CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Medicare Inpatient/Outpatient Unbilled Bad Debts Group Appeals	**Provider Reimbursement Determination for Cost Reporting Periods Ending: Various FYE October 1995- December 2004**
Provider	
vs.	
Noridian Healthcare Solutions, LLC	**Review of: PRRB Dec. No. 2015-D23 Dated: September 14, 2015**
MAC	

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 set forth in §1878(f) (1) of the Social Security Act (Act), as amended, 42 U.S.C. §1395oo (f)). The Center for Medicare Management (CM) submitted comments requesting that the Administrator review the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. The Providers' submitted comments, requesting reversal of the Board's decision. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND THE BOARD'S DECISION

The issue is whether the Providers were required to bill the State Medicaid program and submit a State remittance advice (RA) to the Medicare Contractor (MAC) as a precondition for the Medicare program to pay bad debts for unpaid coinsurance and deductibles for individuals who are eligible for both Medicare and Medicaid.

The Board held that the MAC properly disallowed the Providers' bad debts in this case. The Board found that the applicable statute, regulations, and polices, as well as the decision in *Community Hosp. of the Monterrey Peninsula v, Thompson* 323 F.3d 782 (9th Cir. 2003), have clearly established Medicare's must-bill policy and that the Providers had a duty to bill the State, receive the remittance advice and submit it to the MAC in order to receive reimbursement for the bad debts. The Board also determined that the Providers attempt to

provide alternative documentation did not meet the must-bill requirements and could not be used in place of the state remittance advices. [1]

SUMMARY OF COMMENTS

The Center for Medicaid Management (CM) commented agreeing with the Board's decision regarding the MAC's adjustments. However, CM asserted that the Board misinterpreted the Bad Debt Moratorium and asked the Administrator to clarify the law for the record. CM stated that the Board suggested that if the Providers demonstrated that the Intermediary had accepted a policy prior to August 1, 1987, then the same prong would have allowed that policy to continue to be applied during the moratorium. However the second prong specifies that any acceptance by the Intermediary must be "in accordance with the rules in effect as of August 1, 1987." CM argued that 42 C.F.R. §413.89(e) sets forth four criteria that must be met collectively to claim an allowable bad debt and, arguendo, if a MAC misapplied the bad debt policy prior to August 1, 1987, CM asserts that the Bad Debt Moratorium still would not allow the MAC to misapply a bad debt policy and hence be out of compliance with the regulation and the PRM.

The Providers commented requesting that the Administrator reverse the Board's decision. The Providers argued that the MAC's disallowance violates the Bad Debt Moratorium and, contrary to the Board's assertion, that the Provider's case is not controlled by the Ninth Circuit Court decision. In addition, the Providers asserted that the alternative reports they provided, in lieu of the State remittance advices, should satisfy the must-bill policy. The Providers also alleged that the Board omitted or incorrectly summarized facts to the record in its decision. The Providers also argued that the PRRB incorrectly found HCFA Form 339's instructions required the Providers to "maintain and provide contemporaneous documentation." Finally, the Providers maintained that there was not a must-bill policy in place prior to the Bad Debt Moratorium and that, arguendo, even if applied, the Providers satisfied the requirements.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

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[1] The Board notes that the unpaid coninsurance and deductibles at issue involve the Providers' inpatient and *outpatient* crossover claims. To the extant any outpatient claims involve services for which payments are made under a fee schedule, the Administrator notes that bad debts are not allowed.

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 (Emphasis added.)

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

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

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

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[2] 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.…"

> remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not an allowable cost. (Emphasis added.)

The circumstances under which providers may be reimbursed for the bad debts derived from uncollectible deductibles and coinsurance amounts are set forth at paragraph (e). The regulation at 42 CFR 413.89(e) states that to be allowable, a bad debt must meet the following criteria:

> 1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
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> 2) The provider must be able to establish that reasonable collection efforts were made.
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> 3) The debt was actually uncollectible when claimed as worthless.
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> 4) Sound business judgment established there was no likelihood of recovery at any time in the future.

Further, 42 CFR 413.89(f) explains the charging of bad debts and bad debt recoveries:

> The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made. (Emphasis added.)

To comply with section 42 CFR 413.89(e)(2), the Provider Reimbursement Manual or PRM provides further guidance with respect to the payment of bad debts. Section 310 of the PRM provides the criteria for meeting reasonable collection efforts. A reasonable collection effort, *inter alia*, includes:

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

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

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

Finally, section 312 also states that:

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

Relevant to this case, section 322 of the PRM[3] 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,

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[3] 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...."

> 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.

The patient's Medicaid status at the time of service should be used to determine their eligibility for Medicaid to satisfy the requirement of section 312, which refernces section 322 regarding bad debts under a State Welfare program.) 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 the State's 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 as all responsible parties are expected to be billed. The requirement that the Provider submit a bill to the State (the party responsible to pay) and obtains a remittance advices (or RA) is also consistent with the general record keeping rules of Section 1815(a) and 42 C.F.R. 412.20 and 412.24 requiring contemporaneous auditable documentation kept in the normal course of business to support claim for payment.

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.[4] 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.

[4] JSM 370 (Aug. 10, 2004).

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.[5] The memorandum noted that in Community Hospital of the Monterey Peninsula v. Thompson, 323 F.3d 782 (2003), the Ninth Circuit upheld the must bill policy of the Secretary.[6] 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.[7] 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.[8] The Ninth Circuit panel found that alternative offered at 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 be consistent with the pre-1995 language, which always requires as the only appropriate documentation, that the providers bill the individual States for dual-eligible coinsurance and deductible amounts and receive a remittance advices before claiming as a Medicare bad debt.[9]

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

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[5] Id.

[6] Id. The memorandum cites to Community Hospital of the Monterey Peninsula v. Thompson, 323 F.3d 782 (2003). Section 1878(f) of the Social Security Act provides that: "Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia…." Therefore the Providers are correct that they may also seek review in the District Court for the District of Columbia or the appropriate judicial district located in the Ninth Circuit (i.e., the Circuit in which the Community Hospital case is controlling law.)

[7] Id.

[8] Id.

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

instructions previously laid out at 1102.3L, for open cost reporting periods beginning prior to January 1, 2004 and were allowed payment pursuant to its instructions by the MAC. MACs that followed the now-obsolete section 1102.3L instructions for cost reporting periods prior to January 1, 2004, were permitted to 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. MACs that required the provider to file a State remittance advices for cost reporting periods prior to January 1, 2004 may not reopen the provider's cost reports to accept alternative documentation for such cost reporting periods. This hold harmless policy affects only those providers with cost reports that were open as of the date of the issuance of the memorandum relating to cost reporting periods before January 1, 2004 and who relied on the previous language of section 1102.3L in providing documentation.

Relevant to certain Medicare bad debt claims, section 4008(c) of the Omnibus Reconciliation Act of 1987 (OBRA), as amended by the section 8402 of the Technical and Miscellaneous Revenue Act of 1988, and section 6023 of OBRA 1989 imposed a "moratorium" on changes to the Medicare bad debt policy in effect on August 1, 1987, as applied to hospitals. Specifically, the moratorium states, in part that:

> In making payments to hospitals under [the Medicare Program], the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under [the Medicare program] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under [the Medicare program] (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency).
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> The Secretary may not require a hospital to change its bad debt collection policy <u>if a fiscal Intermediary, in accordance with the rules in effect as of August 1, 1987</u>, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy. (Emphasis added.)

In addition, the Conference Report accompanying the 1988 legislative amendment states that:

> [T]he Congress intended that the actions of the fiscal intermediaries occurring prior to August 1, 1987 to approve explicitly hospital's bad debt collection

> practices, to the extent such action by the fiscal Intermediary was consistent with the regulations, PRRB Decisions, or program manuals and issuances, are to be considered an integral part of the policy in effect on that date, and thus not subject to change. However, the conferees do not intend to preclude the Secretary from disallowing bad debt payments based on the regulations, PRRB decisions, manuals, and issuances in effect prior to August 1, 1987.[10]

With respect to this latter consideration, the court in Hennepin County Medical Center v. Shalala, 81 F.3d 743 (8th Cir. 1996), explained that:

> In passing the moratorium, Congress was motivated to prevent unexpected consequences to providers from the inspector general's proposed changes in the criteria for ` bad debt reimbursement. 1988 Conf. Rep. 277, reprinted in 1988 U.S.C.C.A.N. at 5337. Permitting correction of errors made by intermediaries in the application of rules existing on August 1, 1987 is consistent with that policy. It appears Congress merely sought to freeze a moment in time, forbidding the Secretary to change the criteria after that date, but allowing full enforcement of the policies in place before it.
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> Requiring that a provider's policies were in accord with the rules existing in 1987 does not render the moratorium meaningless. It leaves intermediaries, the PRRB, HCFA, and the Secretary free to correct improper applications of the rules as they existed and as they were interpreted on August 1, 1987. It prevents those entities from retroactively applying new rules or new interpretations of existing rules, however. This interpretation coincides with the intent of Congress that the inspector general not revise the Secretary's interpretations of the existing rules.
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> …
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> There is also no indication that the 1989 amendment was intended to prevent the Secretary from applying the rules existing on August 1, 1987, as Congress had explicitly intended she be able to do under the 1987 and 1988 amendments. 1988 Conf. Rep. 277, reprinted in 1988 U.S.C.C.A.N. at 5337. The 1989 conference report describes the amendment in that year as a "Clarification of continuation of August 1987 hospital bad debt recognition policy." 1989 Conf. Rep. at 737, reprinted in 1989 U.S.C.C.A.N. at 3340 (emphasis added). The House Report from the same year emphasized that the amendment "further clarified" the "existing prohibition." H.R.Rep. No. 247, 101st Cong., 1st Sess. 998–99 (1989), reprinted in 1989 U.S.C.C.A.N.1906, 2469–70. Since the 1989 amendment was a clarification of the earlier

[10] H.R.Rep. 100-1104 (October 21, 1988) to accompany H.R. 4333 [Pub. L. 100-647], at 277.

> amendments, there is no reason to believe that Congress intended to disavow its earlier statements that the existing rules, including the reopening regulation, were to be enforced.[11]

In fulfilling the requirements of sections 312 and 322 of the PRM, Medicare requires a provider to bill the State and receive a remittance advice that documents the Medicaid status of the beneficiary at the time of service, and the State's liability for unpaid deductibles and coinsurance as determined and verified by the State. Accordingly, revised section 1102.3L of the PRM, Part II (Exhibit 5 to Form CMS-339)[12] requires the submission of the following documentation:

1. Evidence that the patient is eligible for Medicaid, e.g., Medicaid card or I.D. number
2. Copies of bills for Medicare deductibles and coinsurance that were sent to the State Medicaid Agency.
3. Copies of the remittance advice from the State Medicaid Agency showing the amount of the provider's claim(s) for Medicare deductibles and coinsurance denied.

In this case, the Providers are all located in California and participants in the California State Medicaid program, Medi-Cal. For the cost reporting periods at issue, the Provider claimed as bad debts for uncollected coinsurance and deductible amounts related to the care of dual eligibles and did not submit State RAs for each bad debt claim.[13] The MAC disallowed the uncollected coinsurance and deductible amounts as bad debts for which there were no State Medicaid remittance advices. The Providers stated that the State Medi-Cal program failed to issue remittance advices in some instances and also that Medi-Cal changed its payment policy and imposed a payment ceiling. The Providers maintained that, as a result of the payment ceiling, the Medi-Cal payments were often zero or only a dollar or two in 80% of the claims submitted. Accordingly the Providers alleged that it was not cost-effective for them to bill Medi-Cal.[14] In lieu of billing Medi-Cal to obtain the State remittance advicess, the Providers contracted in 2007, after the cost reports at issue, with what it claimed was the same contractor used by the State of California to produce reports to submit with their cost reports as an alternative documentation to the State remittance

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[11] Hennepin County Medical Center v. Shalala, 81 F.3d 743, 750-751 (8th Cir. 1996).

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

[13] The Providers testified that they billed for some of the dual eligible patients but due to various factors related to the billing process they decided, as a business decision, to stop billing, alleging that it was not cost effective. See Transcript of Oral Hearing (Tr.) pp 153-170.

[14] Providers' Final Position Paper at 6; Tr. at 138, 153 (Aug. 23, 2012).

advices. While the Providers initially suggested the claims were being run by the State's software, the EDS reports that the Providers obtained from the contractor were certified as follows: "INFORMATION PROVIDED ON THIS REPORT IS DERIVED FROM CLAIMS DATA SUBMITTED BY A. CARLSON ASSOCIATES ON BEHALF OF ITS HOSPITAL CLIENTS AND PROCESSED (ELIGIBILITY VERIFIED AND MEDI-CAL PAYMENT/CUTBACK COMPUTED) ACCORDING TO MEDI-CAL PROCEDURES AND POLICIES USING PAYMENT RATES IN EFFECT AT THE TIME OF SERVICE."[15]

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 Administrator finds that, regardless of any alleged omissions by the State to provide the Medicaid remittance advices and the payment ceiling, or the alleged financial inconvenience to do so, the Providers were required to bill for and produce the remittance advices as a condition of including crossover bad debt claims on its cost report. Accordingly, the failure to produce the Medicaid remittance advices represents a failure on the part of the Providers to meet the necessary criteria for Medicare payment of bad debts related to these claims and the MAC was correct to deny the crossover bad debt claims for the cost years at issue.

In order to determine the State's liability and, likewise, the amount of coinsurance and deductible attributable to Medicare bad debt, the Providers are required to bill the State for these claims and receive a remittance advice. It is only through the State's records and claims system that the amount of any payment can be determined. This necessity is recognized by the statute at section 1903(r)(1) as it requires automated facilitation of cross-over claims between State Medicaid programs and the Medicare program for dual eligible patients. The policy requiring a provider to bill the State, 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) 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 from the responsible party (i.e. the State) 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

[15] See Providers' Post Hearing Brief at 16.

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, which has been in effect since prior to August 1, 1987, 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 and a remittance advice issued 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 and applied to prior cost years prior to August 1, 1987.[16] 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 and receive a remittance advice from the State for its Medicaid patients.

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[16] 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. The record also contains letters from the three Intermediaries setting forth the must-bill policy. *See* Providers' Exhibits' P-2, P-3, P-4 and P-6. See also *St. Joseph Hospital*, PRRB Dec. No. 84-D109 (April 16, 1984)(holding that collection efforts were not adequate when a Provider failed to take a claim to collections to collect amounts owed by the Medicaid systems.) See, e.g., Concourse Nursing Home, PRRB Dec. No. 83-D152 (1977 and 1978 cost years denied as there was no documentation that actual collection efforts were made to obtain payment from the Medicaid authorities before account balances were considered uncollectable).

This requirement is reasonable as 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. Thus, regardless of a State's rates, only through billing and receiving a State Medicaid Remittance advice can a provider demonstrate that a State is or is not liable for any portion thereof.

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. A provider must demonstrate that a debt was uncollectible when claimed as worthless. With respect to a dual eligible, this can only be done by billing the welfare agency for each deductible or coinsurance amount and receiving a partial or total denial of the claim. The denial must be documented and made available to the auditor upon request. Thus, it is unacceptable for a provider to write-off a Medicare bad debt as worthless under 42 C.F.R. §413.89(e) without first billing, then receiving, and finally submitting to Medicare, the remittance advice from the State. Even in cases where the provider has calculated that the State has no liability for outstanding deductible and coinsurance amounts, the provider must bill the State and receive a remittance advice before claiming a bad debt as worthless because, as stated above, the State has the most current and accurate information to make a determination on the beneficiaries status at the time of the services and to determine the State's cost sharing liability for all covered stays of dual eligible beneficiaries.

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 since the beginning of the program. 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 MAC 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 MAC, contrary to this principle. Further, any suggestion that amounts subsequently recovered can be offset in subsequent years, ignores that the incentive to bill (and hence recover the bad debt) has been removed once Medicare prematurely pays the bad debt.

However, the Providers, although conceding the decision not to bill was made because it determined it was not "cost effective", now state that they satisfied the alternative criteria at section 1102.3L and that section 1102.3L was the only fair notice that providers received between 1995 and 2004 on the CMS requirements for establishing unpaid coinsurance and deductible and was rescinded in violated of the moratorium and APA requirements. The Providers also contend that, even if section 1102.3L is not followed, the EDS reports from the contractors qualified as State remittance advices.

The Administrator finds that the Providers' arguments suggesting reliance and the contention that section 1102.3L was the only "fair notice" of the policy for claiming unpaid insurance deductibles and bad debts, ignores the longstanding foregoing PRM provisions, bad debt and documentation regulations and longstanding policy set forth in Administrator decisions established prior to August 1, 1987 and the cost years in this case. The Providers also claim that CMS' retraction of section 1102.3L was a change in bad debt policy in violation of the bad debt moratorium, etc.[17] However, section 1102.3L was not added until after the moratorium date and the Administrator finds that the bad debt moratorium does not prohibit the disallowances in this case for these Providers. As the JSM explained, concerning the retraction of section 1102.3L, the addition of this provision in 1995 represented a violation of the Bad Debt Moratorium as it allowed for documentation that deviated from policy established prior to August 1, 1987. The must-bill policy also has been in effect since before August 1, 1987, as is evidenced in numerous Administrator and Board decisions. In addition, the longstanding PRM sections 310 and 312 and 322, when read together, require that the Providers bill the State. Additionally, the longstanding regulations and statute require showing a debt is worthless as claimed and that reasonable collection efforts have been met and requires the maintaining of contemporaneous documentation to support a claim. Moreover as the Community court noted, in the alternative, section 1102.3L needs to be read to require documentation reflecting "data available from the Institution's basic

[17] The recent case in Mountain States Health Alliance v. Burwell, No. 13-641 (RDM) involves the similar collection effort criteria which is not an issue in this case and the court incorrectly, *inter alia*, failed to recognize the administrative holding in the cases cited for support reflected the cost years for which legal threats were not allowed against the beneficiaries and hence were consistent with the prohibition and did not reflect a change in policy to allow dissimilar collection efforts and also fails to recognize when the end result is correct in a case the Administrator may decline to review or summarily affirm the issue when another issue in the case is reviewed to prevent a case from being bifurcated.

accounts, as usually maintained (42 C.F.R. 413.26(a)). In this case the Providers have not maintained "contemporaneous documentation in the ordinary course of business to support their claims" which in fact, the State remittance advices represent.

In addition, any relief CMS grants based on a Provider's reliance on section 1102.3L is set forth under criteria of the JSM "hold harmless" policy. While suggesting "reliance" on section 1102.3L, the Providers do not show that in past years the Providers had claimed and that the MAC had, in fact, allowed payment under section 1102.3L. More specifically, the Providers did not demonstrate that they meet the criteria for the hold harmless provision set forth in JSM-370 for the cost years in this case. The "hold harmless" policy found in the August 10, 2004 JSM-370, applies to a provider who has previously relied on alternative billing methods permitted under 1102.3L:

> **This memorandum is to serve 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 1102.3L 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 allowable 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 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 issuance of this memorandum, relating to cost reporting periods before January 1, 2004, and who relied on the previous language of section 1102.3L in providing documentation. [18]

Accordingly, under the hold harmless provision, the Providers failed to demonstrate that prior to January 1, 2004, the Providers relied on Section 1102.3L and alternative documentation to support their crossover bad debt claims and that the MAC accepted such documentation and made payment based upon such documentation. The Providers in this case had, in prior years, previously billed and received remittance advicess, but decided that it was no longer cost effective for them to do so and instead, long after the fact,[19] tried to use

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[18] JSM 370 (Aug. 10, 2004). MAC Exhibit I-41.

[19] The record shows that the contractor, EDS was contracted with on May 14, 2007. Provider Exhibit P-95 and P-103.

alternative documentation created after the cost years at issue.[20] Consistent with those failures, as payment *had not* ever been made for the years at issue 1994 through 2005 to the Providers consistent with section 1102.3L. (erroneously added in 1995), upon which reliance can be based, the Administrator also notes that, on its face, only a small percentage of the multiple cost years appealed in this extremely large gropu could have possibly been open cost reports for periods beginning prior to January 1, 2004 and unsettled on the date of the August 10, 2004 JSM-370. The JSM instructs that MACs that required the provider to filed a State remittance advice for cost reporting periods prior to January 1, 2004 *may not reopen* the provider's cost report to accept alternative documentation for such cost reporting periods. Therefore, the Providers did not show that the JSM "hold harmless" policy applies to the Providers' cost years in this case.

Further, the Providers' contentions that the EDS reports qualify as remittance advices also fails. First the EDS reports are not contemporaneously generated State documents. Second, on its face, while the Providers suggest they are the same as remittance advices, as the Board properly observed, they were not validated, certified or adopted as State documents and do not quality as State remittance advices.

In sum, 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 payor of last resort.

[20] See Providers' Post Hearing Brief at pp 13-17.

DECISION

The Board's decision is affirmed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: Nov. 12, 2015

/s/
Patrick H. Conway, M.D., MSc
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services