CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Diversicare 05-06 Medicare Bad Debts Group	**Medicare Reimbursement Cost Reporting Period(s) Ending: Various -8/31/2005;12/31/2005; 01/31/2006; and 02/28/2006**
Providers	
vs.	
Blue Cross Blue Shield Association/ National Government Services, Inc.	**Review of: PRRB Dec. No. 2011-D3 Dated: October 22, 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 commented requesting 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's adjustments to the Provider's Medicare bad debts were proper.

The Board found that the Intermediary improperly denied the Providers the right to claim additional Medicare bad debts because there is no absolute requirement that the Providers

bill the state Medicaid program and receive a Medicaid remittance advice (RA) prior to claiming unpaid deductible and coinsurance amounts as bad debts for dual eligible beneficiaries. The Board stated that, while it believes that a RA is one source of documentary evidence to support reasonable collection efforts, it is not the only reliable source of evidence. The Board stated that this case was unique because, due to circumstances beyond the Providers' control, they were unable to obtain the RAs.

The Board also found that the "must bill" policy does not violate the bad debt moratorium because there is no evidence that the Intermediary has changed its policy. The Board concluded that although there was not a violation of the bad debt moratorium, the Providers had actively pursued obtaining RAs and demonstrated reasonable collection efforts in their attempts to recover the bad debts.

SUMMARY OF COMMENTS

The Centers for Medicare (CM) commented, requesting reversal the decision of the Board.[1] CM stated that the Intermediary properly disallowed the bad debts because the Provider did not adhere to the policies requisite to meet the bad debt regulatory criteria, i.e., the must bill policy. In order to comply with 42 CFR 413.89(e), as well as with Section 322 of the Provider Reimbursement Manual (PRM), Medicare policy requires the Provider to document the State's liability for any cost-sharing amounts related to unpaid Medicare deductible and coinsurance amounts for dual-eligible beneficiaries. CM reiterated that, to effectuate this program requirement, Medicare has mandated the Provider to bill the State to determine whether the State is liable for payment: the "must bill" policy. CM maintained that the State's responsibility to determine its cost-sharing liability regarding dual-eligible beneficiaries is critical because individual States maintain complex billing systems and documentation requirements unique to each of their individual programs.

Specifically, CM noted that this determination is important for the eligibility category known as the Qualified Medicare Beneficiary (QMB) that was established as part of the Medicare Catastrophic Act of 1988 many years after the last changes to Chapter 3 of the PRM. QMBs are individuals, meeting the definition in §1905(p)(1) of the Act, who may be eligible for full Medicaid benefits or may have Medicaid eligibility limited to payment of Medicare Part A and B premiums and cost-sharing amounts. They are also Medicare

[1] 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."

beneficiaries entitled to the full range of Medicare covered services and provider options without regard to whether those services are covered under the Medicaid State Plan. Section 1905(p)(3) of the Act imposes liability for cost-sharing amounts for QMB's on the States, though Section 1902(n)(2) allows the States to limit that amount to the Medicaid rate and essentially pay nothing toward dual eligible patients' 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 the beneficiary's unpaid deductible amounts.

Further, CM pointed out that, for QMBs, Section 3690.14(A)(1) and (2) of the State Medicaid Manual requires the State Agency to provide, through the State Plan, the payment rates applicable for services that are covered or not covered, respectively, by the State Plan to determine the amount of Medicare coinsurance and deductibles that the State is responsible to pay. 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 informational retrieval systems that CMS determines "are compatible with the claims processing and information retrieval systems used in the administration of title XVIII" and "are capable of providing accurate and timely data."

CM further argued that the "must bill" policy was outlined clearly for bad debts for dual-eligible beneficiaries in a Joint Signature Memo (JSM) that was issued on August 10, 2004. The JSM was a reiteration of longstanding Medicare policy, and it was specifically related to Change Request No. 2976 that was issued on September 12, 2006 revising Part II, Section 1102.3L of the PRM, relating to Exhibit 5 to Form CMS No. 339.[2] CM reiterated that in those instances where the State owes none or only a portion of the dual-eligible patient's deductible or co-insurance, 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 as demonstrated with a State remittance advice. Even if the State Plan Amendment limits the liability to the Medicaid rate, a Provider can only verify the current dual-eligible status of a beneficiary and determine whether the State is liable for any portion by billing the State.

Finally, CM stated that JSM-370 reiterated instructions that specified in Change Request 2796 and meets the criteria of a JSM and does not set policy, convey new instructions, or provide clarification of existing requirements that affect contractor operations. If a JSM is transmitted into the clearance process, but is found not to be in accordance with applicable program criteria, a JSM will be returned to the originating component for a manual instruction prepared and submitted via the formal Change Management/Change Request

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

process. CM asserts that JSM-370, as with any JSM, has met the criteria of what constitutes a JSM.

The Providers commented requesting the Administrator affirm the Board's decision. The Providers stated that the failure to produce paid remittance advices from the State of Tennessee was not due to any inaction on part of the Provider. The Providers asserted that the Board's decision must be affirmed because the debt at issue is uncollectible and reimbursable bad debt. The Providers made vigilant collection efforts, notwithstanding the debt's uncollectible nature. The Providers further asserted that the Intermediary's reliance on JSM 370, in demanding remittance advices, is not consistent with relevant law and should be given little weight as it is not the appropriate vehicle to set policy.

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. [3]

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

[3] The Administrator notes that the Provider sent additional comments on December 2, 2010. The Administrator cannot consider these additional comments because they are untimely but they have been made a part of the Administrative record.

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,[4] 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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[4] 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.
>
> 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 PRM provides further guidance with respect to the payment of bad debts. Section 310 of the PRM provides the criteria for meeting reasonable collection efforts. A reasonable collection effort, *inter alia*, includes:

> the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations.... (See Section 312 for indigent or medically indigent patients.) (Emphasis added.)

Moreover, Section 310.B states that the provider's collection effort is to be documented "in the patient's file by copies of the bill(s)...." Section 312 of the PRM explains that individuals who are Medicaid eligible as either categorically or medically needy may be automatically deemed indigent. However, Section 312.C requires that:

> The provider must determine that no source other than the patient would be legally responsible for the patient's medical bills; e.g., title XIX, local welfare agency and guardian.... (Emphasis added.)

Finally, Section 312 also states that:

> [O]nce indigence is determined, and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 [reasonable collection effort] procedures. (See Section 322 of the PRM for bad debts under State welfare programs.)

Relevant to this case, Section 322 of the PRM[5] notes that:

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

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

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

> In some instances the State has an obligation to pay, but either does not pay anything or pays only part of the deductible, or coinsurance because of a State payment "ceiling." For example assume that a State pays a maximum of $42.50 per day for the SNF services and the provider's cost is $60.00 a day. The coinsurance is $32.50 a day so that Medicare pays $27.50 ($60.00 less $32.50). In this case, the State limits its payment towards the coinsurance to $15.00 ($42.50 less $27.50). In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of §312 are met. (Emphasis added.)

Section 322 of the PRM concludes by explaining that:

> If neither the title XIX plan, nor State or local law requires the welfare agency to pay the deductible and coinsurance amounts, there is no requirement that the State be responsible for these amounts. Therefore, any such amounts are includable in allowable bad debts provided that the requirements of §312, or if applicable, §310 are met. (Emphasis added.)

The patients' Medicaid status at the time of service should be used to determine their eligibility for Medicaid to satisfy the requirement of Section 312. A patient's financial situation and Medicaid eligibility status may change over the course of a very short period of time. The State maintains the most accurate patient information to make the determination of a patient's Medicaid eligibility status at the time of service and, thus, to determine its cost sharing liability for unpaid Medicare deductibles and coinsurance. In addition, it is clear from Section 322 of the PRM that the amount that can be claimed as bad debts is the amount the State "does not pay" which presumes that the State has been billed.

The Administrator, through adjudication, further addressed this policy in Community Hospital of the Monterey Peninsula, PRRB Dec. No. 2000-D80. As a result of that litigation, CMS issued a memorandum on August 10, 2004 regarding bad debts of dual-eligible beneficiaries.[6] The Joint Signature Memorandum (JSM-370) restated Medicare's longstanding bad debt policy that:

[6] JSM 370 (Aug. 10, 2004), Intermediary's Final Position Paper (Jul. 30, 2008), Section IV.

> [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.[7] 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.[8] The memorandum also stated that regarding dual-eligible beneficiaries, Section 1905(p)(3) of the Act imposes liability for cost-sharing amounts for QMBs on the States through Section 1902(n)(2) that allows the States to limit that amount to the Medicaid rate and essentially pay nothing towards dual-eligible cost-sharing if the Medicaid rate is lower than what Medicare would pay for the service.[9] Where the State owes none, or a portion of the dual-eligible deductible and coinsurance amounts, the unpaid liability for the bad debt is not reimbursable until the provider bills the State and the State refuses payment, all of which is demonstrated through a Remittance Advice.

Importantly, the memorandum also indicated that, in November 1995, language was added to the PRM at Section 1102.3L, which was inconsistent with the must bill policy.[10] 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.[11]

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

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.

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

A fundamental requirement to demonstrate that an amount is, in fact, unpaid and uncollectible, is to bill the responsible party. Section 310 of the PRM generally requires a provider to issue a bill to the party responsible for the beneficiaries' payment. Section 312 of the PRM, while allowing a provider to deem a dually eligible patient indigent and claim the associated debt, first requires that no other party, including the State Medicaid program is responsible for payment. Section 322 of the PRM addresses the circumstances of dually eligible patients where there is a State payment ceiling. That Section states that the "amount

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

that the State does not pay" may be reimbursed as a Medicare bad debt. This language plainly requires that the provider bill the State as a prerequisite of payment of the claim by Medicare as a bad debt and that the State make a determination on that claim. The above policy has been consistently articulated in the final decisions of the Secretary addressing this issue, since well before the cost year in this case.[13]

Consistent with the statute, regulation and PRM, a provider must bill the State and the State must process the bills or claims to produce a remittance advice for each beneficiary to determine their Medicaid status, at the time of service and the State's liability for unpaid Medicare deductible and coinsurance amounts. Thus, it is unacceptable for a provider to write-off a Medicare bad debt as worthless without ensuring that the State has been billed (whether through the automated crossover claim or direct billing) and having received a determination from the State as to the amount of its financial obligation. The State has the most current and accurate information to make a determination on the beneficiaries status at the time of the services and to determine the State's cost sharing liability for all covered stays of dual eligible beneficiaries.[14]

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

[14] In addition to verifying the validity of the provider's bad debt, submission of the claim to the State and preservation of the remittance advice is an essential and required record keeping criteria for Medicare reimbursement. Under Section 1815 of the Act, no Medicare payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider. Consistent with the statute, the regulations require that providers maintain verifiable and supporting documents to justify their requests for payment under Medicare. The regulation at 42 CFR 413.20 provides that: "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for provider determination of costs payable under the program.... Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained...." As used in the context of the regulation at §413.20, "maintain" means that the provider is required to keep "contemporaneous" records and documentation throughout the

In this case, the Providers are five skilled nursing facilities located in Tennessee. This appeal involves the Intermediary's disallowance of crossover bad debts included in the Providers' cost reports submitted for various years ending in 2005 and 2006. The Providers' crossover bad debt claims at issue are related to covered services and derived from deductible coinsurance amounts. The Intermediary disallowed some of the bad debts submitted, relating to Medicare/Medicaid crossover claims, based on the Providers' failure to provide Medicaid paid remittance advices, which the Intermediary stated was required for reimbursement under the Secretary's "must bill" policy.

TennCare is Tennessee's Medicaid service provider/administrator. In November 2004, TennCare launched a new system for processing Medicaid Level 1 & 2 claims electronically.[15] The Providers alleged that there were several technical issues due to the launch of the new electronic system which led to a backlog of its Level 1 and Level 2 claims. The Providers' further asserted that these technological issues eventually hindered the Providers' ability to process its bad debt crossover claims, the specific claims at issue in this appeal.[16] During this time, the Providers' bad debt crossover claims were still being processed manually and submitted by mail in paper format.[17]

The Providers maintained that prior to the electronic conversion they had not experienced any significant difficulty with TennCare's processing of mailed-in crossover claims and that when a problem would arise, TennCare denied the Provider any method of recourse to solve

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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.

[15] Providers' Post Hearing Brief at 3. Level 1 &Level 2 claims are for room and board claims for both non-skilled nursing homes and skilled care nursing home residents and are not the same type of claim as the bad debt crossover claims at issue in this case. The Providers asserted that the prompt payments of these claims are critical to the operation of their business and thereby making them the priority.

[16] Providers' Post Hearing Brief at 4-5. The Providers alleged & testified the various problems with the electronic system included claims being duplicated, paid at incorrect rates, transposing of patient's records, patient eligibility issues, and data being entered by the Providers but never received by TennCare due to technical errors, etc.

[17] The Providers further asserted that during this time, TennCare had prioritized processing Level 1 and 2 claims ahead of crossover claims, which were still being submitted by mail on paper invoice and manually inputted into the system.

the issue.[18] Additionally, the Providers' asserted that they diligently attempted to contact TennCare on a weekly basis to receive RAs for the crossover claims but that TennCare was more focused on the higher priority Level 1 & 2 claims and shelved or ignored some of the crossover claims submitted in 2005 and 2006.[19] The Provider claimed that for all the bad debts at issue in this case, the Provider timely billed and re-billed TennCare and that it is due to the failures on the part of TennCare, and not to any fault of the Providers, that the Providers were unable to receive the RAs required by the Intermediary's "must bill" policy.[20]

This case turns on the undisputed fact there are no determinations by the State on these claims. The Administrator finds that, in order to determine the State's liability and, likewise, the amount of coinsurance and deductible attributable to Medicare bad debt, the Providers must first resolve the issue with the State and receive a determination from the State on the amount of the State obligation on the claims at issue. The shorthand reference to the policy at issue as the "must-bill" policy does not fully capture the requirements that must be met. The policy not only requires that the claim be billed, but that a determination must be made by the State on the State's financial and legal obligations.[21] The Providers in this case have not demonstrated that the bad debts now identified by the Providers were "actually uncollectible when claimed as worthless" and that "there is no likelihood of recovery at any time in the future" and that sound business judgment has established no likelihood of recovery in the future. While the Administrator notes that the Providers testified to actively pursuing RAs, until such time as the Providers receive a determination from the State on these claims, the claims cannot be allowed as Medicare bad debts.

In light of the foregoing, the Providers have not demonstrated that the bad debts claimed by the Provider were actually uncollectible and worthless when written off in the respective cost report periods. The Provider did not receive the paid remittance advice from the State as needed to meet the reasonable collection effort requirements of the regulation and manual

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[18] Provider's Post Hearing Brief at 6-7.
[19] Provider's Post Hearing Brief at 8.
[20] Provider's Post Hearing Brief at 9.
[21] 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.

provisions for the claims at issue in this case for the cost reporting periods at issue. 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.[22] 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 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.

[22] 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 at 42 CFR 413.20. 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. 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.

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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.[23]

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.[24] Because the State has not issued RAs for these services contemporaneous with these 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 Provider has not shown that it has 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.[25] For the

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[23] 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.

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

[25] 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

cost reporting period 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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the Medicare funding, with the providers claims for payment which can be made under two different program for which Medicare is the payor 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: 12/30/10

/s/
Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

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