

**CENTERS FOR MEDICARE AND MEDICAID SERVICES**  
*Decision of the Administrator*

**In the cases of:**

**Memorial Hermann Continuing  
Care Hospital**  
  
**Providers**

**vs.**

**Cahaba Safeguard Administrators, LLC**  
  
**Intermediary**

**Claim for:**

**Cost Reporting Period(s) Ending:  
02/28/2005 and 02/28/2007**

**Review of:  
PRRB Dec. No. 2017-D6  
Dated: February 9, 2017**

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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. No comments were received.

**ISSUE AND BOARD'S DECISION**

The issue is whether the Medicare Contractor's adjustment to apply the "must bill" policy to bad debts related to dual eligible Medicare and Medicaid beneficiaries was proper.

The Board held that the MAC correctly denied the bad debt reimbursement based on the Provider's failure to bill and receive the required state remittance advice (RAs). Additionally, the Board held that there was no evidence in the record to demonstrate that the Bad Debt Moratorium was violated.

**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. 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 Medicare administrative contractors (MACs) 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, 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:

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.

The regulation at 42 CFR 413.1 explains that: “This part sets forth regulations governing Medicare payment for services furnished to beneficiaries” and continues to state that: “Under reasonable cost reimbursement 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...” 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.

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

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

Further, 42 CFR 413.89(f) explains the charging of bad debts and bad debt recoveries: The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made. (Emphasis added.)

To comply with section 42 CFR 413.89(e)(2), the Provider Reimbursement Manual or PRM provides further guidance with respect to the payment of bad debts.

Section 310 of the PRM provides the criteria for meeting reasonable collection efforts. A reasonable collection effort, inter alia, includes: “the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations.... (See section 312 for indigent or medically indigent patients.)” (Emphasis added.)

Moreover, Section 310.B states that the provider's collection effort is to be documented "in the patient's file by copies of the bill(s)...."

Section 312 of the PRM explains that individuals who are Medicaid eligible as either categorically or medically needy may be automatically deemed indigent. However, section 312.C requires that:

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

Finally, section 312 also states that:

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

Relevant to this case, section 322 of the PRM provides 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.)

Relevant to this case, 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.<sup>1</sup> 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

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<sup>1</sup> 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...."

or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of §312 are met. (Emphasis added.)

Section 322 of the PRM concludes by explaining that:

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

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

The Administrator, through adjudication, further addressed this policy in Community Hospital of the Monterey Peninsula, PRRB Dec. No. 2000-D80 (Oct. 31, 2000). As a result of that litigation, CMS issued a joint memorandum on August 10, 2004 regarding bad debts of dual-eligible beneficiaries. The Joint Signature Memorandum (JSM-370) restated Medicare's longstanding bad debt policy that:

[I]n those instances where the State owes none or only a portion of the dual eligible patient's deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State remittance advice). Even if the State Plan Amendment limits the liability to the Medicaid rate, by billing the state, a provider can verify the current dual-eligible status of the beneficiary and can determine whether or not the State is liable for any portion thereof. Thus, in order to meet the requirements for a reasonable collection effort with respect to deductible and coinsurance amounts owed by a dual-eligible beneficiary, the longstanding policy of Medicare is that a provider must bill the patient or entity legally responsible for such debt and receive a determination by the State on such a claim.

The memorandum noted that in, *Community Hospital of the Monterey Peninsula v. Thompson*, supra, (2008), the Ninth Circuit upheld this policy of the Secretary. 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. Where the State owes none, or a portion of the dual-eligible deductible and coinsurance amounts, the unpaid liability for the bad debt is not reimbursable until the provider bills the State and the State refuses payment, all of which is demonstrated through a Remittance Advice. Importantly, the memorandum also indicated that, in November 1995, language was added to the PRM at section 1102.3L, which was inconsistent with this policy. The Ninth Circuit panel found that section 1102.3L was inconsistent with the Secretary's policy and also noted that, effective in August of 1987, Congress had imposed a moratorium on changes in bad debt reimbursement policies and, therefore, the Secretary lacked authority in November of 1995 to promulgate 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-eligible co-pays and deductibles before claiming Medicare bad debts. 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.

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 (to pre-1995 language) section 1102.3L of the PRM, Part II (Exhibit 5 to Form CMS-339) 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.

(See Change Request 2796, issued September 12, 2003.)

The Provider in this case is a long term care hospital (“LTCH”) located in Houston, Texas. For the fiscal years at issue (FYE 2005 and 2007), the Provider did not enroll in the State's Medicaid program and, did not bill the Texas Medicaid program for any deductible or coinsurance amounts attributable to these dual eligible beneficiaries.

During the cost reporting periods at issue, the Provider claimed Medicare bad debts on its cost reports for all unpaid coinsurances and deductibles for beneficiaries who were also eligible for Medicaid benefits under the State's Medicaid program (i.e., dual eligible beneficiaries) but did not include State issued remittance advices (RAs). The MAC disallowed all the bad debts based upon the "must bill" policy which requires the Provider to bill the State Medicaid program and obtain a RA.

After a review of the record and the applicable law and Medicare policy, the Administrator agrees with the Board and finds that the Provider failed to meet all the regulatory requirements and the Manual guidelines for reimbursement of the subject amounts as Medicare bad debts. The bad debts claimed by the Provider on its cost report should be disallowed because the Provider, as a matter of choice, decided to be a Medicare-only facility and failed to determine if the State was liable for any cost sharing amounts and, thus, the Provider failed to determine that the debt was actually uncollectible when claimed as worthless as required under 42 C.F.R 413.89(e)(3) and Chapter 3 of the PRM.<sup>2</sup>

In order to determine the State's liability and, likewise, the amount of coinsurance and deductible attributable to Medicare bad debt, the Provider is required to bill the State for these claims and receive a determination from the State on that claim. 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. 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 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) 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

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<sup>2</sup> Tr. at 68:6-7.

that the State does not pay" may be reimbursed as a Medicare bad debt. This language plainly requires that the provider bill the State as a prerequisite of payment of the claim by Medicare as a bad debt receive a determination on that claim and that the State make a determination on that claim.

Reading the sections together, the Administrator concludes that, in situations where a State is liable for all or a portion of the deductible and coinsurance amounts, the State is the responsible party and is to be billed, and a determination made by the State in order to establish the amount of bad debts owed under Medicare. The above policy has been consistently articulated in the final decisions of the Secretary addressing this issue, since well before the cost year in this case.<sup>3</sup> 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.

The policy at issue is referred to as the "must-bill" policy. The policy in fact requires a determination by the State on a filed claim. This policy concerning dual-eligible beneficiaries continues to be critical because individual States administer their Medical Assistance programs differently and maintain billing and documentation requirements unique to each State program. The State maintains the most current and accurate information to determine if the beneficiary is a QMB, at the time of service, and the State's liability for any unpaid QMB deductible and coinsurance amounts through the State's issuance of a remittance advice after being billed by the provider. Consistent with the statute, regulation and PRM, a provider must bill the State and the State must process the bills or claims to produce a remittance advice for each beneficiary to determine their Medicaid status, at the time of service and the State's liability for unpaid Medicare deductible and coinsurance amounts. Thus, it is unacceptable for a provider to write-off a Medicare bad debt as worthless without first billing the State and receive a determination from the State. Even in cases where the provider has calculated that the State has no liability for outstanding deductible and coinsurance amounts, the provider must bill the State and receive a remittance advice before claiming a bad debt as worthless because, as stated above, the State has the most current and accurate information to make a determination on the beneficiaries' status at the time of the services and to determine the State's cost sharing liability for all covered stays of dual eligible beneficiaries.

The Providers in this case made a business decision not to participate in the Medicaid program. This business decision does not change the dual eligible status of a Medicare beneficiary for which a State may be liable for cost sharing amounts. The State has a

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<sup>3</sup> See, e.g., California Hospitals Crossover Bad Debts Group Appeal, PRRB Dec. No. 2000-D80 (Oct. 31, 2000); See also California Hospitals at n.16 (listing cases). 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.

statutory obligation to determine its cost sharing liability concerning dual eligible beneficiaries, regardless of the Medicare only status of the Provider providing the services. 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. The Administrator finds that the Provider decided not to participate in the Medicaid program and did not bill the State for the claims at issue in this case to receive a determination from the State on the coinsurance and deductible amounts. Thus, the Provider has not demonstrated that it meets the necessary criteria for Medicare payment of bad debts related to these claims.

The Provider also argues that the MAC had paid previous claims that were submitted without a State RA and, accordingly, the Provider believed this meant that they were exempt from this requirement. However, the record does not support that prior claims were affirmatively allowed on that basis and the record does not show affirmative agency action upon which the Provider reasonably relied.

The Administrator, also recognizes that the Joint Stipulations stated that there was "no mechanism for non-participating Medicaid providers to bill Texas Medicaid" and receive RAs. However, regardless of the "mechanism" the Texas Medicaid program provides, the non-Medicaid enrollment status of a provider does not change the legal responsibilities that result from the dual eligible status of a Medicare beneficiary for which a State may be liable for cost sharing amounts depending upon its Medicaid rate. Pursuant to section 1902(a)(10)(E) of the Act, the State has a statutory obligation to determine its cost sharing liability concerning dual eligible beneficiaries, regardless of the Medicare-only participating status of the entity providing the services. This legal responsibility is reflected in CMS' State Medicaid Manual (SMM), wherein it is set forth the State's statutory duty to determine its cost sharing liability. Section 3490.14(B) specifically provides that:

[S]ubject to State law a provider has the right to accept a patient either as private pay only, as a QMB only, or (if the patient is both a QMB and Medicaid eligible) as a full Medicaid patient, but the provider must advise the patient, for payment purposes, how he/she is accepted. Medicaid payment of Medicare deductible and coinsurance amounts may be made only to Medicaid participating providers, even though a Medicare service may not be covered by the Medicaid State plan. *A provider agreement necessary for participation for this purpose (e.g., for furnishing the services to the individual as a QMB) may be executed through the submission of a claim to the Medicaid agency requesting Medicaid payment for Medicare deductibles and noninsurance for QMBs.*

Consequently, States must be able to process dual eligible beneficiary claims to determine the State's cost sharing liability. In instances where the State does not process a dual

eligible claim, a Provider's remedy must be sought with the State. If a State does not have the ability to process dual eligible beneficiary claims for all types of Medicare providers, then the State is out of compliance with the Federal statute and the Provider must take steps to ensure that the State complies.<sup>4</sup>

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

Notably, 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 Medicare program is reasonably balancing the accuracy of the bad debt payment and the need to ensure the fiscal integrity of the Medicare funding, with the providers' claims for payment which can be made under two different program for which Medicare is the payer of last resort. As the State has a legal obligation to pay the bad debts and the State has not made a determination on these claims, the elements of the bad debts regulation are not met.

Consequently, States must be able to process dual eligible beneficiary claims to determine the states' cost sharing liability. In instances where the state does not, the Providers remedy must be sought with the state. If a state does not have the ability to process dual eligible

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<sup>4</sup> See Alpha Comm. Mental Health Ctr. vs. Holly Benson, as Sect. of Health Care Admin., Case No. 2008 CA 004161 (2nd Cir. 2010).

beneficiary claims for all types of Medicare providers, then the state is out of compliance with the Federal statute and the state must be forced to comply. Providers in this case acknowledged that after reaching out and explaining the circumstances to some states, they were eventually allowed to enroll in that states Medicaid program in order to bill and receive RAs. Where States are made aware of their duty and still refuse to enroll Providers for the purpose of billing and receiving RAs then the appropriate course would be for the Providers to take legal action within their states.

In light of the foregoing, the Provider has not demonstrated that the bad debts that were identified by the Provider was actually uncollectible and worthless. Because the Provider has 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 Provider has not shown that they have used reasonable collection efforts. Further, the Administrator finds that the Board properly determined, based on the record and law, that the Bad Debt Moratorium provisions did not prohibit the denial of the unpaid coinsurance and deductibles claimed in this case.

Decision

The decision of the Board is adopted and affirmed in accordance with the foregoing opinion.

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

Date: 4/17/17

/s/  
Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services