CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Hope Horizon Center, Inc. **and** **Homestead Behavioral Clinic, Inc.** **Providers** **vs.** **Blue Cross Blue Shield Association/** **First Coast Service Options, Inc.** **Intermediary**	**Medicare Reimbursement** **Cost Reporting Periods:** **FYEs 2005, 2006** **2007, and 2008** **Review of:** **PRRB Dec. No. 2010-D29** **Dated: May 18, 2010**

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 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 Intermediary's adjustment disallowing bad debts arising from coinsurance and deductibles for dual eligible Medicare and Medicaid beneficiaries was proper.[1]

[1] The Providers agreed to rely on the record established in Case No. 08-1878 (Hope Horizon Center, Inc. for FYE Nov. 30, 2006).

The Board found that the Providers met the requirement for reasonable collection efforts related to the dual eligible beneficiaries as required under 42 C.F.R. §413.89 and program guidance in the Provider Reimbursement Manual (PRM) at §§308, 310, 312 and 322. The Board reversed the Intermediary's adjustments and found that the Intermediary improperly disallowed the bad debts arising from coinsurance and deductibles for dual eligible Medicare and Medicaid beneficiaries.

The Board stated that the ultimate question for the Board is whether the Providers have met the requirements of 42 C.F.R. §413.89 and program guidance in the PRM at §308. The Board rejected the Intermediary's assertion that the Joint Signature Memorandum (JSM) 370 reiterated the "must bill" policy for 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.

The Board also found that JSM-06345 instructs the Florida Intermediaries to suspend the prior "must bill" instructions in JSM-370 (08-03-04). The Board noted that the two signatories on the original JSM are also on the subsequent JSM. The subsequent JSM modification shows CMS' recognition that JSM-370 "must bill" requirements may not be reasonable in some circumstances.

The Board found that the Florida statute regarding Medicaid Provider Fraud at §409.920(2)(b) states that it is unlawful to "knowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program… A person who violates this subsection commits a felony of the third degree,…" The Parties have stipulated that consistent with Florida law in 1998, Florida's Medicaid State plan was amended to eliminate any coverage responsibility for Providers and similarly situated Community Mental Health Clinic "CMHCs." The Board found that it would be unreasonable to place the Providers in jeopardy of a criminal action by requiring them to bill in accordance with the JSM-370 to collect Medicare bad debts.

The Board found that the Medicare requirement to bill and obtain a remittance advice was a matter of impossibility for the Providers. The impossibility is made more compelling because CMS participated in the "errors" that created the impossibility by initially approving the amendment to the State plan and then requiring modifications to be made only prospectively. The Intermediary reluctantly conceded that the Providers took all reasonably necessary steps to obtain a remittance advice. The Providers are the only stakeholders not at fault in this situation.

Finally, the Board found that the Intermediary's reliance on Community Hospital of the Monterey Peninsula, 323 F.3d 782 (9th Cir. 2003) was misplaced because the court did not deal with circumstances existing here that make billing impossible. The Monterey case involved a Medicaid state plan that applied a payment ceiling which limited the amount of payment or resulted in no payment for coinsurance and deductibles. The Board stated that there was nothing in Monterey Peninsula to indicate that Court considered billing impossibility or, if those circumstances had been presented, the must-bill requirement would have been found to be a reasonable implementation of the regulation and manual provisions.

Thus, for the foregoing reasons, the Board found that the Providers met the regulatory and manual requirements for a reasonable collection effort related to the dual eligible beneficiaries. Furthermore, given the unique circumstances in the State of Florida, the Board also found that the associated bad debts were actually uncollectible when the Providers claimed them as worthless.

SUMMARY OF COMMENTS

Providers' Comments

The Providers commented, requesting that the Administrator affirm the Board's decision. The Providers stated that they are distinguishable from the Provider in Royal Coast Rehabilitation (PRRB Dec. No. 2010-D13) since they had been issued Medicaid crossover numbers by the Florida Medicaid program in 1997 so that they could bill the Medicaid program and receive Medicaid payment of dual-eligible coinsurance and deductible amounts.

In May 1998, the Providers received a letter from the State Medicaid program notifying them of a change in the State law that "prohibits Florida Medicaid from making payment toward the Medicare deductible and coinsurance for any service that is not covered by Florida Medicaid." This was also construed to be a "disenrollment" of the Providers from the Florida Medicaid program effective July 1, 1998.

Subsequent to this notification, the Providers did not change their billing practices and continued to submit bills to the Intermediary for processing, however, the Medicaid remittance advices for their dual-eligible patients indicated zero payments. This practice was continued until 2003 when the Florida Medicaid program stopped issuing remittance

advices for dual-eligibles. As such, there was no way for the Providers to obtain remittance advices as supportive documentation required by the Medicare program.

The Providers stated that they took all the appropriate steps to meet the Medicare requirements for entitlement to bad debt reimbursement for dual-eligibles, including their efforts to obtain remittance advices. The Provider stated that CMS and the Florida Medicaid program have erred, and their errors have seriously disadvantaged them.

CM's Comments

The Centers for Medicare (CM) 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 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 Joint 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 operational 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 noted that the State of Florida was out of compliance with its statutory requirement to process and make determinations on claims involving QMBs. Neither CMS, nor the Board has authority to excuse the State from complying with the Federal requirements to determine its cost sharing liability, even if the Medicaid State Plan was approved in error.

Accordingly, the CM stated that the bad debts claimed by the Providers on their cost reports for the reporting periods ending in 2004 through 2008 should be disallowed because the

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

Providers did not bill the State and receive a remittance advice to meet the reasonable collection effort requirements.

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 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.…"

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) 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 regulation at 42 CFR 413.89(e) states that to be allowable, a bad debt must meet the following criteria:

> 1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

> 2) The provider must be able to establish that reasonable collection efforts were made.
>
> 3) The debt was actually uncollectible when claimed as worthless.
>
> 4) Sound business judgment established there was no likelihood of recovery at any time in the future.

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 $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:

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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...."

> 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.

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),

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

[6] Id.

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 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]

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

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 are Medicare-certified Community Mental Health Centers (CMHCs) with Partial Hospitalization Programs (PHP) located in Florida. In 1998, consistent with the Florida law, Florida's Medicaid State Plan was amended to eliminate any coverage responsibility for QMB coinsurance and deductibles for the type of services furnished by the appealing Providers and similarly situated CMHCs. The Providers in this case continued to receive remittance advices from the Florida Medicaid Program. On or about October 2003, the Providers were notified by the Florida Medicaid Program that they would no longer be receiving remittance advices. In their Medicare Cost Reports filed by the Providers with the Intermediary, the Intermediary disallowed the portion of the bad debts claimed by the Providers on the basis that they were not in compliance with the CMS "must bill policy."

On March 28, 2006, the Deputy Secretary for Medicaid at Florida's Agency for Health Care Administration (AHCA) was advised by CMS that the 1998 amendments that eliminated co-pay liability for QMBs was approved in error and the plan must be corrected at the risk of loss of Federal Financial Participation (FFP). The Florida legislature removed the statutory impediment to covering such co-payments for QMBs in 2008.[13]

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

[13] See Intermediary Exhibit I-6 and Royal Coast Rehabilitation Center, Admin. Dec. 2010-D13, (herein incorporated by reference) at pp. 13-14.

The central issue in this case is whether the Providers are obligated to pursue collection from the party responsible for the beneficiary's financial obligations, including the State Welfare programs per PRM-I §322 in the case of a dual-eligible. The Administrator finds that the Providers in this case, despite the State of Florida's change in Medicaid law, were required to bill and receive remittance advices from the State of Florida, to demonstrate reasonable collection efforts. The Administrator finds that the Providers in this case did not satisfy this requirement, and as such, the bad debt claims were properly disallowed by the Intermediary.

Furthermore, the Administrator finds that State of Florida's legislative change cannot shift its cost sharing responsibility by structuring its Medicaid Program to avoid payment of a legal obligation. This premise has been historically upheld by the courts in GCI Health Care Center v. Thompson, 209 F. Supp 2d 63 (D.D.C. 2002) in which the Court affirmed the Administrator's decision that denied Medicare bad debt reimbursement for deductible and coinsurance amounts the Arizona Medicaid Program was obligated to pay, and Community Hospital, supra, which led to the issuance of CMS JSM-370.

In addition, the State Medicaid Manual, CMS Pub. 45 §3490.14(A), which provides that the State agency is "required to pay for Medicare Part A and Part B deductibles and coinsurance for Medicare services, whether the services are covered in the Medicaid State Plan." A State can establish a rate for payment of its deductible obligation at less than 80 percent of the Medicare rate as long as the rate is found to be reasonable by CMS in approving the plan.

In March 2006, Florida Medicaid was notified by CMS of a deficiency in its State Plan.[14] The letter from CMS made it clear that, even when a service is not provided under the Medicaid State Plan, the State is responsible for paying the Medicare coinsurance and deductibles for all services covered under Medicare Part A, B and C for eligible QMBs. Florida's legislative change does not eliminate the existence of its legal obligation to pay deductibles and coinsurance for services furnished by the Providers to QMBs.

The Administrator finds that the bad debts claimed by the Providers on their cost reports should be disallowed because the Providers failed to submit the claims to the State and obtain a remittance advice to determine if the State was liable for any cost sharing amounts for purposes of claiming the bad debts in these periods. 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.

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[14] See Intermediary Exhibit I-6.

The Providers are required to 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 the regulations cited above, 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 had 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 because 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. 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 remain unpaid (i.e. were billed) may be included in allowable costs. In addition, paragraph (e) of that regulation requires, *inter alia*, a provider to establish that a reasonable collection effort was made and that by receiving a determination from the State, the debt was actually uncollectible when claimed.

A fundamental requirement to demonstrate that an amount is, in fact, unpaid and uncollectible, is to bill the responsible party. Section 310 of the PRM generally requires a provider to issue a bill to the party responsible for the beneficiaries' payment. Section 312 of the PRM, while allowing a provider to deem a dually eligible patient indigent and claim the associated debt, first requires that no other party, including the State Medicaid program is responsible for payment. Section 322 of the PRM addresses the circumstances of dually eligible patients where there is a State payment ceiling. That section states that the "amount that the State does not pay" may be reimbursed as a Medicare bad debt. This language plainly requires that the provider bill the State as a prerequisite of payment of the claim by Medicare as a bad debt receive a determination on that claim and that the State make a determination on that claim. 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.[15] 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 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 receives a determination from the State.[16] In light of the foregoing, the Providers have not

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[15] *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.

[16] In addition to verifying the validity of the provider's bad debt, submission of the claim to the State and preservation of the remittance advice is an essential and required record keeping criteria for Medicare reimbursement. Under Section 1815 of the Act, no Medicare

demonstrated that the bad debts identified by the Providers were actually uncollectible and worthless for the periods in which they were claimed.

As noted for the reasons set forth in CM's comments, the Board also incorrectly dismissed the JSM 370 as a valid means of communicating established, longstanding policy. The Board also incorrectly interpreted the subsequent JSM-06345 as being inconsistent with CMS longstanding policy as it restates such a policy and only issues a temporary instruction regarding tentative settlement. A subsequent JSM/TDL-10172, dated March 12, 2010, instructs intermediaries on settling the final notices of program reimbursement and instructs the intermediary to disallow the dual eligible bad debts not billed to the State of Florida.

While 42 CFR 413.89 explains the criteria needed to be met to claim a bad debt, the regulation at 42 CFR 413.89(f) addresses the timing of when a bad debt can be claimed consistent with the general Medicare documentation requirements. The amounts uncollected from specific beneficiaries are to be charged off as bad debts in the accounting period in which accounts are properly deemed to be worthless. Thus, the Providers are not foreclosed from claiming these bad debts in the future once the claims have been processed by the State and remittance advices are issued.[17]

Providers may only be reimbursed for the bad debts derived from uncollectible deductibles and coinsurance amounts when the debt is related to covered services and derived from

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payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider. Consistent with the statute, the regulations require that providers maintain verifiable and supporting documents to justify their requests for payment under Medicare. The regulation at 42 CFR 413.20 provides that: "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for provider determination of costs payable under the program.... Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained...." As used in the context of the regulation at §413.20, "maintain" means that the provider is required to keep "contemporaneous" records and documentation throughout the cost year and to then make available those records to the intermediary in order to settle the cost report in the normal course of business. Here the Provider has not submitted claims to the State, received and "maintained" the required remittance advices contemporaneous with the cost reporting period and furnished such documents to the Intermediary, contrary to this principle.

[17] See also §314 of the PRM and Palms of Pasadena v. Sullivan, 932 F.2d 982 (D.C. 1991) discussing when a bad debt may be claimed.

deductible and coinsurance amounts; the provider is be able to establish that reasonable collection efforts were made; the debt was actually uncollectible when claimed as worthless; and sound business judgment established there was no likelihood of recovery at any time in the future.

Because the Providers have not billed their respective States and the States did not issue remittance advices for these services contemporaneous with the cost reporting periods, the bad debts cannot be demonstrated as "actually uncollectible when claimed as worthless" and that "there is no likelihood of recovery at any time in the future" and that sound business judgment has established no likelihood of recovery in the future. In addition, as there is a third party, the State of Florida that is 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 change their billing practices in 1998 when the State of Florida effectuated its legislative change to the Medicaid program. The Providers continued to send their bills directly to the Intermediary for processing and chose not to direct bill the State of Florida. In addition, the Providers could have submitted claims directly to the State of Florida when it was notified in 2003 that the State would cease generation of remittance advices.

The Medicaid and Medicare programs are authorized by different provisions of the Social Security Act and financed under different mechanisms.[18] 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.

Finally, the Administrator finds that any prior erroneous approvals of State Plan Amendments 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

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[18] 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.

required bad debt provisions are not satisfied. As the State has legal obligation to pay the bad debts and the State has 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: 07/13/2010

/s/
Marilyn Tavenner
Principle Deputy Administrator
Centers for Medicare & Medicaid Services

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: _____ _____

Marilyn Tavenner
Principle Deputy Administrator
Centers for Medicare & Medicaid Services

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