CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
SD 94/95/96-97 Inpatient Crossover Bad Debts Groups/Sharp HC 97 Inpatient Unproc Crossover Bad Debts Grp San Diego County, California	**Medicare Reimbursement Cost Reporting Period(s) Ending: Various -1994, 1995, 1996 and 1997**
Providers	
vs.	
Blue Cross Blue Shield Association/ National Government Services, Inc.	**Review of: PRRB Dec. No. 2010-D20 Dated: March 18, 2010**
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 parties were notified of the Administrator's intention to review the Board's decision. CMS' Center for Medicare (CM) commented, requesting reversal of the Board's decision. The Intermediary 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 Providers have been properly paid for bad debts for Medicare deductible and coinsurance amounts associated with Medicaid eligible inpatients for services between May 1, 1994 and June 30, 1998.

The Board found that the Intermediary improperly denied the Providers the right to claim additional Medicare bad debts. The Board stated that it believed the Intermediary had the documentation necessary to easily determine the amounts in which the State was not obligated to pay. The Board found that the contractual agreement between the State of California and CMS did define a process for determining bad debts. The Board stated that both the Providers and Intermediary appropriately followed CMS directives as well as the process and concluded that the Providers made an effort to request reimbursement for all Medicare deductible and coinsurance amounts attributable to dual eligible patients from the State. The Board held that all the bad debts at issue were billed by the Providers as supplied by the Statistical and Reimbursement System (PS&R) reports. In addition, the inpatient crossover claims data was directly transferred to the State Medicaid agency, Medi-Cal, by the Intermediary pursuant to a system which automatically transferred Medicare claims data to the Medicaid program.

The Board further found that the Intermediary incorrectly used §322 Part I of the Provider Reimbursement Manual (PRM) to deny crossover bad debts. According to the Board, that section interprets the Medicare bad debt regulation at 42 CFR §413.80 to provide that where the State is obligated to pay all or any part of the Medicare deductibles or coinsurance amounts, the amounts are not allowed by Medicare. It further states that any portion of such amounts that the State is not obligated to pay can be included. The Board found that based on the Agreement, the process of automatic transfer of claims data and accountability of bad debts in the PS&R reports, the Intermediary could easily determine the amounts which the State is not obligated to pay. The Board concluded that, if any refunds results after Medicare bad debts have been determined, the Intermediary can later offset those recoveries when they are received.

SUMMARY OF COMMENTS

CM commented, requesting reversal the decision of the Board. CM stated that the bad debts in question should be disallowed because the Providers failed to determine that the debt was actually uncollectible when claimed as worthless as required under section 413.89(e)(3) of the regulation and Chapter 3 of the PRM. Since the State failed to make a determination of its cost sharing liability, the Providers should look to the State for a possible resolution.

According to CM, the Board's opinion that the Intermediary had documentation to determine the amounts in which the State is not obligated to pay is incorrect and, therefore, these amounts cannot be verified until the State makes such a determination. The State

maintains the most current and accurate patient and financial information to determine the beneficiary's dual eligible status, at the time of service, and to determine the State's cost sharing liability for all covered stays of dual eligible beneficiaries including QMBs.

CM stated that a Provider must bill the State and the State process the bills/claims to produce a remittance advice for each beneficiary to determine a patient's Medicaid status, at the time of service and to determine the State's liability for payment of Medicare deductible and coinsurance amounts. Under section 413.89(e)(3) of the regulation, it is unacceptable for a provider to write off a Medicare dual eligible beneficiary bad debt as worthless without first billing the State. Even if the Providers believed it had calculated that the State has no liability for outstanding deductible and coinsurance amounts, the Providers must bill the State and receive a remittance advice before claiming a bad debt as worthless. The State has the most current patient eligibility and financial information to make the most accurate determination of its liability through its automated billing system.

In addition, CM noted that the Board stated that a contractual agreement between the State of California and CMS did define a process for determining bad debts. The Medicare bad debts related to crossover claims are controlled by the settlement agreement between CMS, the State of California, and the Plaintiff Hospitals. CM asserted that the Providers were informed that any disagreement with the details of the reprocessing reports should be taken up with the State of California.

According to CM, in order to comply with section 413.89(e)(3) of the regulations and section 322 of the PRM, Medicare policy requires a provider to document the State's liability for any cost sharing amounts related to unpaid Medicare deductible and coinsurance amounts for dual eligible beneficiaries. To effectuate this, Medicare has required the Providers to bill the State to determine if the State is or is not liable for payment (cost sharing liability) – referred to as the "must bill" policy. This allows a claim by claim adjudication to determine the State's cost sharing liability.

CMS clearly outlined the "must bill" policy for reimbursement of bad debts associated with dual eligible beneficiaries in a Joint Signature Memorandum (JSM) issued to all intermediaries on August 10, 2004 (JSM-370). JSM-370 properly reiterated the instructions that were issued in Change request 2796 on September 12, 2003. Change Request 2796 was issued as a direct result of the Ninth Circuit Federal Court decision which upheld the Secretary's discretion to apply the must bill policy for dual eligible beneficiaries.[1]

[1] See, Community Hospital of Monterey Peninsula v. Thompson, 323 F.3d 782 (9th Cir. 2003)

Accordingly, Change Request 2796 revised section 1102.3L of the PRM, Part II (Exhibit 5 to Form CMS-339) to require providers to submit, in part, the following; the patient's name, Medicare and Medicaid numbers, dates of service that correlate to the bad debt, and the remittance advice dates that will enable CMS' Medicare Administrative Contractor (or Medicare Intermediary) to verify the authenticity of the Medicare patient and the related bad debt.

The original language in PRM-II Section 1102.3L, that was added in November of 1995, was deemed by the Ninth Circuit Court of Appeals as being "inconsistent with the Secretary's must bill policy…" The Court stated that, "Because a regulation has the force of law, an interpretation of the regulation in Part II of the PRM 'that is inconsistent with [the] regulation [should] not be enforced.'[2]

The Court further stated that, "Effective in August of 1987, Congress imposed a moratorium on changes in the bad-debt-reimbursement policies, and the Secretary lacked authority in November 1995 to effect a change in policy." As a result of the Ninth Circuit decision, Change request 2796 changed the language in the PRM-II Section 1102.3L to revert back to pre-1995 language which offers no alternative to billing the individual States.

A beneficiary's Medicaid status at the time of service should be used to determine their eligibility for Medicaid in order to satisfy the requirement in section 312 of the PRM, and to determine the State's cost sharing liability. A beneficiary's financial situation and Medicaid eligibility status may change over the course of a very short period of time. The State maintains the most current patient eligibility and financial information to make the most accurate determination of its cost sharing liability for unpaid Medicare deductibles and coinsurance.

Thus, JSM-370 restated Medicare's longstanding bad debt policy that 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, 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's responsibility to determine its cost sharing liability concerning dual eligible beneficiaries is critical because individual States maintain complex billing systems and

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[2] See, Nat'l Med. Enters. v. Bowen, 851 F.2d 291, 293 (9th Cir. 1988).

documentation requirements unique to each State program. This determination is more important for the Medicaid eligibility category known as a Qualified Medicare Beneficiary (QMB) which was established by the Medicare Catastrophic Act of 1988- years after the last change to Chapter 3 of the PRM January 1983. QMBs are individuals who meet the definition in section 1905(p)(1) of the Social Security Act. QMBs may be eligible for full Medicaid or may have Medicaid eligibility limited to payment of Medicare Part A and B premiums and Medicare cost sharing (deductibles and coinsurance). All QMBs are Medicare beneficiaries, entitled to the full range of Medicare-covered services and Medicare provider options, without regard to whether those services are covered under the Medicaid State Plan, and are eligible for Medicaid payment of their cost sharing expenses. The State's responsibility to determine its cost sharing liability for QMBs is further described at section 3490.14(A) of the State Medicaid Manual (CMS Pub. 45) (SMM); *Payment of Medicare Part A and Part B Deductibles and Coinsurance—State Agency Relationship.*

CM also stated that section 1905(p)(3) of the Act imposes liability for cost sharing amounts for QMBs 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 eligible coinsurance amounts if the Medicaid rate is lower than what Medicare would pay for the service. However, in most cases, the State will always be liable to pay for a beneficiary's unpaid deductible amounts. For QMBs, section 3490.14(A)(1) and (2) of the SMM requires the State Agency to provide, through the State Plan, the payment rates applicable for services that are covered or not covered, respectively, by the State Plan to determine the amount of Medicare coinsurance and deductibles that the State is responsible to pay.

The Intermediary commented, requesting reversal the Board's decision. The Intermediary stated that while the California's Medicaid program historically paid the full cost sharing of for all inpatient crossover claims, in 1994 the State of California stopped paying coinsurance and deductible amounts for in-patient crossover claims, beginning with admissions on or after May 1, 1994. Because the State's action violated its approved Medicaid plan, Intermediaries were instructed not to allow unpaid Medicare coinsurance and deductible amounts for crossover claims as bad debts on the Medicare cost reports. Litigation ensued over whether or not the State had an obligation to pay for crossover claims. During this period, the State was not processing crossover claims, but automatically zeroing out the crossover bills.

In late 1998, the State agreed to settle the litigation and reprocess crossover claims by March 31, 1999. Medicare then agreed to take the State determination of crossover claims and use it to reimburse providers for crossover bad debts for the period May 1, 1994 and April 4,

1999. The Intermediary was instructed to make a lump sum payment (actually broken in two payments) to the Providers based on the reprocessing of crossover claims by the State of California. Providers were told that if they had problems with the computation of the Medicare bad debt amount, they should contact the Intermediary. However, if they had problems with specific claims data included or excluded from the State report, they should contact the State.

The Intermediary contended that Medicare payment for bad debts related to crossover claims is controlled by the settlement entered into by CMS, and the State of California. The lump sum payments were based on the State's reprocessing of crossover claims, and each hospital was given a copy of the detail of that reprocessing. Providers were informed that any disagreement with the detail in the reprocessing of crossover claims should be taken up with the State of California. Accordingly, the Intermediary stated that the Board's decision is in conflict with the settlement entered into by CMS and should be reversed.

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

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,[3] which provides that the determination of reasonable cost must be based on costs actually incurred and related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. The regulation states that the objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. However, if the provider's costs include amounts not reimbursable under the program, those costs will not be allowed.

Consistent with these reasonable cost principles and payment requirements, the regulatory provision at 42 CFR 413.89(a) (2004)[4] 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

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

[4] Formerly designated at 42 CFR 413.80 and redesignated in 2004 at 42 CFR 413.89 without substantive change.

> 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. 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. Bad debts arising from other sources are not an allowable cost. (Emphasis added.)

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.
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> 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.
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> 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[5] 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.)

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[5] Sections 1905(p)(1) and 1905(p)(3) of the Act requires State participation in payment of coinsurance and deductibles for QMBs although it may be limited. Thus, the first paragraph of section 322 in that respect does not reflect the latest version of the Medicaid Act regarding QMBs when it states: "Effective with the 1967 amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically needy or medically needy persons...."

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. (Emphasis added.)

The patients' Medicaid status at the time of service should be used to determine their eligibility for Medicaid to satisfy the requirement of section 312. A patient's financial situation and Medicaid eligibility status may change over the course of a very short period of time. The State maintains the most accurate patient information to make the determination of a patient's Medicaid eligibility status at the time of service and, thus, to determine 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 and the State had rendered a determination on such a claim.

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.[6] 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 and receive a determination by the State on such a claim.[7] The memorandum noted that in, Community Hospital of the Monterey Peninsula v. Thompson, supra, (2008), the Ninth Circuit upheld this policy of the Secretary.[8] 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 and essentially pay nothing towards dual-eligible cost-sharing if the Medicaid rate is lower than what Medicare would pay for the service.[9] Where the State owes none, or a portion of the dual-eligible deductible and coinsurance amounts, the unpaid liability for the bad debt is not reimbursable until the provider bills the State and the State refuses payment, all of which is demonstrated through a Remittance Advice.

Importantly, the memorandum also indicated that, in November 1995, language was added to the PRM at section 1102.3L, which was inconsistent with this policy.[10] The Ninth Circuit panel found that section 1102.3L was inconsistent with the Secretary's policy and also noted that, effective in August of 1987, Congress had imposed a moratorium on changes in bad debt reimbursement policies and, therefore, the Secretary lacked authority in November of 1995 to 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

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[6] JSM 370 (Aug. 10, 2004), Intermediary's Final Position Paper (Oct. 25, 2004), Ex. I-2
[7] Id.
[8] Id., citing 323 F.3d 782.
[9] Id.
[10] Id.

requires providers to bill the individual States for dual-eligibles' co-pays and deductibles before claiming Medicare bad debts.[11]

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 11102.3L instructions for cost reporting periods prior to January 1, 2004, may reimburse providers they service for dual eligible bad debts with respect to unsettled cost reports that were deemed allowed using other documentation in lieu of billing the State. Intermediaries that required the provider to file a State Remittance Advice for cost reporting periods prior to January 1, 2004 may not reopen the provider's cost reports to accept alternative documentation for such cost reporting periods. This hold harmless policy affects only those providers with cost reports that were open as of the date of the issuance of the memorandum relating to cost reporting periods before January 1, 2004 and who relied on the previous language of section 1102.3L in providing documentation.[12]

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 section 1102.3L of the PRM, Part II (Exhibit 5 to Form CMS-339)[13] 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.

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[11] See Change Request 2796, issued September 12, 2003.

[12] Id.

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

As has been noted, it is only through the State's records and claims system can the amount of any payment be determined and in most cases the State will always be liable to pay for a beneficiary's unpaid deductible amounts. The policy requiring a provider to bill the State and receive a determination on that claim, where the State is obligated *either by statute or under the terms of its plan to pay all, or any part of* the Medicare deductible or coinsurance amounts, is consistent with the general statutory and regulatory provisions relating specifically to the payment of bad debts and generally to the payment of Medicare reimbursement. As reflected in 42 CFR 413.89(d)(1), the costs of Medicare deductible and coinsurance amounts which remain unpaid (i.e. were billed and a State determination on the bill received) may be included in allowable costs. In addition, paragraph (e) of that regulation requires, *inter alia*, a provider to establish that a reasonable collection effort was made and that by receiving a determination from the State, the debt was actually uncollectible when claimed.

A fundamental requirement to demonstrate that an amount is, in fact, unpaid and uncollectible, is to bill the responsible party. Section 310 of the PRM generally requires a provider to issue a bill to the party responsible for the beneficiaries' payment. Section 312 of the PRM, while allowing a provider to deem a dually eligible patient indigent and claim the associated debt, first requires that no other party, including the State Medicaid program is responsible for payment. Section 322 of the PRM addresses the circumstances of dually eligible patients where there is a State payment ceiling. That section states that the "amount that the State does not pay" may be reimbursed as a Medicare bad debt. This language plainly requires that the provider bill the State as a prerequisite of payment of the claim by Medicare as a bad debt and that the State make a determination on that claim. 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.[14]

[14] *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 CMS 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 CMS 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.

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 ensuring that the State has been billed (whether through the automated crossover claim or direct billing) and having received a determination from the State as to the amount of its financial obligation. 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.[15]

In this case, until 1994, the State of California's Medi-cal program generally paid 100 percent of the Medicare deductible and coinsurance. On May 1, 1994, Medi-Cal stopped paying 100 percent due to a new State policy. Payment for coinsurance and deductibles was limited to the Medicaid payment rate for services provided to qualified Medicare beneficiaries (QMBs) and other Medicaid patients. If the Medicare payment was lower than the amount Medicaid would have paid had it been the primary payer, Medicaid would pay the difference of the two payments up to the amount of deductible and coinsurance. However, Medi-Cal implemented this new policy prior to obtaining approval from CMS to amend its' State Plan.
On February 28, 1996, CMS approved the State Plan retroactively to May 1, 1994, allowing Medi-Cal to pay for the deductible and coinsurance if the Medicaid rate exceeded the

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[15] 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.

Medicare rate. Subsequently, by a letter dated November 24, 1997, CMS issued guidance to all State Medicaid Directors explaining the implementation of the effects of the Balanced Budget Act of 1997 on QMBs. The letter pointed out that the requirement for Medicaid to pay Medicare cost-sharing for QMBs was originally enacted in the Medicare Catastrophic Coverage Act of 1988. The State Medicaid Manual, addressing that requirement, provided that States have the option to pay Medicare cost-sharing in amounts based either on the full Medicare-approved amount, or on the amount that the State pays for the same service on behalf of a Medicaid recipient not entitled to Medicare. Because some Federal courts had interpreted the Medicaid law as not giving States this choice, the section 4714 of the Balanced Budget Act of 1997 (BBA) was enacted that clarified that States have flexibility in establishing the amount of payment for Medicare cost-sharing in their Medicaid State plans. The letter explained specifically that section 4714 of BBA amended section 1902(n) of the Social Security Act to clarify that a State is not required to provide any payment for any expenses incurred relating to Medicare deductibles, coinsurance, or copayments for QMBs to the extent that payment under Medicare for the service would exceed the amount that would be paid under the Medicaid State plan if the service were provided to an eligible recipient who is not a Medicare beneficiary.

In the meantime, several California hospitals filed a lawsuit in United States Federal Court against the California Department of Human Services, the State agency responsible for Medi-Cal, seeking prospectively to compel full payment of Medicare coinsurance and deductibles for all QMB claims. Initially, the hospitals obtained a favorable United States District Court ruling enjoining Medi-Cal from paying less than the full amount of the Medicare coinsurance and deductibles.[16] However that case was subsequently reversed in Beverly Community Hospital Association vs. Belshe, 132 F3d 1259 (9th Cir. 1997), where the Ninth Circuit Court of Appeals addressed the issue of whether the Balanced Budget Act of 1997, which included §4714 amending 42 USC §1396(n), could be applied retroactively. The parties to the appeal in Beverly Community Hospital Association did not dispute that if the new statutory provision (which Congress had captioned "Clarification Regarding State Liability for Medicare Cost-Sharing") was applicable, then the previous decision by the District Court should be reversed. The Ninth Circuit Court of Appeals stated that Congress was deliberately targeting what were known to be existing disputes involving §4714(c) of the BBA 1997 and went on to prescribe a retroactive effective date of the amendment to the statute. Accordingly, the Circuit Court concluded that Section 4714 of the BBA 1997 was a

[16] See, Beverly Community Hospital Association vs. Belshe, 132 F3d 1259 (9th Cir 1997) (the initial District Court decision that found on behalf of the California hospitals was reversed by the Ninth Circuit of Appeals.)

clarification of the original intent of Congress when it passed Section 1396(n), and thus, could be applied retroactively.

Subsequent to the Circuit Court's decision in Beverly Community Hospital Association, and pursuant to an agreement with CMS, the State of California reprocessed the claims in its system. The State processed claims for dates between May 1, 1994 through April 4, 1999 and determined its cost sharing obligations. The State Medi-Cal program furnished reports to the Intermediary showing the claim comparison of the amount paid by Medicare and the Medicaid payment rate for inpatient dual eligible claims for the time period of May 1, 1994 through April 4, 1999. Based on these reports the Intermediary issued lump sum payments to hospitals for the Medicare coinsurance and deductible amounts retroactively to May 1, 1994 that were unpaid by the State. Having received a State determination on these claims listed, the related unpaid coinsurance and deductible amounts were considered allowable Medicare bad debts by CMS. The final reports produced by Medi-Cal regarding inpatient claims in the Medicaid claims system and the lump sum payments were furnished to the Providers in August, 1999. Upon review of the reports, the Providers believed the reports did not include all inpatient claims during the period allegedly covered by the lump sum payments.

The Provider maintained that not all claims were included in the Medicare bad debt listing for the lump sum payment and that the State was not cooperating and would not address the claims at issue. They alleged that the PS&R and the DSH Medicaid eligibility data could be used to compute the Medicare bad debts. The Board found that the Providers had complied with the Medicare billing requirements, primarily it seems, because the Board found that Medicare inpatient claims were automatically "crossed-over" to the Medicaid claims system. By billing Medicare, it seems that under the Board's interpretation of the Medicare bad debt provisions, the Providers had fulfilled their obligations. Using the DSH Medicaid data and PS&R, the Board concluded that there was sufficient documentation for the Intermediary to determine the Medicare bad debts. However, the Intermediary concluded that the contested claims were never filed with the State or otherwise processed by the Medicaid agency and hence not part of the negotiated lump sum payment.[17] Only claims submitted to the Medicaid agency (whether by automated crossover or direct billings), for which there was a State determination of the State obligation, would have been part of that payment.[18]

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[17] *See*, e.g., Tr. 72, Provider Exhibit P-10 (Intermediary letter dated April 1, 1099).

[18] The Providers also did not submit Medicaid remittance advices showing "crossover claims" contemporaneous with the period which were not included in the listing upon which the Medicare bad debts payment was made.

The record shows that the bad debt claims on the listing used to make the Medicare bad debt payment were the reprocessed claims in the Medi-Cal programs system for those periods.[19] The Intermediary letter dated April 1, 1999, explained to the Provider that "the state has agreed, effective around April 1999 to process prospective crossover claims in accordance with HCFA's expectations. Furthermore, the State has agreed to reprocess retroactive crossover claims *in its system* [i.e., billed claims] dating back to May 1, 1994 to determine its cost sharing obligations."[20] The Intermediary's August 24, 1999 letter to the provider

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[19] Despite suggestions otherwise, the Medicare bad debt lump payment was consistent with the "must bill" policy as it was based on claims (bills) submitted to the Medicaid agency (whether by direct billing or crossover claims) upon which the State made determinations of its obligation prior to Medicare allowing the bad debt.

[20] See also *The Medicare/Medi-Cal Crossover Claims Overview*, dated September 2000, stated that: "Some Medi-Cal recipients are eligible for services under the federal Medicare program. For most services rendered, Medicare requires a deductible and/or coinsurance that, in some instances, is paid by Medi-Cal. A claim billed to Medi-Cal for Medicare deductible and coinsurance is called a crossover claim. This type of claim has been approved or paid by Medicare. This section contains eligibility information and general guidelines about Medicare/Medi-Cal crossover claims. Legal Constraints. Medi-Cal Reimbursement—California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services…. The following exceptions apply to Qualified Medicare Beneficiaries Medicare Beneficiaries (QMBs) for claims with dates of service before August 1, 1999. See "Crossover Programs" on a following page for additional information on the QMB program. Exception 1: For Part A inpatient crossover claims for recipients with aid code(s) 10, 20, 60 and/or 80 ("pure QMB" and "QMB plus" recipients), Medi-Cal reimburses the amount of the Medicare deductible and coinsurance (cost-sharing). This reimbursement is allowed pursuant to a federal court order in Beverly Community Hospital v. Belshe, effective December 11, 1995. For QMBs identified as "QMB only" recipients, Medi-Cal will render retroactive reimbursement for acute care hospital inpatient crossover claims for dates of service on or after May 1, 1994 (*State Plan Amendment 94-008*). QMB only recipients are identified by Medi-Cal with aid code 80 only. Retroactive reimbursement for QMB only recipients must be offset by subtracting any previously allowed Medicare "Bad Debt Allowance." Exception 2: For recipients with aid code 80 only (QMB only), Medi-Cal reimburses the full Medicare Part B deductible and coinsurance."
http: files. medi-cal.ca.gov/pubsdoco/publications/.../ medicare_z01.doc

specifically explained that "any disagreement related to claims data contained in and/or missing from the reports has to be addressed with the State."[21] Regarding the claims that were in the Med-Cal system, the Intermediary claims manager, during the cost years at issue, indicated that the Intermediary did have the ability to automatically crossover Medicaid claims to the State. However, the claims manager stated there were problems with the system and the "crossover' did not always work properly. As a result, some claims did not automatically transfer to Medicaid.[22]

For the periods at issue and prior to the State's reprocessing of the claims, the Providers' witness was also aware of this cross over process explaining that the Providers submitted bills to Medicare and Medicare would send information (the claim) to Medi-Cal and Medi-Cal would process the claim and pay the bill.[23] The Providers' witness acknowledged that contemporaneous with the cost years at issue, the Providers employed an outside contractor "to start finding out how much is going though the system and then started dropping some bills directly to Medi-Cal but not of all of them."[24] The witness stated that a contractor was hired "because we realized within the industry that people were all having problems and that the way to correct the situation was to start hiring people to drop bills directly to Medi-Cal."[25] The Providers' witness further clarified that: "They are all suppose to come over. We don't know why months are missing. This was new to us. All of a sudden things started going haywire in the process. We don't control the process. We just thought they were going to correct the process by the time they were done, but they did not."[26] (Emphasis added.) However, while the crossover process may have been out of the Providers control, it was within their control as they themselves have demonstrated, to identify and direct bill those claims that did not successfully cross over to the Medicaid system.

Regarding the claims that appeared on the reprocessed list used by CMS to pay the Medicare bad debt, the Provider stated that both billed and cross-over claims were on the list.[27] The

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The State publication also stated that claims that require direct Medi-Cal billing included claims that should be cross-over claims, but have not shown up on the remittance advice within three weeks.

[21] Provider Exhibit 2.

[22] Provider Exhibit 11.

[23] Tr. 84.

[24] Tr. 85

[25] Tr. 93-94.

[26] Tr. 85.

[27] *See* Tr. 92-93. ("Q. The things that did appear on the listings …were those claims that the hospital submitted separate bills for? A. Not all of them. Some of those [claims that were on

Provider witness acknowledged that the contractor work, directly billing claims that were determined not to have automatically crossed over (determined through the examination of the Medicaid remittance advices), was positively reflected in the fact that the "dollar amount" (and hence missing claims) decreased in later periods (concurrent with the work of the contractor) when the listing at issue is examined across all the cost years involved.[28] While not determinative of this case, the record thus supports a conclusion that these claims were not in the State's system, that is, they were not billed whether through the automated crossover claims billing or direct billing and, therefore, as they were not in the State system they were not part of the claims reprocessed by the State in the listing.

This case turns on the undisputed fact there are no determinations by the State on these claims. The Administrator finds that, in order to determine the State's liability and, likewise, the amount of coinsurance and deductible attributable to Medicare bad debt, the Providers must first resolve the issue with the State and receive a determination from the State on the amount of the State obligation on the claims at issue. The shorthand reference to the policy at issue as the "must-bill" policy does not fully capture the requirements that must be met. The policy not only requires that the claim be billed, but that a determination must be made

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the listing] would have been from the time that we hired an outside group to bill anything that wasn't found through the cross over process. Some of those would have been in there but it had claims in there that we had not billed directly to the State because they went through the cross over process. So yeah, then the listing included billed claims to the Medicare program that crossed over that weren't [directly] billed to the Medicaid program.") The Provider did not document that cross-over claims—that is, claims that actually showed up on a Medicaid remittance advice as billed to Medicaid through the crossover process—were missing from the list.

[28] Tr. 97-99. ("Q So the lists that…the claims that were on that were claimed—you're saying some of those claims would have been claims that went through this crossover process? A. Yeah, it's a mixture. Some bills were bills they're all billed to Medicare and they were all crossed over. Medicaid just missed a bunch and those that were missed in the later years were actually half so it's a mixture of some billed directly to Medicaid but all of them billed directly to Medicare. Q. You mean a separate bill being dropped…A. A separate bill sometimes. Q. And that's later with this contract thing? A. Yeah. Q. And for—that would not have been 1994. A. No, It would have been 94 or 95. It would have been later in the period and they could find it at a later period and you can notice in the schedule that the dollar amount they were able to catch some because the dollar amounts went down that were missed later on in the period so the process helped. We just don't know why full periods all of a sudden disappeared in the first—we didn't know what the problem was why the State could not find everything that was crossed over…")

by the State on the State's financial and legal obligations.[29] This is a requirement regardless of whether a claim is "billed" through an automatic crossover or if the provider directly bills the State Medicaid program. In light of the foregoing, the Providers in this case have not demonstrated that the bad debts now identified by the Providers were "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. Moreover, while not determinative of this case, the Providers were aware that some claims were not crossing over and were not showing up on the Medicaid remittance advices and required direct billing of the State. The Providers decided not to take such action to direct bill in all such cases. In sum, until such time as the Providers receive a determination from the State on these claims, the claims cannot be allowed as Medicare bad debts.[30] The Providers also do not meet the hold harmless provisions of JSM-370.[31]

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

[30] 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 payer of last resort.

[31] While the Board suggests any amounts subsequently recovered can be offset in subsequent years, the incentive to bill (and hence recover the bad debt) has been removed once Medicare prematurely pays the bad debt.

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: 5/17/2010

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

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