L. No. 100-203, § 4008(c), 101 Stat. 1330, 1355 (1987), as amended by Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8402, 102 Stat. 3342, 3798 (1988), as amended by Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6023, 103 Stat. 2106, 2167 (1989) (reprinted in 42 U.S.C. § 1395f note). The Medicare Contractor similarly includes additional supportive exhibits with its Post-Remand Consolidated Final Position Paper.

(1) Must determine whether the State's Title XIX Medicaid Program (or a local welfare agency, if applicable) is responsible to pay all or a portion of the beneficiary's Medicare deductible or coinsurance amounts;

(2) Must submit a bill to its Medicaid/Title XIX agency (or to its local welfare agency) to determine the State's cost sharing obligation to pay all or a portion of the applicable Medicare deductible and coinsurance;

(3) Must submit the Medicaid remittance advice received from the State to its Medicare contractor;

(4) Must reduce allowable Medicare bad debt by any amount that the State is obligated to pay, either by statute or under the terms of its approved Medicaid State plan, regardless of whether the State actually pays its obligated amount to the provider; and

(5) May include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

(B) When, through no fault of the provider, a provider does not receive a Medicaid remittance advice ***because the State does not permit a Medicare provider's Medicaid enrollment***[28] for the purposes of processing a beneficiary's claim, or because the State does not generate a Medicaid remittance advice, the provider—

(1) Must submit to its contractor, all of the following auditable and verifiable documentation:

(i) The State's Medicaid notification stating that the State has no legal obligation to pay the provider for the beneficiary's Medicare cost sharing.

(ii) A calculation of the amount the State owes the provider for Medicare cost sharing.

(iii) Verification of the beneficiary's eligibility for Medicaid for the date of service;

(2) Must reduce allowable Medicare bad debt by any amount the State is obligated to pay, regardless of whether the State actually pays its obligated amount to the provider; and

[28] (Emphasis added.)

> (3) May include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

Thus, there is now, as of 2020, an explicit RA requirement for instances where a provider *could have* enrolled in the Medicaid program and received an RA. In cases where a provider *was unable to* enroll in the Medicaid program, alternative documentation may be submitted to demonstrate that reasonable collection efforts were made.[29]

With regard to this alternative documentation in cases where a provider's state does not issue an RA, the Secretary explained:

> [A]lternative documentation to a Medicaid RA could be obtained by providers from a State that demonstrates it will not enroll the provider in Medicaid, or a certain class of a type of provider, for the limited purpose of processing a claim for determining cost sharing liability. Providers could obtain alternative documentation to a RA such as a State Medicaid notification where the State has no legal obligation to pay the beneficiary's Medicare cost sharing. . . . Alternatively, in a State that has a Medicare cost sharing liability for a beneficiary's service, the provider could obtain alternative documentation to a Medicaid RA that sets forth the State's Medicare cost sharing liability that would then be deducted from the provider's Medicare bad debt reimbursement. In addition to verifying the state's cost sharing liability, it will also be important that any alternative documentation to a Medicaid RA accurately verifies a beneficiary's eligibility for Medicaid for the date of service.[30]

In response to comments regarding what types of alternative documentation would be acceptable, the Secretary continued:

> We agree with many commenters' suggestions and believe that the vital items needed to substitute a Medicaid RA must contain all of the following: (1) The State Medicaid notification stating that the State has no obligation to pay the beneficiary's Medicare cost sharing or notification evidencing the provider's inability to enroll in Medicaid for purposes of processing a crossover cost sharing claim, (2) documentation setting forth the State's liability, or lack thereof, for the Medicare cost sharing, and (3) documentation verifying the beneficiary's eligibility for Medicaid for the date of service.

[29] For further discussion concerning CMS' guidance on its Medicare bad debt policy for dual eligibles prior to these amendments, refer to *Kindred*, 2018-D05 at 3-5.
[30] 85 Fed. Reg. 58432, 59001-59002 (Sept. 18, 2020).

> We believe that under (1) . . . . if the provider was not recognized by the State Medicaid Agency as a Medicaid provider type, then documentation evidencing that the State Medicaid Agency does not recognize the provider as a Medicaid provider type for purposes of processing a Medicare crossover cost sharing claim would be sufficient to evidence the State's notification of no obligation to pay the beneficiary's Medicare cost sharing.
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> We also believe that under (2) . . . documentation setting forth the State's liability for the Medicare cost sharing, or lack thereof, can be produced by the provider, in part, from the State Plan documents and may also include other documents such as state and state contractor fee schedules or payment rates, or other documents the provider produces that can be verified by the contractor.
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> Regarding (3) . . . documentation verifying the beneficiary's eligibility for Medicaid for the date of service could take the form of an eligibility report from a state's eligibility verification system.[31]

For the alternative documentation described in (1)-(3), above, the Secretary emphasized that "Medicare contractors will afford providers flexibility in producing documentation" serving as an alternative to an RA.[32]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

The Administrator issued an Order remanding these cases to the Board on November 12, 2020. The Order simply directed the Board to "take actions consistent with the Court Order and memorandum Opinion in this case[.]" It stated that "the case was remanded to the Secretary to consider whether absent the Remittance Advice Requirement, the Providers are entitled to bad debt reimbursement." On January 28, 2021, the Board reopened these nine cases and noted that CMS issued a Final Rule on September 18, 2020, effective October 1, 2020, concerning (among other things) LTCHs.[33] The Board also stated that this Final Rule would "be taken into consideration by the Board, as appropriate and relevant, when adjudicating these cases."[34]

A. Positions of the Parties

Following the Board's Notice of Reopening, the Providers filed a new Post-Remand Consolidated Final Position Paper.[35] They note that this is the second time the Board is considering this case,

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[31] *Id.* at 59003.
[32] *Id.*
[33] *Id*. at 58989, 58999-59004.
[34] Notice of Reopening Pursuant to the Deputy Administrator's Order of Remand at 5 (Jan. 28, 2021).
[35] Providers' Post-Remand Consolidated Final Position Paper (Apr. 23, 2021). For a summary of the Providers' arguments in their original Final Position Paper, refer to *Kindred*, 2018-D05 at 5. *See also* 85 Fed. Reg. at 58999-9004.

and that the only reason ever given by the Medicare Contractor for denying the bad debts at issue was the "inability to satisfy the RA Requirement."[36] They explain that the District Court issued an opinion "finding that the RA requirement violates the Bad Debt Moratorium and is unenforceable" and that the "[b]illing [r]equirement has been satisfied" in these cases.[37] Since the Secretary did not appeal the District Court's decision, it is bound by the judgement and the Providers urge the Board to reverse the Medicare Contractor's bad debt denials.[38]

The Providers acknowledge that CMS issued a Final Rule effective October 1, 2020, which added new evidentiary requirements for reasonable collection efforts for dual eligibles at 42 C.F.R. § 413.89(e)(2)(iii).[39] They claim that the new rule "does not provide any way for providing 'reasonable collection efforts' for providers who chose not to enroll in a State's Medicaid program," but that it is also "dependent upon the existence of an RA [r]equirement that does not violate the Bad Debt Moratorium."[40] The Secretary acknowledges as much, according to the Providers, but disagrees with any assertion that the RA requirement did not predate the Bad Debt Moratorium.[41] The Providers argue that the Secretary, in making this assertion, relied on the same evidence presented in these cases to the District Court, which ultimately rejected the contention that the RA requirement predated the Bad Debt Moratorium.[42]

The Providers also outline their position on the Board's function and authority on remand:

> The regulation at 42 C.F.R. § 405.1875 makes clear that the purpose of remand is not to consider new evidence or arguments because a case cannot be remanded for the "[p]resentation of evidence existing at the time of the Board hearing that was known or reasonably may be known" or the "[p]resentation of an alternative legal basis concerning an issue in dispute." 42 C.F.R. § 405.1875(f)(2). Further the parties are bound by the Court Order and Memorandum Opinion, which were not appealed.[43]

The Providers continue by suggesting that all legal and factual issues have been resolved either through the parties' stipulations or the District Court's Memorandum Opinion. They claim that it is undisputed that the Providers incurred dual eligible bad debts which were disallowed; that the Providers invoiced the relevant State Medicaid programs; that they could not obtain RAs because the States refused to issue them; and that the bad debts were disallowed solely based on the Providers' inability to obtain RAs.[44]

The Providers conclude that the new provisions of 42 C.F.R. § 413.89 cannot be applied retroactively as a general matter, but also that "the Secretary cannot avoid the final, unappealed

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[36] Providers' Post-Remand Consolidated Final Position Paper at 2.
[37] *Id.*
[38] *Id.* at 2-3.
[39] *Id.* at 9 (citing 85 Fed. Reg. 58432, 58989, 58999-59004 (Sept. 18, 2020)).
[40] *Id.* at 10.
[41] *Id.* at 10-11 (quoting 85 Fed. Reg. at 59002).
[42] *Id.* at 11.
[43] *Id.* at 13.
[44] *Id.*

judgment from the District Court by creating a brand new requirement."[45] The Provider argues that the District Court already found that the RA requirement violated the Bad Debt Moratorium, so the Secretary's insistence that it does not is not supportable and an invalid basis to ignore the findings and holdings of the District Court.[46]

Likewise, the Medicare Contractor filed a new final position paper in response.[47] In its Post-Remand Consolidated Final Position Paper, the Medicare Contactor begins by quoting the new provision found at 42 C.F.R. § 413.89(e)(2)(iii) (2020) related to the establishment of reasonable collection efforts for indigent dual-eligible beneficiaries. It also quotes 42 C.F.R. §§ 413.20 and 413.24 related to the requirement for Providers to maintain adequate data to support their allowable costs. On remand, the Medicare Contractor claims the Board "must determine if, without the requirement of state Medicaid remittance advices, the providers qualify for bad debt reimbursement."[48]

The Medicare Contractor disagrees that there is nothing for the Board to decide on remand, and argues that the "provider has failed to submit support to show the State's cost sharing liability or even if the beneficiaries were eligible for Medicaid during their patient state."[49] The new regulation at 42 C.F.R. § 413.89(e)(2)(iii) permits alternative documentation when Medicaid RAs are not available, but the Providers here have not submitted any alternative documentation. Also, there are instances where the "must bill" policy was appealed via a protested item and, as such, no bad debt listings were submitted to support the claims.[50]

The remainder of the Medicare Contractor's brief discusses the history of the RA requirement, asserting it has existed since 1985. Even absent the RA requirement, the Medicare Contractor argues that "the provider believes that certain bad debts relating to unpaid Medicare deductibles and coinsurance for dual-eligible beneficiaries should be reimbursed by Medicare without having documented any State issued support of cost sharing or Medicaid eligibility verification."[51] They summarize their argument as follows:

> The provider has accepted the patients as "indigent" based on their status as a Medicaid beneficiary. However, no evidence has been presented to confirm the State is not responsible for these debts nor has the provider documented the Medicaid coverage was in effect during the dates of service. Thus, reasonable collection efforts have not been made and it has not been established that the debt was uncollectible when claimed.[52]

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[45] *Id.* at 15.
[46] *Id.*
[47] MAC Post-Remand Consolidated Final Position Paper (June 2, 2021). For a discussion of the Medicare Contractor's arguments in their original Final Position Paper, refer to *Kindred*, 2018-D05 at 6.
[48] MAC Post-Remand Consolidated Final Position Paper at 7.
[49] *Id.*
[50] *Id.* at 8-9.
[51] *Id.* at 17.
[52] *Id.* at 19.

The Providers filed an Optional Response Position Paper on July 6, 2021.[53] In the Providers' Response, they note that "while the Intermediary admits that this case was remanded to determine reimbursement of the bad debts in the absence of the invalid RA Requirement, it continues to rely on the RA Requirement, contrary the [*sic*] District Court decision that is binding on the MAC and this Board."[54] They suggest that the Medicare Contractor is ignoring the Memorandum Opinion from the District Court,[55] which remanded *these* cases "to reconsider whether, *absent the RA Requirement*, the Providers are entitled to bad debt reimbursement."[56] Instead, the Medicare Contractor continues to argue the validity of the RA requirement, or suggest that Providers could submit "alternative documentation" pursuant to the newly established 42 C.F.R. § 413.89(e)(2)(iii). The Providers also claim the Medicare Contractor is ignoring stipulations between the parties from earlier proceedings in these cases which agree that "the Providers billed the relevant State Medicaid programs, that those Medicaid programs refused to pay any portion of the amounts at issue, and that the Intermediary refused to pay the Bad Debts solely because of the absence of State-issued RAs."[57]

B. Board's Request for Information

On February 7, 2022, the Board issued a Request for Information, where it acknowledged the conflict between (1) the District Court's Memorandum Opinion and the Administrator's Remand Order, which directed the Board to consider whether the Providers are entitled to bad debt reimbursement absent the RA requirement, and (2) the Board's controlling regulation at 42 C.F.R. § 405.1867, requiring it to apply certain regulations, including 42 C.F.R. § 413.89(e)(2)(iii), which is to be applied retroactively.

The Board ordered the parties to "identify the portion of the retroactive regulations that encompasses (no more no less) the 'Remittance Advice Requirement" and to "identify which of the remaining retroactive regulations, if any, may be applicable" to the Board's directive to determine "whether, *absent the [Remittance Advice] Requirement*, the Providers are entitled to bad debt reimbursement."[58]

The Medicare Contractor did file a response to the Board's RFI on March 8, 2022, but it did not add any new arguments. It merely copied excerpts from the Post-Remand Consolidated Final Position Paper filed June 2, 2021 that related to the Bad Debt Moratorium and Medicare Intermediary Manual provisions from 1985.

The Providers also filed a response to the Board's RFI on March 9, 2022. They claim the Memorandum Opinion and Order from the District Court "are final and binding on all parties (including the Secretary and the Board) and conclusively establish that there is not - and cannot be - a Remittance Advice Requirement [for the Providers] for the reporting periods at issue in [these cases]."[59] The directive from the District Court is clear: to "reconsider whether, *absent* the

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[53] Providers' Response to MAC's Post-Remand Consolidated Final Position Paper (July 6, 2021).
[54] *Id.* at 1.
[55] *Id.* at 2.
[56] *Kindred*, 2020 WL 3574614 at *8 (emphasis added).
[57] Provider's Response to MAC's Post-Remand Consolidated Final Position Paper at 3.
[58] Board Request for Information at 2 (Feb. 7, 2022).
[59] Providers' Response to Board Request for Information at 2 (Mar. 9, 2022).

Remittance Advice Requirement, the Providers are entitled to bad debt reimbursement."[60] This directive precludes the Board from applying any RA requirement, and the regulation at 42 C.F.R. § 413.89(e)(2)(iii) is merely a retroactive RA requirement, and "the entirety of these purported retroactive regulations conflicts with the District Court's ruling."[61]

The Providers argue that the obligation found at 42 C.F.R. § 405.1867 for the Board to comply with certain regulations "does not permit the Board to disregard a binding Court Order."[62] They also claim that 42 C.F.R. § 405.1875(f)(2) precludes the application of the new, retroactive regulations, because paragraph (iv) of that subsection declares that "[p]resentation of an alternative legal basis concerning an issue in dispute" is not an acceptable basis for remand. They further claim that 42 C.F.R. § 405.1888(c)(2) prohibits the Board reopening a decision "based on [a] change or legal interpretation or policy by CMS in a regulation." and concludes that this "preclude[s] the Board from considering any new requirements or interpretations in the retroactive regulations."[63]

The Providers claim that "the sole and exclusive focus of the retroactive regulations" at 42 C.F.R. § 413.89(e)(2)(iii)(A)(3) and (e)(2)(iii)(B)(1)(i) is the RA requirement, as evidenced by the discussion in the Federal Register that accompanied their promulgation.[64] According to the Providers, this requirement was rejected by the District Court, so the new regulations cannot "be applied without violating the court's valid and binding judgment."[65] The Providers also filed a Reply to the Medicare Contractor's Response to the Board's Request for Information on April 1, 2022. They claim that the Medicare Contractor's response was not responsive to the Board's request for information and simply argues the validity of the RA requirement, which is not at issue in this remand.[66]

The Board issued a Notice of Record Hearing on December 18, 2023 and the record officially closed on January 18, 2024.

C. Board's Analysis on Remand

At the outset, the Board notes that 42 C.F.R. § 405.1867 requires it to comply with certain regulations, including 42 C.F.R. § 413.89(e)(2)(iii) (2020). These amended regulations are to be applied retroactively and are applicable to the Providers and cost reports at issue in these cases. The District Court remanded these cases to the Administrator, which in turn remanded them to the Board, "to consider whether, absent the [RA] requirement, the Providers are entitled to bad debt reimbursement."[67] Thus, consistent with the District Court's remand order, the Board is

[60] *Id.* at 4.
[61] *Id.*
[62] *Id.* at 3.
[63] *Id.*
[64] *Id.* at 4.
[65] *Id.* at 4-5.
[66] Provider's Reply to Intermediary's Response to Board Request for Information at 2 (Apr. 1, 2022).
[67] Notice of Reopening Pursuant to the Deputy Administrator's Order of Remand at 5.

required to apply 42 C.F.R. § 413.89(e)(2)(iii) (2020), minus the explicit RA requirement to determine if the Providers are entitled to the bad debts as claimed.[68]

For Providers where a State permits a Medicare provider's Medicaid enrollment (whether as participating or nonparticipating) for the purposes of processing a beneficiary's claim, the Board is required to apply 42 C.F.R. § 413.89(e)(2)(iii)(A) ***except for*** 42 C.F.R. § 413.89(e)(2)(iii)(A)(3), which is the specific provision requiring an RA. Similarly, for Providers where the State does not permit a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, the Board must still apply 42 C.F.R. § 413.89(e)(2)(iii)(B) because these is no RA requirement; these are states in which obtaining an RA is not possible "because the State does not permit a Medicare provider's enrollment for the purposes of processing a beneficiary's claim, or because the State does not generate a Medicaid remittance advice. . ."[69]

1. States in Which the Kindred LTCHs and SNF <u>Could</u> Be Certified as Medicaid Providers But Did Not Enroll

Providers have a general obligation to furnish information requested by the Secretary to determine the amounts due to such provider. 42 U.S.C. § 1395g(a) states:

> 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 . . . . 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 . . . .

In addition to this requirement, Providers must maintain and furnish documentation to support any claimed costs. 42 C.F.R. § 413.20 states:

> (a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. . . .

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[68] The Board recognizes that the Providers contend that they "should be reimbursed promptly" because: (1) the District Court invalidated the RA Requirement which is "the sole basis on which the Bad Debts at issue were denied"; and (2) "the [Medicare Contractor] has not offered any other basis for denying reimbursement of the Bad Debts and no issues remain open as a basis for denying Providers reimbursement." Providers' Post-Remand Consolidated Final Position Paper at 13-14. The Board disagrees. In this regard, the Medicare Contractor's original decision relied upon the RA Requirement and did not reach any other arguments. More importantly, in its decision, the District Court made clear through the following statements that the Providers continue to have a burden of proof: (1) "[because] I conclude the RA Requirement violates the Bad Debt Moratorium, I do not reach Kindred's remaining arguments" (*Kindred*, 2020 WL 3574614 at *8); and (2) the District Court remanded to the Secretary "who is directed to reconsider whether, *absent the RA Requirement*, the Providers are entitled to bad debt reimbursement" (*Id.* (emphasis added)). Thus, the Board is directed to review other arguments, *apart from the RA Requirement*, and apply the relevant Medicare regulations, manual provisions and other guidance to determine whether the Providers are entitled to the bad debts as claimed. As discussed below, the Board finds that the Providers are not entitled to the bad debts as claimed.

[69] 42 C.F.R. § 413.89(e)(2)(iii)(B).

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> (d) *Continuing provider recordkeeping requirements*. (1) The provider must furnish such information to the contractor as may be necessary to—
>
> (i) Assure proper payment by the program, including the extent to which there is any common ownership or control (as described in § 413.17(b)(2) and (3)) between providers or other organizations, and as may be needed to identify the parties responsible for submitting program cost reports.
>
> (ii) Receive program payments; and
>
> (iii) Satisfy program overpayment determinations.

This general requirement is also emphasized in 42 C.F.R. § 413.24:

> (c) *Adequacy of cost information.* Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another.

Further, this documentation is generally expected to be contemporaneous (*i.e*., maintained in the ordinary course of business).[70]

The record before the Board shows that the Providers could have enrolled in the state Medicaid programs in: (1) Massachusetts;[71] (2) Tennessee;[72] and (3) beginning in 2012, Pennsylvania.[73] For the States allowing LTCH and SNF enrollment, the Providers had no excuse for not enrolling as a Medicaid provider and obtaining a Medicaid billing number. The Providers' decision *not* to enroll in a particular state Medicaid program (whether as participating or nonparticipating, as relevant) was a business decision.[74] Nor have they submitted ***any*** documentation (contemporaneous or

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[70] *See Community Hosp. of Monterey Peninsula v. Thompson*, 323 F.3d 782, 793 (9th Cir. 2003); *Mercy Gen. Hosp. v. Azar*, 410 F. Supp. 3d 63, 80 (D.D.C. 2019); *Maine Med. Ctr. v. Burwell*, 775 F.3d 470, 482 (1st Cir. 2015).

[71] Ex. A, Stipulations at ¶ 6 (stating Massachusetts Providers could have enrolled in the Massachusetts Medicaid Program as an acute inpatient hospitals *but have not attempted to do so*).

[72] *Id*. at ¶ 7.

[73] *See* Ex. P-1 and Ex. A, Stipulations at ¶ 5.

[74] *See* 85 Fed. Reg. at 59003 (". . . if the provider could have enrolled as a Medicaid provider, but chose not to do so for reasons such as inconvenience or a business decision, the evidence of non-enrollment would be an impermissible document to accept as an alternate to the Medicaid RA acceptance.").

otherwise)[75] which confirms that, with respect to the bad debts at issue, the state's Medicaid program is not responsible for Medicare coinsurance and deductibles of the relevant dual eligibles or QMBs. In this respect, the Board notes that the Providers made business decisions not to enroll in the state's Medicaid program and have not submitted any alternative documentation (*i.e.*, documentation in lieu of RAs[76]) that confirms the state's Medicaid program is not responsible for Medicare coinsurance and deductibles of the relevant dual eligibles or QMBs.

Indeed, following the remand of these nine cases, the Medicare Contractor requested "any and all documentation that [the Providers] believe supports [their] position that these bad debts should have been reimbursed."[77] The Providers have not at any point, following the remand of these cases, submitted any additional documentation that would illustrate compliance with either 42 C.F.R. § 413.89(e)(2)(iii)(A) (minus the RA requirement) or 42 C.F.R. § 413.89(e)(2)(iii)(B) (allowing for alternative documentation). The Providers have made clear that they believe "[t]he documentation that supports Kindred's position is in the administrative record[.]"[78]

As noted by the Secretary:

> Any amount that the State is obligated to pay [for a dual eligible patient], either by statute or under the terms of its approved Medicaid State plan, will not be included as an allowable Medicare bad debt, regardless of whether the State actually pays its obligated amount to the provider. However, the deductible and/or coinsurance amount, or any portion thereof, that the State is not obligated to pay and which remains unpaid by the beneficiary can be included as an allowable Medicare bad debt.[79]

Thus, without any documentation illustrating the amount a State is obligated to pay, the Medicare Contractor and the Board are unable to determine the amount of allowable Medicare bad debt. Based on the documentation in the record, the Kindred Providers *cannot demonstrate* their compliance with the requirements set forth in 42 C.F.R. § 413.89(e)(2) to establish that reasonable collection efforts have been made on the claimed bad debts. Specifically, as required by 42 C.F.R. § 413.89(e)(2)(iii)(A)(1), the Board is unable to determine whether each "State's

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[75] *See supra* notes 26-32 and accompanying text (discussing documentation that may be submitted in lieu of an RA).
[76] Ironically, in their original (*i.e*., pre-remand) Consolidated Final Position Paper, the Providers pointed to the November 1995 bad debt instructions for the CMS Form 339 (PRM 15-2, Ch. 11, Transmittal 4 (Nov. 1, 1995) (copy at Ex. P-4) to support their position that, prior to 2005, an RA was not required "where the provider can establish that Medicaid is not responsible for payment." Pre-Remand Consolidated Final Position Paper at 11 (quoting PRM 15-2, Ch. 11, Transmittal 4 attached thereto as Ex. P-4). The Providers then assert that consistent with that Transmittal (Ex. P-4), "the Provider's documentation of Medicaid eligibility and nonpayment was deemed sufficient to support crossover bad debt." *Id*. However, the Providers did not comply with those instructions. These instructions specify that, "to establish that Medicaid is not responsible for payment," the provider may, in lieu of billing, furnish documentation of Medicaid eligibility and proof that "non-payment would have occurred if the . . . claim had been filed with Medicaid." Ex. P-4 at 8-9. It is not clear from this statement what documentation of eligibility has been provided. Regardless, the Providers have not furnished any evidence that the States allowing LTCH and SNF enrollment are not otherwise responsible for payment under the relevant state Medicaid plan had a claim been filed.
[77] Supplemental Stipulations of Fact ⁋ 10 (July 12, 2021); Ex. B.
[78] *Id*. at ⁋⁋ 11, 13; Ex. B.
[79] 85 Fed. Reg. at 59000.

Title XIX Medicaid Program (or a local welfare agency, if applicable) is responsible to pay all or a portion of the beneficiary's Medicare deductible or coinsurance amounts." Without this information, the Providers cannot demonstrate that they have "reduce[d] allowable Medicare bad debt by any amount that the State is obligated to pay" and only "include[d] the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt" as required by 42 C.F.R. § 413.89(e)(2)(iii)(A)(4)-(5). *Nor have the Providers submitted any alternative documentation* (contemporaneous or otherwise) that would satisfy the requirements set forth in 42 C.F.R. § 413.89(e)(2)(iii)(B).[80]

The regulatory requirement to provide alternative documentation is consistent with PRM 15-1 § 322 as discussed above in **Subsection C** of the STATEMENT OF FACTS.[81] Regardless, it is prudent and sensible that the Medicare Program, as a payor secondary to the relevant state Medicaid program, would expect documentation to establish that: (1) these patients are in fact indigent by virtue of being Medicaid eligible to thereby by-pass the Providers' normal bad debt collection process under PRM 15-1 § 310; and (2) the relevant Medicaid program (*as the primary payor*) has no responsibility to pay or, if it does, how much that Medicaid program would pay so that the Medicare Program may determine its own liability, if any, to the Providers. Again, in this case, the Providers have not offered *any* documentation (whether an RA or other

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[80] In November 1995, CMS (then known as the Health Care Financing Administration or "HCFA") issued a similar policy statement in PRM 15-2 § 1102.3(L) (Transmittal 4, Nov. 1995) allowing for certain documentation as an alternative to RAs:

> Evidence of the debt arising from Medicare/Medicaid crossovers may include a copy of the Medicaid remittance showing the crossover claim and resulting Medicaid payment or non-payment. *However, it may not be necessary for a provider to actually bill the Medicaid program to establish a Medicare crossover bad debt* ***where the provider can establish that Medicaid is not responsible for payment***. *In lieu of billing the Medicaid program*, the provider must furnish documentation of:
>
> - *Medicaid eligibility* at the time services were rendered (via valid Medicaid eligibility number), and
> - *Nonpayment would have occurred* if the crossover claim had actually been filed with Medicaid.
>
> The payment calculation will be audited based on the state's Medicaid plan in effect on the date that the services were furnished. Providers should be aware of any change in the Medicaid payment formula that might impact the crossover calculation, and ensure that these changes are reflected in the claimed Medicare bad debt.

(Emphasis added.) On August 10, 2004, CMS issued the Joint Signature Memorandum 370 ("JSM-370") that withdrew § 1102.3L and reverted back to the pre-1995 language which required providers to bill state Medicaid programs before claiming Medicare bad debt. *See also In Providers – Medicare Inpatient/Outpatient Unbilled Bad Debts Group Appeals v. Noridian Healthcare Solutions, LLC*, PRRB Dec. No. 2015-D23 (Sept. 14, 2015), *affirmed*, CMS Adm'r (Nov. 12, 2015) (both the Administrator and the Board discuss some of the history behind PRM 15-2 1102(L) (1995)); *Maine Med. Ctr. v. Burwell*, 775 F. 3d 470, 475, 480 (1st Cir. 2015) (concluding that "some version" of a "must bill" policy has generally been enforced and that a general requirement (as opposed to a *per se* requirement) to obtain a Medicaid RA for crossover claims is entitled to deference where "the Secretary has made exceptions and accepted alternative documentation *from the State* where circumstances warranted the exception.") (emphasis in original)).

[81] Pursuant to PRM 15-1 § 322 and their burden under 42 C.F.R. § 405.1871(a)(3), the Providers must establish that that the relevant state Medicaid program is not responsible, *i.e.,* establish "*the State is* [*not*] ***obligated*** either by statute or under the terms of its plan *to pay all, or any part, of the Medicare deductible or coinsurance amounts*" and that the amount it is claiming for the bad debts is for that "***portion*** of deductible or coinsurance amounts that the State is not obligated to pay." PRM 15-1 § 322.

alternative documentation) to establish that the relevant state Medicaid program is responsible but would not make any payment on the services furnished notwithstanding the fact that, pursuant to 42 C.F.R. § 405.1871(a)(3), they "carr[y the] burden of production of evidence and burden of proof [to] establish[], by a preponderance of the evidence, that [they are] entitled to relief on the merits of the matter at issue."

Therefore, the Board concludes that the Medicare Contractor's disallowance of the Kindred Providers' bad debt was proper as it relates to the Providers located in Massachusetts, Tennessee, and, beginning in 2012, Pennsylvania.

2. States in Which the Kindred LTCHs Could Not Enroll as Medicaid Providers.

The Board's review of the record shows that LTCHs in the state of Pennsylvania prior to 2012 were unable to enroll in the state's Medicaid program and, therefore, were unable to bill the Pennsylvania Medicaid program.[82] At that time, Pennsylvania did not recognize nor reimburse LTCHs, including but not limited to the Kindred LTCHs. As a result, the LTCHs in Pennsylvania (prior to 2012) are specifically governed by 42 C.F.R. § 413.89(e)(2)(iii)(B) (2020).

While the Kindred LTCHs could not enroll in the state Medicaid program as LTCHs, the Board is still bound to apply 42 C.F.R. § 413.89(e)(2)(iii)(B) (2020).[83] The Board has previously found[84] that the Kindred LTCHs in Pennsylvania (prior to 2012) are providers that were "not recognized by the State Medicaid Agency as a Medicaid provider type . . ."[85] The record does not, however, contain any "calculation of the amount the State owes the provider for Medicare cost sharing"[86] or "verification of the beneficiary's eligibility for Medicaid for the date of service"[87] for any of these bad debts.[88] As noted by the Medicare Contractor, there could be instances where the State was liable for cost sharing, or the beneficiaries at issue may have had a gap in Medicaid coverage and, "[w]ithout support, the [Medicare Contractor] cannot assume the respective state is not liable."[89] The Board notes again that, following the remand of these nine cases, the Medicare Contractor requested "any and all documentation that [the Providers] believe supports [their] position that these bad debts should have been reimbursed"[90] but that the Providers have not submitted any new or supporting documentation (whether contemporaneous or otherwise). Again, as discussed above, the need for supporting documentation is consistent with PRM 14-1 § 322 and both prudent and sensible. Accordingly, the Board affirms the Medicare Contractor's dual eligible bad debt adjustment for periods prior to 2012 for the Kindred LTCHs located in Pennsylvania.

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[82] Ex. A, Stipulations at ¶ 5.
[83] 42 C.F.R. § 405.1867.
[84] *Kindred*, 2018-D5 at 8.
[85] 85 Fed. Reg. at 59003. *See also* 42 C.F.R. § 413.89(e)(2)(iii)(B)(1)(i).
[86] 42 C.F.R. § 413.89(e)(2)(iii)(B)(1)(ii).
[87] 42 C.F.R. § 413.89(e)(2)(iii)(B)(1)(iii).
[88] *See supra* notes 26-32 and accompanying text (discussing documentation that may be submitted to satisfy these requirements).
[89] MAC Post-Remand Consolidated Final Position Paper at 18.
[90] Supplemental Stipulations of Fact at ⁋ 10 ; Ex. B.

DECISION:

After considering the law and program instructions, the evidence presented, and the parties' contentions, the Board affirms: (1) the Medicare Contractor's dual eligible bad debt adjustments for the Providers that chose not to enroll in the Medicaid programs in Massachusetts, Tennessee, and, beginning in 2012, Pennsylvania; and (2) the Medicare Contractor's dual eligible bad debt adjustments where the state's Medicaid program (Pennsylvania - prior to 2012) would not enroll an LTCH.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD:

9/25/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

APPENDIX A
SCHEDULE OF PROVIDERS

SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Page No. 1 of 1

Group Name Kindred 06 LTCH/SNF Bad Debts

Date Prepared April 2, 2008

Representative Tracy M. Field, Arnall Golden & Gregory

Issue Bad Debt: Must Bill

Case No. 08-0585G

				A	B	C	D	E	F	G
Provider No.	Provider Name	FYE	Intermediary	Date of Final Determination	Date of Hearing Request	Number of Days	Audit Adjustment Number	Approx. Amount (in $'s)	Original Case No. (if any)	Date of Add/ Transfer
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	08/31/06	WPS Health Insurance	12/21/07	3/4/08	74	10, 11, 12	$121,206	N/A	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	08/31/06	WPS Health Insurance	1/11/08	3/4/08	53	15	$291,784	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	08/31/06	WPS Health Insurance	12/31/07	3/4/08	64	13, 14	$67,670	N/A	N/A
39-2032	Kindred Healthcare Delaware Darby, Delaware County, PA	08/31/06	WPS Health Insurance	1/2/08	3/4/08	62	16	$102,796	N/A	N/A
39-2043	Kindred Hospital Heritage Valley Beaver, Beaver County, PA	06/30/06	Mutual of Omaha Insurance	8/3/07	1/10/08	160	10	$45,126	N/A	N/A
44-5140	Primacy Healthcare & Rehab Memphis, Shelby County, TN	06/30/06	Mutual of Omaha Insurance	11/2/07	1/10/08	69	2	$83,044	N/A	N/A

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SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Page No. 1 of 1

Group Name Kindred 07 Bad Debts Appeals

Date Prepared December 11, 2009

Representative Tracy M. Field, Arnall Golden & Gregory

Issue Bad Debt: Must Bill

Case No. 09-1589GC

				A	B	C	D	E	F	G
Provider No.	Provider Name	FYE	Intermediary	Date of Final Determination	Date of Appeal	Number of Days	Audit Adj. No.	Amount in Controversy (Reimbursement Effect)	Original Case No. (if any)	Date of Add/ Transfer
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	08/31/07	WPS Health Insurance	11/26/08	05/04/09	159	9	$169,452	N/A	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	08/31/07	WPS Health Insurance	12/05/08	05/04/09	150	12	$367,993	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	08/31/07	WPS Health Insurance	12/23/08	05/04/09	132	9	$100,061	N/A	N/A
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	08/31/07	WPS Health Insurance	01/06/09	05/04/09	118	6	$203,999	N/A	N/A
39-2032	Kindred Healthcare Delaware Darby, Delaware County, PA	08/31/07	WPS Health Insurance	01/27/09	05/04/09	97	9	$279,040	N/A	N/A
44-5140	Primacy Healthcare & Rehab Memphis, Shelby County, TN	06/30/07	WPS Health Insurance	11/13/08	05/04/09	172	1	$124,356	N/A	N/A

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SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Group Name Kindred 08 Bad Debts Appeals

Page No. 1 of 1

Representative Glenn P. Hendrix, Arnall Golden Gregory LLP

Date Prepared November 29. 2010

Case No. ~~TBD~~ 10-0090GC

Issue Bad Debt: Must Bill

				A	B	C	D	E	F	G
Provider No.	Provider Name	FYE	Intermediary	Date of Final Determi-nation	Date of Appeal	Number of Days	Audit Adj. No.	Amount of Reimburs-ement	Origina l Case No. (if any)	Date of Add/ Transfer
39-2042	Kindred Hospital Wyoming Valley Wilkes Barre, Luzerne County, PA	02/29/08	WPS Health Insurance	08/6/09	11/3/09	89	7	$60,605	N/A	N/A
39-2043	Kindred Hospital Heritage Valley Beaver, Beaver County, PA	06/30/08	WPS Health Insurance	07/24/09	11/3/09	102	4	$23,042	N/A	N/A
44-5140	Primacy Healthcare & Rehab Memphis, Shelby County, TN	06/30/08	WPS Health Insurance	05/13/09	11/3/09	174	7, 9	$120,272	N/A	N/A
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	08/31/08	WPS Health Insurance	11/24/09	5/10/10	167	11	$169,795	N/A	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	08/31/08	WPS Health Insurance	11/20/09	5/10/10	171	9, 13	$247,699	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	08/31/08	WPS Health Insurance	01/15/10	5/10/10	115	9, 13	$315,471	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	08/31/08	WPS Health Insurance	01/19/10	5/10/10	111	9, 15	$127,467	N/A	N/A
39-2032	Kindred Hospital Delaware Darby, Delaware County, PA	08/31/08	WPS Health Insurance	01/14/10	5/10/10	116	7, 12	$141,512	N/A	N/A
39-2049 39-5110	Kindred Hospital Pittsburgh North Shore Pittsburgh, Allegheny County, PA	9/30/08	WPS Health Insurance	2/25/10	5/10/10	74	16	$75,695	N/A	N/A

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SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Group Name Kindred 09 Bad Debts Appeals **Page No.** 1 **of** 1

Representative Glenn P. Hendrix, Arnall Golden & Gregory **Date Prepared** 08/18/2015

Case No. 11-0028GC **Issue** Bad Debt: Must Bill

				A	B	C	D	E	F	G
Provider No.	**Provider Name**	**FYE**	**Intermediary**	**Date of Final Determination**	**Date of Appeal**	**Number of Days**	**Audit Adj. No.**	**Amount of Reimbursement**	**Original Case No. (if any)**	**Date of Add/ Transfer**
39-2042	Kindred Hospital Wyoming Valley Wilkes Barre, Luzerne County, PA	02/28/09	WPS Health Insurance	06/28/10	10/11/10	105	10	$24,821	N/A	N/A
39-2043	Kindred Hospital Heritage Valley Beaver, Beaver County, PA	06/30/09	WPS Health Insurance	04/23/10	10/11/10	171	9	$64,794	N/A	N/A
44-5140	Primacy Healthcare & Rehab Memphis, Shelby County, TN	06/30/09	WPS Health Insurance	09/07/10	10/11/10	34	5,6	$43,127	N/A	N/A
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	08/31/09	WPS Health Insurance	11/05/10	3/15/11	130	6	$149,220	N/A	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	08/31/09	WPS Health Insurance	01/18/11	3/15/11	56	11	$208,361	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	08/31/09	WPS Health Insurance	01/10/11	3/15/11	64	9,14	$358,601	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	08/31/09	WPS Health Insurance	12/17/10	3/15/11	88	8,12	$98,847	N/A	N/A
39-2032	Kindred Hospital Delaware Darby, Delaware County, PA	08/31/09	WPS Health Insurance	12/22/10	3/15/11	83	12	$285,108	N/A	N/A
39-2049	Kindred Hospital Pittsburgh North Shore Pittsburgh, Allegheny County, PA	09/30/09	WPS Health Insurance	12/21/10	3/15/11	84	6,10	$129,369	N/A	N/A

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SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Group Name Kindred 10 Bad Debts Appeals

Page No. 1 of 1

Representative Glenn P. Hendrix, Arnall Golden & Gregory

Date Prepared August 30, 2012

Case No. 12-0147GC

Issue Bad Debt: Must Bill

				A	B	C	D	E	F	G
Provider No.	Provider Name	FYE	Intermediary	Date of Final Determination	Date of Appeal	Number of Days	Audit Adj. No.	Amount of Reimbursement	Original Case No. (if any)	Date of Add/ Transfer
44-5140	Primacy Healthcare & Rehab Memphis, Shelby County, TN	6/30/2010	WPS Health Insurance	7/29/2011	1/23/2012	178	5, 6	$50, 079	N/A	N/A
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	8/31/2010	WPS Health Insurance	12/2/2011	1/23/2012	52	13	$150, 695	N/A	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	8/31/2010	WPS Health Insurance	11/18/2011	1/23/2012	66	6, 10	$315, 918	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	8/31/2010	WPS Health Insurance	11/18/2011	1/23/2012	66	9, 13	$87, 320	N/A	N/A
39-2032	Kindred Hospital Delaware County Darby, Delaware County, PA	8/31/2010	WPS Health Insurance	12/21/2011	1/23/2012	33	7, 11	$233, 066	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	8/31/2010	WPS Health Insurance	12/22/2011	1/23/2012	32	12	$409, 251	N/A	N/A
39-2049, 39-6110	Kindred Hospital Pittsburgh North Shore Pittsburgh, Alleghany County, PA	9/30/2010	WPS Health Insurance	12/21/2011	1/23/2012	33	8, 14	$74, 695	N/A	N/A
39-2043	Kindred Hospital Heritage Valley Beaver, Beaver County MA	6/30/2010	WPS Health Insurance	10/21/2011	4/17/2012	179	8	$160,363	N/A	N/A

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SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

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Group Name Kindred Healthcare 2011 Bad Debts CIRP Group

Representative Glenn P. Hendrix, Arnall Golden & Gregory

Date Prepared March 28, 2014

Case No. 13-2822GC

Issue Bad Debt: Must Bill

Lead Intermediary WPS Health Insurance

				A	B	C	D	E	F	G
Provider No.	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case No(s).	Date of Direct Add/ Transfer(s) to Group
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	8/31/2011	WPS Health Insurance	5/1/2013	08/13/2013	104	8, 12	$201,701	N/A	N/A
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	8/31/2011	WPS Health Insurance	4/15/2013	08/13/2013	120	7, 12	$180,889	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	8/31/2011	WPS Health Insurance	2/18/2013	08/13/2013	117	9, 15	$590,684	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	8/31/2011	WPS Health Insurance	4/12/2013	08/13/2013	123	8, 14	$144,220	N/A	N/A
39-2032	Kindred Hospital Delaware County Darby, Delaware County, PA	8/31/2011	WPS Health Insurance	4/5/2013	08/13/2013	130	8, 11	$278,502	N/A	N/A
39-2049	Kindred Hospital Pittsburgh North Shore Pittsburgh, Alleghany County, PA	9/30/2011	WPS Health Insurance	5/16/2013	08/13/2013	89	18	$84,357	N/A	N/A

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SCHEDULE OF PRRB PROVIDERS: BAD DEBTS

Group Name Kindred 12 Bad Debts Appeals

Page No. 1 of 1

Representative Glenn P. Hendrix, Arnall Golden & Gregory

Date Prepared 8/18/2015

Case No. 14-1622GC

Issue Bad Debt: Must Bill

				A	B	C	D	E	F	G
Provider No.	Provider Name	FYE	Intermediary	Date of Final Determination	Date of Appeal	Number of Days	Audit Adj. No.	Amount of Reimbursement	Original Case No. (if any)	Date of Add/ Transfer
22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	08/31/12	WPS Health Insurance	11/18/13	01/03/14	46	8	$230,415	N/A	N/A
39-2028	Kindred Hospital Pittsburgh Oakdale, Allegheny County, PA	08/31/12	WPS Health Insurance	11/25/13	01/03/14	39	13	$114,656	N/A	N/A
39-2042	Kindred Hospital Wyoming Valley Wilkes Barre, Luzerne County, PA	02/28/12	WPS Health Insurance	07/05/13	01/03/14	182	6,9	$160,551	N/A	N/A
39-2043	Kindred Hospital Heritage Valley Beaver, Beaver County, PA	06/30/12	WPS Health Insurance	11/27/13	01/03/14	37	5	$66,566	N/A	N/A
39-2027	Kindred Hospital Philadelphia Philadelphia, Philadelphia County, PA	08/31/12	WPS Health Insurance	01/17/14	03/12/14	54	15	$440,262	N/A	N/A
22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	08/31/12	WPS Health Insurance	01/31/14	03/24/14	52	10	$166,374	N/A	N/A
39-2049	Kindred Hospital Pittsburgh North Shore Pittsburgh, Allegheny County, PA	09/30/12	WPS Health Insurance	03/14/14	04/14/14	31	10	$86,111	N/A	N/A
39-2046	Kindred Hospital South Philadelphia Philadelphia, Philadelphia County, PA	10/31/12	Novitas Solutions	09/11/14	09/24/14	13	16	$255,266	N/A	N/A
39-2032	Kindred Hospital Delaware County Darby, Delaware County, PA	10/31/12	Wisconsin Physicians Service	06/24/15	07/28/15	34	4	$202,208	N/A	N/A

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MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

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Case No.: 15-3239GC

Date Prepared September 4, 2015

Group Name Kindred Healthcare 2013 Bad Debts CIRP Group

Group Representative Glenn P. Hendrix, Arnall Golden & Gregory

Lead Intermediary WPS Health Insurance

					A	B	C	D	E	F	G
#	Provider No.	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case No(s).	Date of Direct Add/ Transfer(s) to Group
1	22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	8/31/2013	WPS Health Insurance	5/21/2015	08/18/2015	89	8	$143,341	N/A	N/A
2	22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	8/31/2013	WPS Health Insurance	7/20/2015	08/18/2015	29	12	$252,746	N/A	N/A

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MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

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Case No.: 16-1252GC

Date Prepared May 25, 2017

Group Name Kindred Healthcare 2014 Bad Debts CIRP Group

Group Representative Glenn P. Hendrix, Arnall Golden & Gregory

Lead Intermediary WPS Health Insurance

					A	B	C	D	E	F	G
#	Provider No.	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case No(s).	Date of Direct Add/ Transfer(s) to Group
1	22-2044	Kindred Hospital Boston North Shore Peabody, Essex County, MA	8/31/2014	WPS Health Insurance	11/24/2015	03/04/2016	111	12	$150,398	N/A	N/A
2	22-2045	Kindred Hospital Boston Boston, Suffolk County, MA	8/31/2014	WPS Health Insurance	11/11/2015	03/04/2016	124	12	$230,800	N/A	N/A