CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Select Specialty '05 Medicare Dual Eligible Bad Debts Group	**Medicare Reimbursement Cost Reporting Periods: FYE Various Months in 2005**
Providers	
vs.	
Blue Cross Blue Shield Association/ Wisconsin Physicians Service	**Review of: PRRB Dec. No. 2010-D25 Dated: April 13, 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. The Providers commented requesting that the Board's decision be affirmed. Accordingly, the case is now before the Administrator for final administrative decision.

ISSUE AND BOARD'S DECISION

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

The Board examined the regulations at 42 C.F.R. §413.89 and program guidance in the Provider Reimbursement Manual (PRM) at §§308, 310, 312 and 322 to determine whether

the CMS must-bill policy should apply to the Providers, a non-participant in the Medicaid program. The Board first looked to 42 C.F.R. §413.89 and PRM-I §308 and determined that neither contain a specific requirement to bill the State. The Board instead found that the sections require that the provider make reasonable collection efforts and apply sound business judgment to determine whether debt was actually uncollectible.

The Board also examined PRM-I §310, which provides guidance on reasonable collection efforts, and held that the section is inapplicable to the determination of reasonable collection efforts for indigent patients and specifically refers to §312 of the PRM for guidance as to indigent and or medically indigent patients. Upon review of §312 of the PRM, the Board noted that the plain language states that Medicaid eligible beneficiaries are automatically deemed indigent and that a provider is not required to take further steps to prove their indigence.

In addition to no specific requirement to bill, the Board also determined that the Providers has no legal requirement to participate in Medicaid as a pre-condition to participation in Medicare or to obtain Medicare reimbursement. The Board pointed out that if a provider is not participating in Medicaid that the State Medicaid will not pay bills, even if submitted by the Providers. For those reasons, the Board determined that that the Manual Provisions on bad debt were not intended to apply to dual eligible bad debt claims of non-Medicaid participating providers.

The Board rejected the Intermediary's assertion that the Joint Signature Memorandum (JSM) 370 reiterated the must bill policy for the Providers. The Board stated that a JSM is not the appropriate vehicle to set policy. Thus, the Board found that the Intermediary changed its policy inappropriately because it disallowed bad debts based upon the JSM and that even if the JSM was appropriate the Providers would still prevail because the State is not required to pay bad debts to non-participating Medicaid providers.

Thus, for the foregoing reasons, the Board found that the Intermediary's must-bill policy has no foundation in law and is beyond the requirements of the regulations and manual. The Board additionally found that the application of the must-bill policy to dual-eligible bad debts when the Providers did not participate in the Medicaid program is improper.

SUMMARY OF COMMENTS

Intermediary Comments

The Intermediary commented requesting that the Administrator reverse the Board's decision and the Intermediary's adjustments be affirmed. The Intermediary asserted that the Administrator should apply the "must-bill" policy. The Intermediary also contends that the Board's decision is incorrect because the providers failed to establish that reasonable collection efforts using sound business judgment were employed and that the bad debt was actually uncollectible when claimed as worthless. The Intermediary noted that the Board failed to understand that the primary issue before the Board was not the "must bill" policy but whether the Providers employed a reasonable collection effort and whether the bad debt was actually uncollectible when claimed as worthless. The Intermediary maintained that the Secretary's must bill collection effort requirement imposed as a prerequisite of payment is entitled to deference.

Providers' Comments

The Providers commented, requesting that the Administrator affirm the Board's decision. The Providers stated that for reasons set forth in the decision, the Intermediary has no reasonable basis to impose the must-bill policy on non-Medicaid participating providers under the regulations and guidance materials. Additionally, the Providers noted that it has no capability to comply with the must-bill policy. Thus, the Providers asserted that it would be arbitrary and capricious for the Administrator to reverse the Board's decision.[1]

CM's Comments

The Centers for Medicare commented requesting that the Administrator reverse the Board's decision. The CM stated that, in order to be reimbursed for Medicare bad the debts, the Providers must comply with §413.89(e)(3) of the regulation and PRM-I § 322. Thus, the

[1] The Providers also commented on May17, 2000 requesting that the Administrator strike from the record CM's comments because they were not received timely. The Administrator notes that in the Notice of Review to the parties dated April 20, 2010, reference is made to 42 C.F.R. §405.1801(a), with respect to definition of "date of receipt." Under 42 C.F.R. §405.1801(a)(iii), "date of receipt" is "presumed to be 5 days after the date of issuance of an intermediary or reviewing entity [i.e., the Administrator or Deputy Administrator of CMS]" letter. The Administrator received the comments on May 10, 2010 by hand delivery from CM. Thus, CM's comments were timely.

Providers are required to document the State's liability for any cost sharing amounts related to unpaid Medicare deductible and coinsurance amounts for dual eligible beneficiaries. The CM noted that the Medicare must-bill policy is an effectuation of this requirement and the policy was clearly outlined in the Joints Signature Memorandum (JSM) issued to all Intermediaries on August 10, 2004 (JSM-370). The CM stated that the JSM properly reinstated the instructions that were issued in Change Request 2796 on September 12, 2003 and as a direct result of the Ninth Circuit Federal Court decision in *Community Hospital of Monterrey Peninsula v. Thompson*.[2]

The CM further noted that the beneficiary's Medicaid status at the time of service is required by PRM-I §312 and the State maintains the most current eligibility and financial information to make the most accurate determination of its cost sharing liability for unpaid Medicare deductibles and coinsurance. Additionally, CM pointed out that States are required by section 1903(r)(1) of the Act to have an operation mechanized claims processing and retrieval systems, approved by CMS, that is "capable of providing accurate and timely data" as a precondition to receive Medicare payments.

The CM disagreed with the Board's finding that CMS has recognized two exceptions to the "must bill" policy. The CM stated that Section 1905(a) of the statute precludes payment for medical assistance provided to patients aged twenty-two through sixty-four that receive services in Institutions for Mental Diseases (IMDs). Therefore, CM argued that this is a statutory requirement and not an exception to existing policy. For these patients, the State Medicaid programs have no obligation (whether the State Plans cover the full Medicare rate or not) and hence, should not be billed for services. The patients retain their Medicaid eligibility, however, and cost-sharing resumes once they are discharged. If the IMD is a participating Medicare Provider, the services are Medicare covered services, and the Provider has met all other criteria under the regulations, then the coinsurance and deductible amounts for this group would qualify as Medicare bad debts and should be reimbursed as such.

Second, the CM disagrees with the Board's statement that CMS has granted exceptions to Community Mental Health Centers (CMHCs) because these institutions are not licensed by the State and therefore cannot enroll in the State Medicaid program or have their Medicaid claims processed. The CM stated that there are no exceptions to the must bill policy. Any payment of bad debt amounts without documentation of billing the State Medicaid program and receiving a remittance advice is not acceptable.

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[2] 323 F.3d 782 (9th Cir. 2003).

Finally, the CM stated that the Providers' business decision not to participate in the Medicaid program does not change the patient's dual eligible status, nor a State's statutory obligation to determine its cost sharing liability, regardless of the Provider's Medicare only status. Therefore, a Provider must bill the State and accordingly, the State must 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 determine the State's liability for payment of Medicare deductible and coinsurance amounts. The Providers did not do so in this case.

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]

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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

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

> *Requirements for Medicare*. Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, cost of services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally mean the provider has not recovered the cost of services covered by that revenue. 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

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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.…"

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[4] notes that:

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

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

> In some instances the State has an obligation to pay, but either does not pay anything or pays only part of the deductible, or coinsurance because of a State payment "ceiling." For example assume that a State pays a maximum of $42.50 per day for the SNF services and the provider's cost is $60.00 a day. The coinsurance is $32.50 a day so that Medicare pays $27.50 ($60.00 less $32.50). In this case, the State limits its payment towards the coinsurance to

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[4] 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...."

> $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.[5] 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.

[5] JSM 370 (Aug. 10, 2004), Intermediary's Final Position Paper (Oct. 25, 2004), Ex. I-2

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.[6] The memorandum noted that in, Community Hospital of the Monterey Peninsula v. Thompson, supra, (2008), the Ninth Circuit upheld this policy of the Secretary.[7] 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.[8] 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.[9] 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 requires providers to bill the individual States for dual-eligibles' co-pays and deductibles before claiming Medicare bad debts.[10]

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

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[6] Id.
[7] Id., citing 323 F.3d 782.
[8] Id.
[9] Id.
[10] See Change Request 2796, issued September 12, 2003.

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.[11]

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)[12] 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.

After a review of the record and the applicable law and Medicare policy, the Administrator finds that the Providers failed to meet all the regulatory requirements and the Manual guidelines for reimbursement of the subject amounts as Medicare bad debts.

The Providers in this case elected not to sign participation agreements with their corresponding State Medicaid programs. During the cost reporting periods at issue, the Providers claimed Medicare bad debts on their cost reports for unpaid coinsurances and deductibles for beneficiaries who were also eligible for Medicaid benefits under the States' Medicaid program (i.e., dual eligible beneficiaries). The Intermediary disallowed all the bad debts based upon the "must bill" policy which requires the Providers to bill the States' Medicaid programs and obtain a remittance advice (RA).

The Administrator finds that the bad debts claimed by the Providers on their cost reports should be disallowed because the Providers, despite their choice to be Medicare only

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[11] Id.

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

facilities, failed to determine if the State was liable for any cost sharing amounts and, thus, the Providers failed to determine that the debt was actually uncollectible when claimed as worthless as required under 42 C.F.R 413.89(e)(3) and Chapter 3 of the PRM.

The Providers in this case made a business decision not to participate in the Medicaid program. This business decision, however, does not change the dual eligible status of a Medicare beneficiary for which a State may be liable for cost sharing amounts. The States have a statutory obligation to determine their cost sharing liability concerning dual eligible beneficiaries, regardless of the Medicare only status of the Providers providing the services. The States maintain 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.

The Administrator finds that the Providers decided not to participate in the Medicaid program and did not bill their respective States for the claims at issue in this case to receive a determination from the State on the coinsurance and deductible amounts. Thus, they have not demonstrated that they meet the necessary criteria for Medicare payment of bad debts related to these claims. In order to determine the State's liability and, likewise, the amount of coinsurance and deductible attributable to Medicare bad debt, the Providers are required to bill the States for these claims and receive a determination from their respective State on that claim. However, it is only through the State's records and claims systems can the amount of any payment be determined and in most cases the States will always be liable to pay for a beneficiary's unpaid deductible amounts. This necessity is recognized by the statute at section 1903(r)(1) as it requires automated facilitation of cross-over claims between State Medicaid programs and the Medicare program for dual eligible patients.

The policy requiring a providers to bill the States and receive a determination on those claims, where the States are obligated *either by statute or under the terms of its plan to pay all, or any part of* the Medicare deductible or coinsurance amounts, is consistent with the general statutory and regulatory provisions relating specifically to the payment of bad debts and generally to the payment of Medicare reimbursement. As reflected in 42 CFR 413.89(d)(1), the costs of Medicare deductible and coinsurance amounts which <u>remain unpaid</u> (i.e. were billed) may be included in allowable costs. In addition, paragraph (e) of that regulation requires, *inter alia*, a provider to establish that a reasonable collection effort was made and that by receiving a determination from the State, the debt was actually uncollectible when claimed.

A fundamental requirement to demonstrate that an amount is, in fact, unpaid and uncollectible, is to bill the responsible party. Section 310 of the PRM generally requires a provider to issue a bill to the party responsible for the beneficiaries' payment. Section 312 of the PRM, while allowing a provider to deem a dually eligible patient indigent and claim the associated debt, first requires that no other party, including the State Medicaid program is responsible for payment. Section 322 of the PRM addresses the circumstances of dually eligible patients where there is a State payment ceiling. That section states that the "amount that the State does not pay" may be reimbursed as a Medicare bad debt. This language plainly requires that the provider bill the State as a prerequisite of payment of the claim by Medicare as a bad debt receive a determination on that claim and that the State make a determination on that claim. Reading the sections together, the Administrator concludes that, in situations where a State is liable for all or a portion of the deductible and coinsurance amounts, the State is the responsible party and is to be billed, and a determination made by the State in order to establish the amount of bad debts owed under Medicare.

The above policy has been consistently articulated in the final decisions of the Secretary addressing this issue, since well before the cost year in this case.[13] The final decisions of the Secretary have consistently held that the bad debt regulation and the documentation requirements for payment set forth in the law and regulation require providers to bill the Medicaid programs for payment and receive a determination on that claim. These decisions have denied payment when there is no documentation that actual collection efforts were made to obtain payments from the Medicaid authority before an account is considered uncollectible and when the provider did not bill the State for its Medicaid patients.

The policy at issue is referred to as the "must-bill" policy. The policy in fact requires a determination by the State on a filed claim. This policy concerning dual-eligible beneficiaries continues to be critical because individual States administer their Medical Assistance programs differently and maintain billing and documentation requirements

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[13] *See, e.g.*, California Hospitals Crossover Bad Debts Group Appeal PRRB Dec. No. 2000-D80; *See also* California Hospitals at n.16 (listing cases). To the extent any CMS statements may be interpreted as being inconsistent with 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. Consequently any allowance of these bad debts in prior years, as alleged by the Providers would have been contrary to CMS' longstanding policy and not binding in these cost years.

unique to each State program. The State maintains the most current and accurate information to determine if the beneficiary is a QMB, at the time of service, and the State's liability for any unpaid QMB deductible and coinsurance amounts through the State's issuance of a remittance advice after being billed by the provider.

Consistent with the statute, regulation and PRM, a provider must bill the State and the State must process the bills or claims to produce a remittance advice for each beneficiary to determine their Medicaid status, at the time of service and the State's liability for unpaid Medicare deductible and coinsurance amounts. Thus, it is unacceptable for a provider to write-off a Medicare bad debt as worthless without first billing the State and receive a determination from the State. Even in cases where the provider has calculated that the State has no liability for outstanding deductible and coinsurance amounts, the provider must bill the State and receive a remittance advice before claiming a bad debt as worthless because, as stated above, the State has the most current and accurate information to make a 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.[14] In light of the foregoing, the Providers have not demonstrated that the bad debts identified by the Providers were actually uncollectible and worthless.

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[14] In addition to verifying the validity of the provider's bad debt, submission of the claim to the State and preservation of the remittance advice is an essential and required record keeping criteria for Medicare reimbursement. Under Section 1815 of the Act, no Medicare payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider. Consistent with the statute, the regulations require that providers maintain verifiable and supporting documents to justify their requests for payment under Medicare. The regulation at 42 CFR 413.20 provides that: "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for provider determination of costs payable under the program.... Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained...." As used in the context of the regulation at §413.20, "maintain" means that the provider is required to keep "contemporaneous" records and documentation throughout the cost year and to then make available those records to the intermediary in order to settle the cost report in the normal course of business. Here the Provider has decided not to participate in Medicaid and has not submitted claims to the State, received and "maintained" the required remittance advices contemporaneous with the cost reporting period and furnished such documents to the Intermediary, contrary to this principle.

Because the Providers have not billed their respective States and the States did not issue RAs for these services contemporaneous with the cost reporting periods, the bad debts cannot be demonstrated as "actually uncollectible when claimed as worthless" and that "there is no likelihood of recovery at any time in the future" and that sound business judgment has established no likelihood of recovery in the future. In addition, as there are third parties, the States that are responsible for coinsurance and deductibles, the Providers have not shown that they have used reasonable collection efforts. The Providers were aware of the Medicare bad debts reasonable collection efforts requirements and chose not to participate in the Medicaid program. The Providers' business decisions to not participate in the Medicaid program must necessarily include the decision that they have foreclosed the payment of Medicare bad debts for dually eligible patients in making that choice. The PRM requirement that the State be required to make a determination on any debts owed before it may be claimed as a Medicare bad debt has been in place for years prior to these cost years. The PRM makes no distinction between Medicaid participating and non-participating facilities as the Board does here.

The Medicaid and Medicare programs are authorized by different provisions of the Social Security Act and financed under different mechanisms.[15] The reasonable cost payment is made from the Medicare Trust Fund/Supplemental Medical Insurance, while Medicaid is a joint State and Federal program financed, *inter alia*, under State and Federal appropriations with its own separate and distinct rules and authorizations. Consequently, the remittance advices are critical as they document the proper payments that should be made from the respective programs. Moreover, a fundamental principle of the program is that payment be fair to the providers, the "contributors to the Medicare trust fund" and to other patients. In this instance the Medicare program is reasonably balancing the accuracy of the bad debt payment and the need to ensure the fiscal integrity of the Medicare funding, with the providers claims for payment which can be made under two different program for which Medicare is the payer of last resort.

The Administrator also finds that CMS has not recognized two exceptions to the "must bill" policy. The Medicare statute precludes payment for medical assistance provided to patients for certain age ranges at IMDs, and therefore, this provision is a statutory requirement and not an exception to the existing bad debt policies under Medicare. These patients retain their Medicaid eligibility and cost-sharing resumes upon the patient's discharge from the IMD. Therefore if the IMD is a participating Medicare Provider, the services are considered to be

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[15] See also, GCI Health Care Centers v. Thompson, 209 F. Supp. 2163 (D.D.C. April 25, 2002) upholding Medicare bad debt disallowance involving Arizona Medicaid dual eligibles) and discussing different programs and cost-shifting.

Medicare covered services, and the Provider has met all other criteria under the regulations, the coinsurance and deductible amounts for these patients would qualify as Medicare bad debts and would be reimbursed as such.

Likewise, the Administrator finds that CMS has not granted exceptions to CMHCs or IMDs. The State has no obligation to pay with respect to IMDs. Further, CMHCs are not licensed by the State and cannot enroll in the State Medicaid program or have their Medicaid claims processed. Therefore, unlike the Providers in this case who chose not to participate in Medicaid, CMHCs have no choice since they do not have that option.

Finally, the Administrator finds that any prior erroneous payments of bad debts that did not comply with the existing bad debt requirements are not binding as precedent and will not justify nor allow present or future payments of bad debts when the required bad debt provisions are not satisfied. As the States have legal obligations to pay the bad debts and the States have not made determinations on these claims, the elements of the bad debts regulation are not met.

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: 6/9/10

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

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