CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Various Genesis Health Care Corporation Providers	**Medicare Reimbursement Cost Reporting Period Ending: 12/31/2004**
Providers	
vs.	
Blue Cross Blue Shield Association/ Highmark Medicare Services	**Review of: PRRB Dec. No. 2011-D12 Dated: December 2, 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 Management (CM) commented, requesting reversal of the Board's decision. The Providers submitted comments requesting that the Administrator affirm the Board's decision. Accordingly, the case is now before the Administrator for final administrative decision.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary properly adjusted the Providers' bad debts, based on reasonable collection efforts and the "must bill" policy, for the fiscal year ended December 31, 2004.[1]

[1] The bad debts disallowed consisted of two types of disallowances. Some of the bad debts were disallowed because of the Providers failure to document certain collection

The Board addressed the foregoing issue in two parts. The Board first found that the Intermediary improperly denied the claims since the Providers made reasonable collection efforts through their billings and the use of a collection agency consistent with Section 310 of the Provider Reimbursement Manual (PRM) and satisfied the requirements of 42 C.F.R. §413.89. Secondly, the Board found that regarding the "must bill" requirement, the Intermediary's "must bill" policy has no foundation in law or regulation and is beyond the requirements of the regulations and manuals and was improperly applied to the Providers claims. The Board further determined that application of the "must bill" policy to outstanding deductibles and coinsurance amounts due from dually eligible beneficiaries is improper.

SUMMARY OF COMMENTS

CM commented, requesting reversal of the Board's decision. CM asserted that the Intermediary properly disallowed the bad debts because the Provider did not adhere to the requirements set forth in 42 CFR 413.89(e), and Chapter 3 of the PRM. CM first stated that the Providers failed to document a reasonable collection effort as required by Section 310 of the PRM.[2] Secondly, the Providers did not determine if the State is legally responsible for the patient's medical bill because the State failed to correctly process Medicare/Medicaid crossover claims to determine its cost sharing liability for dual eligible beneficiaries as required by Sections 312 and 322 of the PRM. [3] Thus, CM claimed that the Providers failed to meet the reasonable collection effort requirements of sections 413.89(e)(2) and the debt could not be claimed as uncollectible when it was claimed as worthless, as required under 413.89(e)(3), and the likelihood of recovery at any time in the future could not be established under Section 413.89(e)(4) of the regulations.

Regarding the reasonable collection efforts issue, CM referred to the Chapter 3 PRM guidelines that must be met in order to properly claim Medicare bad debts. Section 301 provides that a reasonable collection effort "must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal

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activities and a second group of bad debts, involving Medicare/Medicaid dual eligible beneficiaries, were disallowed because of the "must bill" policy.

[2] CM referred to Battle Creek Health Systems v. Leavitt 498 F.3d 401 (6th Cir. 2007) in support of its argument.

[3] CM referred to Village Green Nursing Home (GCI), PRRB Dec. No. 2000-D59 (2000) and Port Huron Hospital, PRRB Dec. No. 2008-D32 (2008), rev'd. CMS Admin. Dec. (Oct. 14, 2008), in support of its arguments.

financial obligations." Section 310 additionally states that the effort "also includes other actions such as subsequent billings, collection letter and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort." Lastly, Section 310 requires that, "The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow up letters, reports of telephone and personal contact, etc." Thus, CM asserted that if documentation supporting that a reasonable collection effort took place is unavailable, such as in this case, then the account would not be an allowable Medicare bad debt.

CM also addressed the Intermediary's contention that portions of the Providers' bad debts were written off while the accounts were pending at a collection agency and reiterated that it is longstanding policy of CMS that when an account is at a collection agency a provider cannot have determined the debt to be uncollectible and cannot have established that there is no likelihood of recovery under the regulations.[4] CM stressed that, until a provider's reasonable collection effort has been completed, either by in-house efforts or the use of a collection agency, a bad debt cannot properly be claimed to Medicare nor deemed uncollectible merely because it remains unpaid for more than 120 days.

Concerning the second issue, the "must bill" requirement, CM asserted that 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. Thus, CM stated that Medicare has required the Provider to make certain that no source other than the patient would be legally responsible for the patient's medical bill; e.g. Title XIX (Medicaid) or local welfare agency, prior to claiming the bad debt. CM noted that in order to effectuate this requirement, the provider must submit a bill for a dual eligible beneficiary to its Medicare Administrative Contractor (MAC) that would then begin the Medicaid crossover billing process and determine the State's cost sharing liability. Through this billing process, CM also noted, the provider dually satisfies the Section 312 requirement that the provider must determine the beneficiary's Medicaid status at the time of service in order to determine the State's cost sharing liability.

CM further contended that this "must bill" requirement was outlined in the Joint Signature Memorandum (JSM) JSM-370 on August 10, 2004. JSM-370 was issued to implement the instructions issued in Change Request 2796 on September 12, 2003, resulting from the Ninth Circuit Federal Court decision in Community Hospital of Monterey Peninsula v. Thompson,

[4] CM also referenced the Sixth Circuit Court of Appeals decision in Battle Creek Health Systems v. Leavitt 498 F.3d 401 (6th Cir. 2007).

323 F.3d 782 (9th Cir. 2003). CM asserted that Community Hospital applies in this case and that it was a critical upholding in Medicare's policy of the provider's role in determining State's liability. CM noted that Change Request 2796 revised Section 1102.3L of the PRM, Part II to require that Providers submit, in part, 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 Fiscal Intermediary) to verify the authenticity of the Medicare patient and the related bad debt.

CM further addressed the importance of the State's responsibility to determine its cost share liability because each individual State maintains its own complex billing systems and documentation requirements unique to each State program and, thus, it is necessary for determining the status of qualified Medicare beneficiaries (QMBs). CM stated that the Medicare Catastrophic Act of 1988 established the QMB beneficiary category and the State's responsibility to determine its cost sharing liability for QMBs is provided in section 3490.14(A) of the State Medicaid Manual (CMS Pub. 45)(SMM). The Social Security Act (Act) further imposes liability for QMB cost sharing amounts on the States and 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. 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 deductibles that the State is responsible to pay. Furthermore, Section 1903(r)(1) of the Act states that in order for a State to receive payments under Section 1903(a) for automated data systems, a State must have in operation mechanized claims processing and information retrieval systems that CMS determines "are compatible with the claims processing and information retrieval systems used in determination of title XVIII" and "are capable of providing accurate and timely data."

For these reasons, CM asserted that 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 and, accordingly, CMS, the Board, and the Providers are unable to make cost-sharing liability determinations. Moreover, CM stated that a Provider must submit a bill for a dual eligible beneficiary to its MAC (or Medicare FI) to begin the Medicaid crossover billing process with the State and then the State must process these crossover bills/claims to produce a remittance advice (RA) for each beneficiary to determine a State's liability for payment of Medicare coinsurance and deductible amounts.

As a result, CM asserted that under Section 413.89(e)(3) and the reasons listed above, it is unacceptable for a Provider to write off a Medicare dual eligible beneficiary bad debt as worthless without the State determining its liability.

The Providers commented requesting that the Administrator consider the facts specific to this case and uphold the Board's finding that the Providers' special circumstances made complying with the "must bill" policy an impossibility. The Providers noted that they are only challenging the "must bill" policy for bad debts prior to January 1, 2004 and not the entire policy. The Providers claimed that for cost reporting periods prior to January 1, 2004, CMS instructed Intermediaries to hold harmless providers that can demonstrate that the followed the instructions laid out in PRM-II Section 1102.3L . The Providers further alleged that the Community Hospital, supra, decision does not apply here because it did not address the issue of the Intermediary's late and misleading notices and directions to the Providers. Lastly, the Providers asserted that CMS' "must bill" policy was not issued until November 2004 and thus created an impossibility for the Providers to be able to bill the State and receive a remittance advice for years 2002 and 2003, because New Jersey law required patients to be billed within one year of the date of service.

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,[5] 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

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[5] 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.…”

> 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.)

The Manual at §310 further explains:

> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve 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. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See §312 for indigent or medically indigent patients.)
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> A. Collection Agencies A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.
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> B. Documentation Required The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.[6]

[6] See also Battle Creek Health System, Admn. Dec. No. 2004-D40 at 7, referring to the Intermediary Manual, Part IB, 13-2 which stated, "If the bad debt is written-off on the provider's books 121 days after the date of the bill and then turned over to a collection agency, the amount cannot be claimed as a Medicare bad debt on the date of the write-off. It can be claimed as a Medicare bad debt only after the collection agency completes its collection effort" and also referring to June 11, 1990 and April 1, 1992 agency issued

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.)

The PRM at §314 states that uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which such debts are determined to be worthless and non-collectable[7]. This instruction also embodies a burden of the Provider to thoroughly document its claimed bad debts:

> Since bad debts are uncollectable accounts…the Provider should have the usual accounts receivable records-ledger cards and source documents to support its claim…for each account included. Examples of the information that may be retained include…date of bills…date of write off.[8]

Moreover, to ensure that Providers receive reimbursement for services they actually furnish, the Secretary has implemented a number of Medicare documentation regulations at 42 CFR

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memorandum, which stated "Until a provider's reasonable collection effort has been completed, including both in-house efforts and the use of a collection agency, a Medicare bad debt may not be reimbursed as uncollectible. This is in accord with the fourth criterion in section 308 which provides that an uncollected Medicare account cannot be considered an allowable Medicare bad debt unless sound business judgment established that there is not likelihood of recovery at any time in the future. We have always believed that, clearly, there is a likelihood of recovery for an account sent to a collection agency and that claiming a Medicare bad debt at the point of sending the account to the agency would be contrary to the bad debt policy in sections 308 and 310."

[7] PRM, Part I, 15-1 §314.

[8] Id.

§§413.9, 413.20 and 413.24, which in the present issue of bad debt, are elaborated in PRM, Part I, 15-1 §310(B):

> Documentation Required. -- The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

Relevant to this case, section 322 of the PRM[9] 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.)

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[9] 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....”

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.

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.[10] 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

[10] JSM 370 (Aug. 10, 2004), Intermediary's Final Position Paper (July 22, 2009), Ex. I-24

such debt.[11] The memorandum noted that in, Community Hospital of the Monterey Peninsula v. Thompson, supra, (2008), the Ninth Circuit upheld the must bill policy of the Secretary.[12] 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.[13] Where the State owes none, or a portion of the dual-eligible deductible and coinsurance amounts, the unpaid liability for the bad debt is not reimbursable until the provider bills the State and the State refuses payment, all of which is demonstrated through a Remittance Advice.

Importantly, the memorandum also indicated that, in November 1995, language was added to the PRM at section 1102.3L, which was inconsistent with the must bill policy.[14] The Ninth Circuit panel found that section 1102.3L was inconsistent with the Secretary's must – bill policy and also noted that, effective in August of 1987, Congress had imposed a moratorium on changes in bad debt reimbursement policies and, therefore, the Secretary lacked authority in November of 1995 to effect a change in policy. As a result of the Ninth Circuit decision, CMS changed the language in PRM –II Section 1102.3L to revert back to pre-1995 language, which requires providers to bill the individual States for dual-eligibles' co-pays and deductibles before claiming Medicare bad debts.[15]

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

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[11] Id.
[12] Id., citing 323 F.3d 782.
[13] Id.
[14] Id.
[15] See Change Request 2796, issued September 12, 2003.

relating to cost reporting periods before January 1, 2004 and who relied on the previous language of section 1102.3L in providing documentation.[16]

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)[17] 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 are owned by a corporation that operated skilled nursing facilities in New Jersey and Pennsylvania. The Providers are located in New Jersey and claimed Medicare bad debts for deductible and coinsurance amounts pursuant to the application of their collection policy. The Intermediary challenged the propriety of writing off those amounts since the Providers did not provide any documentation to support collection efforts.

The Providers' also claimed Medicare bad debts for unpaid deductible and coinsurance crossover debts related to dual eligible patients whose service dates occurred prior to January 1, 2004. The Providers asserted that the patients were dually eligible for Medicaid and Medicare at the time of service and that Medicaid would not have made a payment if the Provider had billed the State. The Providers do not contest that they never billed the state for the deductible and coinsurance amounts related to these patients and instead argued that they should be excluded from the "must bill" requirement, based on the hold harmless

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[16] Id.

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

provision. The Providers stated that because Riverbend, the Provider's New Jersey Intermediary, did not issue Flash 04-08 until November 2004 that the Providers were not made aware of the "must bill" policy and due to New Jersey State law, were unable to bill the State for its crossover claims for discharges occurring prior to FY 2004.

Reasonable Collection Efforts- The Administrator finds that the Providers did not exercise reasonable collection efforts because they failed to document and clearly demonstrate that the Providers rendered a specific decision of uncollectability and worthlessness, and that sound business judgment reflected no likelihood of recovery existed in the future. The Providers acknowledged that they did not document all of the phone calls they placed to secure debt recovery. The plain language of the Providers collection policy makes telephone calls central to their collection efforts and a failure to document such calls deviated from the Providers' own, self-established, reasonable collection efforts. Accordingly, the lack of documentation demonstrated a failure to establish reasonable collection efforts. Before the Board, the Providers, in response, argued that some of the bad debts disallowed were in fact sent to a collection agency and in that way fulfilled the reasonable collection effort criteria. The Administrator finds that the bad debts that were written off while pending at a collection agency did not "cure" the earlier deficiencies. The Administrator notes the longstanding policy of the agency is that such debts cannot be claimed as "uncollectible" and worthless while such debts are still pending at a collection agency.

"Must Bill" Policy- The Administrator finds that, as the Providers did not bill the State for the claims at issue in this case, 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 is required to bill the State for these claims. However, 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. 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 the debt was actually uncollectible when claimed.

A fundamental requirement to demonstrate that an amount is, in fact, unpaid and uncollectible, is to bill the responsible party. Section 310 of the PRM generally requires a provider to issue a bill to the party responsible for the beneficiaries' payment. Section 312 of the PRM, while allowing a provider to deem a dually eligible patient indigent and claim the

associated debt, first requires that no other party, including the State Medicaid program is responsible for payment. Section 322 of the PRM addresses the circumstances of dually eligible patients where there is a State payment ceiling. That section states that the "amount that the State does not pay" may be reimbursed as a Medicare bad debt. This language plainly requires that the provider bill the State as a prerequisite of payment of the claim by Medicare as a bad debt. Reading the sections together, the Administrator concludes that, in situations where a State is liable for all or a portion of the deductible and coinsurance amounts, the State is the responsible party and is to be billed 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.[18] The final decisions of the Secretary have consistently held that the bad debt regulation and the documentation requirements for payment set forth in the law and regulation require providers to bill the Medicaid programs for payment. These decisions have denied payment when there is no documentation that actual collection efforts were made to obtain payments from the Medicaid authority before an account is considered uncollectible and when the provider did not bill the State for its Medicaid patients.

Moreover, 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.

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

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

write-off a Medicare bad debt as worthless without first billing 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.

In light of the foregoing, the Providers had not demonstrated that the bad debts claimed by the Providers were actually uncollectible and worthless when written off on the various cost reports. The Providers did not bill the State and receive a remittance advice contemporaneous with the cost years at issue, as needed to meet the reasonable collection effort requirements of the regulation and manual provisions for the claims at issue in this case for the cost reporting period at issue and the hold harmless provision does not apply.[19] 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.[20] The amounts

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[19] The Administrator notes that the hold harmless provision, in accordance with JSM-370, does not apply in this case. In order for the provision to be applicable, among other criteria, the cost reporting period in question must occur before January 1, 2004. Thus, the Administrator finds that since this case deals with a FYE of 12/31/2004, the hold harmless provision is not applicable.

[20] 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 Providers have not submitted claims

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 accordance with section 314 of the PRM and 42 CFR 13.89(f), uncollectible Medicare deductible and coinsurance amounts are recognized, and only recognized, in the reporting period in which they are deemed worthless. As the court discussed in Palms of Pasadena v. Sullivan, 932 F.2d 982 (D.C. 1991), regarding when a bad debt may be claimed:

> Bad debts relating to Medicare patients can arise when these patients fail to pay their deductible or coinsurance despite the hospital's bona fide attempts at collection….If Medicare does not reimburse providers for these losses, this "could result in the related costs of covered services being borne by other than Medicare beneficiaries." … Medicare therefore steps in and compensates the provider for its losses, but it does so only after the Medicare patients' accounts actually become worthless…..Pursuant to this method, Medicare paid [the provider] a single amount for each bad debt relating to a Medicare patient, regardless of which hospital services gave rise to the debt.
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> The basic effect of these provisions is to bar providers from reporting bad debts on an accrual accounting basis. Rather, some bad debts-those arising from the failure of Medicare patients to pay their deductible or coinsurance amounts-are to be treated as if the provider were on a cash basis. That is, the provider reports (and is then reimbursed for) such Medicare bad debts only in the accounting period when the particular account receivable actually becomes worthless.[21]

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to the State, received and "maintained" the required remittance advices contemporaneous with the cost reporting period and furnished such documents to the Intermediary, contrary to this principle. Further, 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.

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

These provisions, like that of 42 CFR 413.89(f), ensure the proper recovery of bad debts while safeguarding against double dipping, or duplicative recoveries. In addition, the period in which a bad debt is claimed can affect the amount of the bad debt to be allowed, either because of the offset of recovered debts, or the affect of certain new provisions affecting the percentage of bad debts which will be paid in a specific cost year.[22] Because the Providers have not billed the State and the State had not issued 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 is a third party, the State who is responsible for coinsurance and deductibles, the Providers have not shown that they have used reasonable collection efforts

As the State has a legal obligation to pay the bad debts and the claims have not been submitted for processing to the State, the elements of the bad debts regulation are not met for this cost reporting period.[23] For the cost reporting periods during which contemporaneous remittance advices are received, bad debts may at that time be claimed for that cost reporting period if the criteria of 42 CFR 413.89 are otherwise met.

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

[23] 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.

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: 2/1/11

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

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