PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2014-D6

PROVIDER –
Accord Health 2005 Crossover Bad Debts Group

Provider Nos.: 39-5680, 39-5047 and 39-5409

vs.

INTERMEDIARY –
BlueCross BlueShield Association
Novitas Solutions, Inc.

DATE OF HEARING –
February 5, 2013

Cost Reporting Period Ended - June 30, 2005

CASE NO.: 07-2006GC

INDEX

ISSUE:

Whether the Intermediary's exclusion of unbilled crossover bad debts was proper.[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[2] determine payment amounts due providers under Medicare law, regulation and interpretative guidelines published by CMS.[3]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to Medicare.[4] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[5]

A provider may appeal an intermediary's final determination of total reimbursement (*i.e.*, the NPR) with the Provider Reimbursement Review Board ("Board") provided it meets the following conditions: (1) the provider must be dissatisfied with that final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[6]

BAD DEBT POLICY

In order to claim a bad debt, the regulation at 42 C.F.R. § 413.89(e) specifies that the following criteria must be met:

> (e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:

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[1] Stipulation of Facts at ¶ 3.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[4] *See* 42 C.F.R. § 413.20.
[5] *See* 42 C.F.R. § 405.1803.
[6] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.

> (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 that there was no likelihood of recovery at any time in the future.

CMS issued additional guidance in the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1") on the second criterion requiring "reasonable collection efforts." In particular, PRM 15-1 § 312 address "indigent or medically indigent patients" and states in pertinent part:

> In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. *Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals*. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:
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> A. The patient's indigence must be determined by the provider . . .;
>
> B. The provider should take into account the patient's total resources . . .;
>
> C. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX [i.e., the State Medicaid plan], local welfare agency and guardian; and
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> D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.
>
> Once indigence is determined and the provider concludes that there has been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310

> procedures. (*See §322 for bad debts under State Welfare Programs.*)[7]

Thus, if a patient is eligible for Medicare and Medicaid ("dual eligible"), a presumption of uncollectibility may apply and the provider may claim the related debt without first pursuing collection efforts against the patient.

As noted by the cross-reference in § 312 to § 322, CMS provides the following guidance in § 322 on Medicare bad debts under State welfare programs:

> 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 §310 are met.
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> 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 a State payment "ceiling." For example, assume that a State pays a maximum of $42.50 per day for 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.

Qualified Medicare Beneficiaries ("QMBs") are individuals who are entitled to Medicare Part A, whose family incomes do not exceed 100 percent of the federal poverty line ("FPL"), and whose resources do not exceed certain resource-eligibility standards.[8] QMBs are eligible for payment of Medicare Part B (supplementary medical insurance) premiums and Medicare Part A cost sharing (deductibles and coinsurance), regardless of whether they are eligible for full Medicaid benefits.[9]

Federal statute, 42 U.S.C. § 1902(n)(2), requires the State to pay Medicare copayments, coinsurance and deductibles on behalf of a QMB but may limit such payment to the State's "payment ceiling" which is generally the maximum amount that the State Medicaid program

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[7] (Emphasis added.)
[8] 42 U.S.C. §1396d(p).
[9] 42 U.S.C. §1396d(p)(3).

would pay for the service.[10] In the case in which a State's payment for Medicare cost-sharing for a QMB with respect to an item or service is reduced or eliminated, the amount of payment made under Title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service, and the beneficiary shall not have any legal liability to make payment for the service.[11] Pursuant to PRM 15-1 § 322, any portion of the Medicare copayments, deductibles or co-insurance that the State does not pay can be included as allowable bad debts and reimbursed by Medicare.

"Crossover" claims are claims for services in which the Medicare and Medicaid programs are involved because the individual to whom the services were furnished is a dual eligible. In November 1995, CMS promulgated the following guidance in the Provider Reimbursement Manual, CMS Pub. No. 15-2 ("PRM 15-2"), § 1102.3(L) addressing what evidence is acceptable to document of a bad debt arising from "crossover" claims:

> Evidence of a debt arising from Medicare/Medicaid crossovers may include a copy of the Medicaid remittance showing the crossover claim and resulting Medicaid payment or non-payment. However, it may *not* be necessary for a provider to actually bill the Medicaid program to establish a Medicare crossover bad debt where the provider can establish that Medicaid is not responsible for payment. *In lieu of billing the Medicaid program, the provider must furnish documentation of*:
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> - Medicaid eligibility at the time services were rendered (via valid Medicaid eligibility number), and
> - Nonpayment would have occurred if the crossover claim had actually been filed with Medicaid.[12]

In 2003, the U.S Court of Appeals for the Ninth Circuit ("9th Circuit") reviewed this then-existing guidance in *Community Hosp. of the Monterey Peninsula v. Thompson* ("*Monterey*").[13] In this case, the Secretary asserted that, in order to fulfill the requirement in 42 C.F.R. § 413.80(e) that a provider make a "reasonable collection efforts," a provider "must bill" State Medicaid programs with respect to any deductibles and coinsurance amounts owed by dual-eligible patients and obtain a remittance advice ("RA") from the State Medicaid program detailing the amount of payment, if any. This is known as CMS' "must bill" policy.[14] The 9th Circuit found that, based on the record before it, the § 1102.3(L) guidance was in conflict with

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[10] *See* Balanced Budget Act of 1997 ("BBA"), Pub. L. No. 105-33, § 4714, 111 Stat. 251, 509-510 (1997) (adding 42 U.S.C. § 1902(n)(2) to allow state Medicaid programs to limit payment of cost sharing for dual eligibles to the state Medicaid payment rate (*i.e.*, "the payment ceiling")). *See also McCreary v. Offner*, 172 F.3d 76 (D.C. Cir. 1999) (interpreting § 1902(n)(2) to apply to all QMBs); *Paramount Health Sys. v. Wright*, 138 F.3d 706 (7th Cir. 1998) (interpreting § 1902(n)(2) to apply to all QMBs). Prior to the BBA change in 1997, Pennsylvania was under a court order to pay full Medicare cost sharing. *See Pennsylvania Med. Soc'y v. Snider*, 29 F.3d 886 (3rd Cir. 1994).

[11] 42 U.S.C. §1396a(n)(3).

[12] PRM 15-2, Ch. 11, Transmittal No. 4 (Nov. 1995) (emphasis added) (revising PRM 15-2 § 1102.3(L)).

[13] 323 F.3d 782 (9th Cir. 2003)

[14] *See id.* at 785, 798.

the Secretary's "must bill" policy and that the Secretary had consistently applied that "must bill" policy notwithstanding the § 1102.3(L) guidance.[15] The 9th Circuit further found that the provider's documentation which purported to comply with that then-existing § 1102.3(L) guidance failed to satisfy the regulation, 42 C.F.R. § 413.20(a) because "'in this case, the [p]roviders did not maintain contemporaneous documentation in the ordinary course of business to support their claim.'"[16] Accordingly, the 9th Circuit declined to enforce § 1102.3(L) "to the extent [it] authorized reimbursement to the [p]roviders in this case" and deferred to the Secretary's "must bill" policy.[17]

As a result of the *Monterey* decision, on September 12, 2003, CMS issued Transmittal 5 to revise PRM 15-2 § 1102.3(L) to delete the above-quoted guidance.[18] In addition, on August 10, 2004, CMS issued a directive, Joint Signature Memorandum 370 ("JSM 370"), to intermediaries.[19] The JSM specifies that: "[T]he provider must make certain that 'no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency . . . .' prior to claiming the bad debt from Medicare."[20] The JSM also directs intermediaries to "hold harmless providers that can demonstrate that they followed the instructions previously laid out in [the pre-2003 version of PRM 15-2 §] 1102.3L, for open cost reporting periods beginning prior to January 1, 2004." Intermediaries conveyed the contents of the JSM to providers through Medicare newsletters sent to providers.[21]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Accord Health Service, Inc., is the common owner of the following three skilled nursing facilities ("SNFs") located in Pennsylvania: Kutztown Manor (Provider Number: 39-5680); Greenleaf Nursing & Convalescent (Provider Number: 39-5047); and Briarleaf Nursing & Convalescent (Provider Number: 39-5409) (hereinafter collectively referred to as "Providers").

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[15] *Id.* at 798.

[16] *Id.* at 799 (quoting *California Hosp. 90-91 Outpatient Crossover Bad Debts Grp. v. Blue Cross of Cal.*, Administrator Dec. (Oct. 31, 2000), *rev'g*, PRRB Dec. No. 2000-D80 (Sept. 6, 2000)).

[17] *Id.*

[18] *See* PRM 15-2, Ch. 11, Transmittal 5 (Sept. 12, 2003) (revising § 1102.3(L) "to properly state the instructions to complete Exhibit 5, Column 4 of the 339").

[19] JSM-370 from Director of Chronic Care Policy Group and Acting Director of Medcare Contractor Management Group to All Fiscal Intermediaries (Aug. 10, 2004). CMS instructions on the use of JSMs and Technical Direction Letters ("TDLs") specify that JSMs/TDLs are used by CMS to communicate internally with its contractors and, thus, are not issued to the general public. "JSMs/TDLs are typically used to communicate information to . . . [CMS contractors] that does not warrant a contractor manual instruction." A JSM/TDL is appropriate for a contract award announcement, an emergency alert, and/or a one-time request for information. CMS "cannot use a JSM/TDL . . . [to c]onvey new instructions; or [p]rovide clarification of existing requirements that impact contractor operations" but rather "[i]n these situations, submit a manual instruction through the formal Change Management/Change Request (CR) process." *See* CMS Division of Change & Operations Management of CMS/CMM/Medicare Contractor Management Group, *About Joint Signature Memorandums (JSMs) and Technical Direction Letters (TDLs)*, §§ 1 – 2.2 (May 2010) (only available on the CMS Intranet).

[20] (Quoting PRM 15-1 § 312.)

[21] *See, e.g.,* Mutual of Omaha, Medicare Newsletter at 3-4 (October 1, 2004) (describing to providers the "must bill" policy and the hold harmless provisions relating to PRM 15-2 § 1102.3(L) that are described in JSM 370) (copy included as Intermediary Exhibit I-8).

Novitas Solutions, Inc. ("Intermediary") has assumed the responsibility for these Providers, which were previously serviced by Mutual of Omaha ("Intermediary").

Each of the Providers submitted cost reports to the Intermediary for the fiscal year ending on June 30, 2005 ("FY 2005"). In the course of performing its desk review, the Intermediary reviewed the bad debts claimed by the Providers.

On November 27, 2006, the Intermediary issued an NPR for each of the Providers for FY 2005. In each of these NPRs, the Intermediary disallowed a portion of the bad debts associated with deductible and coinsurance amounts for Medicare beneficiaries who were also eligible for Medicaid (*i.e.*, for dual eligibles).

Each of the Providers filed a timely request for hearing with the Board on January 2, 2007. The Providers' individual appeals were consolidated to form a CIRP group appeal on May 29, 2007. The Providers dispute two portions of the adjustments at issue. The first disputed amount was for Medicare crossover bad debts based on submitted remittance advices ("RAs"), which the parties agreed to a partial administrative resolution. As a result, the sole disputed amount remaining in this appeal involves the bad debts that the Intermediary excluded due to the Providers' failure to comply with CMS' "must bill" policy, more specifically the Providers' failure to present RAs showing that the Pennsylvania Medicaid program was billed for the crossover bad debts amounts.

The parties in this case have reached the following pertinent stipulations for use in this hearing:

2. The parties agreed on 11/21/11 to a partial Administrative Resolution of the Medicare crossover bad debts with a submitted remittance advice and the RNPRs were sent in May 2012. Therefore, no remaining dispute regarding the remittance advice issue is pending before the PRRB.

3. The issue presented for hearing is whether the Intermediary's exclusion of unbilled crossover bad debts was proper. The amount in controversy for this issue is the total of the "Bad Debt Must Bill" for $106,523.18.

4. The Provider submitted cost reports for the fiscal period ending June 30, 2005. On each of the facility's cost report, the Provider claimed bad debts arising from unpaid coinsurance of dual eligible, or "crossover" patients, that is, eligible for Medicare Part A and Pennsylvania's Medical Assistance Program.

5. The Intermediary reviewed Provider's cost reports and issued a Notice of Amount of Program Reimbursement (NPR) for each

> Provider on November 27, 2006. Through the NPRs, the Intermediary notified the Provider that most of the Provider's expenses claimed as bad debt for coinsurance amounts were disallowed.[22]

The Provider was represented by John N. Kennedy, Esq., of Kennedy, PC Law Offices. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of the Blue Cross and Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend that the criteria required to claim a bad debt on the Medicare cost report was met, specifically all four criteria set forth in 42 C.F.R. § 413.89(e) and the PRM 15-1 § 308. In addition, the Providers contend the Secretary's "must bill" policy is an unreasonable interpretation of the 42 C.F.R. § 413.89(e) and PRM 15-1 § 308 in circumstances where it is clear a state will not pay any portion of coinsurance.[23]

The Pennsylvania Department of Public Welfare ("DPW")'s policy regarding payment of coinsurance for dual eligibles is as follows:

> § 1187.102. Utilizing Medicare as a resource.
>
> (a) An eligible resident who is a Medicare beneficiary, is receiving care in a Medicare certified nursing facility and is authorized by the Medicare Program to receive nursing facility services shall utilize available Medicare benefits before payment will be made by the MA Program. If the Medicare payment is less than the nursing facility's MA per diem rate for nursing facility services, the Department will participate in payment of the coinsurance charge to the extent that the total of the Medicare payment and the Department's and other coinsurance payments do not exceed the MA per diem rate for the nursing facility. The Department will not pay more than the maximum coinsurance amount.[24]

Pursuant to the statute, the Pennsylvania DPW will not participate in Medicaid coverage of crossover patient coinsurance amounts when the patient's Medicare payment exceeds the Medicaid per diem rate. The Providers contend that each crossover patient's Medicare payment was compared to the Medicaid per diem rate and determined whether billing the Pennsylvania DPW would have actually resulted in payment of the coinsurance amounts. The results of the comparison showed that nearly all Providers' crossover Patient coinsurance amounts would not qualify for payment by the Pennsylvania DPW because the crossover patient's Medicare

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[22] Stipulation of the Parties at ¶¶ 2-5 (filed Nov. 13, 2012).
[23] *See* Providers' Final Position Paper at 4.
[24] *See* 55 Pa. Code § 1187.102 (2008) (copy included at Provider Exhibit P-5).

payment exceeded the Medicaid per diem rate.[25] The Providers contend that the comparison and analysis of whether billing the Pennsylvania DPW would be a worthwhile procedure, should be considered reasonable collection effort.[26]

The Providers further asserts that Secretary's "must bill" policy contradicts the written guidance, directing the Providers to use sound business judgment to establish no likelihood of future recovery. To require the Providers to submit bills to the Pennsylvania DPW, despite certainty these coinsurance amounts will not be covered, is an unreasonable and unnecessary burden to place upon the Providers. Because the Secretary's "must bill" policy directs the Providers to engage in futile billings and ignore sound business judgment, the Secretary's "must bill" policy is contradictory to the guidance given in 42 C.F.R. § 413.89(e) and the PRM 15-1 § 308.[27]

In support of this contention, the Providers cite to the Pennsylvania state statute prohibiting the submission of false claims to the Pennsylvania DPW:

> § 1407. Provider prohibited acts, criminal penalties and civil remedies.
>
> (a) It shall be unlawful for any person to:
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> (1) Knowingly or intentionally present for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under medical assistance, or to knowingly present for allowance or payment any claim or cost report for medically unnecessary services or merchandise under medical assistance, or to knowingly submit false information, for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise under medical assistance, or to knowingly submit false information for the purpose of obtaining authorization for furnishing services or merchandise under medical assistance.[28]

The Providers contend that the Secretary's "must bill" policy unreasonably requires the Providers to submit false claims to the Pennsylvania DPW in order to abide by the Secretary's "must bill" policy. Pursuant to the state statute, providers are prohibited from submitting false claims to the Pennsylvania DPW and, therefore, the Intermediary's reliance upon the Secretary's "must bill" policy was inappropriate.[29]

The Providers also cite to the Provider Reimbursement Manual, CMS Pub 15-2 ("PRM 15-2"), § 1102.3(L), which was promulgated in November 1995, and remained in effect until 2003,

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[25] *See* Provider Exhibit P-6 (Providers' Bad Debt Logs and Spreadsheets).
[26] *See* Providers' Final Position Paper at 4-5.
[27] *See id.* at 5-6
[28] *See* 62 Pa. Cons. Stat. Ann. §1407 (Lexis 2007) (copy included at Provider Exhibit P-7).
[29] *See* Providers' Final Position Paper at 6-7.

when the 9th Circuit found that the provision to be inconsistent with the Secretary's "must bill" policy in *Monterey*. The Providers contend that, in determining the legal effect of PRM 15-2 § 1102.3(L), the 9th Circuit relied upon their finding that the *Monterey* providers consistently asked for reimbursement without evidence of billing the state throughout the *Monterey* relevant period (1989-1995), and reimbursement was consistently denied. Due to these findings, the 9th Circuit concluded that the *Monterey* providers could not claim that their reliance interests were unfairly frustrated.[30]

The Provider was reimbursed by the Intermediary during fiscal periods prior to FY 2005 without the necessity of providing Medicaid RAs, making the instant case altogether distinguishable from *Monterey*. Prior to FY 2005, the Providers contend that they developed a reliance interest upon the fact the Intermediary reimbursed the Providers for bad debts resulting from coinsurance amounts of crossover patients without the necessity for Providers to submit a bill to the Pennsylvania DPW for crossover patient coinsurance claims. The Providers knew with certainty that they would not be paid by the Pennsylvania DPW. The Providers were reimbursed for crossover patient bad debts for prior years in which the Intermediary did not require Providers to bill the State. Thus, the Intermediary's disallowance of Providers' bad debts for FY 2005 unfairly frustrated Providers' reliance interests.[31]

In support of the proposition that there is not a "must bill" policy, the Providers cite to the following prior Board decisions: *Various Genesis Health Care Corp. Providers v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2011-D12 (Dec. 2, 2010), *rev'd*, Administrator Dec. (Feb. 1, 2011) ("*Genesis*"); and *Hope Horizon Ctr., Inc. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D29 (May 18, 2010), *rev'd*, Administrator Dec. (July 13, 2010) ("*Hope Horizon*"). In particular, the Providers note that the Board stated the following in its 2011 decision for *Genesis*:

> Based on the foregoing, the Board finds the Intermediary's application of the bad debt collection policy to include an absolute requirement that the Providers obtain Medicaid remittance advices (RA) prior to claiming Medicare bad debts is unsupported by the applicable statute, regulations, manual provisions, and case precedent.[32]

The Providers also note that the Board stated the following in its 2010 decision for *Hope Horizon*:

> Third, the Florida statute regarding Provider Fraud at §409.920(2)(b) states that it is unlawful to "[k]nowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program . . . A person who violates this subsection

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[30] *See id.* at 7 (citing to *Monterey*, 323 F.3d at 798).
[31] *See id.* at 8.
[32] *See* Providers' Supplemental Position Paper at 3(citing to PRRB Dec. No. 2011-D12).

> commits a felony of the third degree, . . ." The Parties have stipulated that consistent with Florida law in 1998, Florida's Medicaid State plan was amended to eliminate any coverage responsibility for QMBs coinsurance and deductibles for the type of services furnished by the appealing Providers and similarly situated CMHCs. The Board finds it would be unreasonable to place the Provider in jeopardy of a criminal action by requiring it to bill in accordance with JSM-370 to collect Medicare bad debts.[33]

The Providers contend that, through the arbitrary and capricious adherence to the Secretary's "must bill" policy, the Intermediary has, in effect, shifted the burden of the costs of Providers' Medicare recipients to Providers' non-Medicare recipients. In doing so, has violated 42 U.S.C. § 1395x(v)(1)(A)(i) which prohibits this type of cost shifting:

> (i) take into account both direct and indirect costs of providers of services...in order that...the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.[34]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Providers' method for writing off bad debts for dual eligible without billing the State do not constitute "reasonable collection efforts" as contemplated by 42 C.F.R. § 413.89(e). The Intermediary further contends that this regulation clearly states that a provider must prove that a bad debt is "uncollectible when claimed as worthless" and that "reasonable collection efforts" using "sound business judgment" were employed. Thus, the Intermediary concludes that the Providers' policy to not bill the Pennsylvania Medicaid program for each dual eligible's Medicare deductible and coinsurance amounts and to not receive contemporaneous documentation of a payment or denial (*i.e.*, an RA) fails to comply with the PRM 15-1 § 312 requirement that "no source other than the patient would be legally responsible for the patient's medical bills."[35]

The "must bill" policy is a reasonable reading of the regulations and has been upheld by the CMS Administrator[36] and the courts such as the 9th Circuit in *Monterey.* Accordingly, the

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[33] *Id.* at 4(citing to PRRB Dec. No. 2010-D29).
[34] *See* Providers' Final Position Paper at 8-9.
[35] *See* Intermediary's Final Position Paper at 6-7.
[36] *See, e.g., California Hosps. Bad Debts Grp. v. Blue Cross/Blue Shield of Cal.*, Administrator Dec. (Oct. 31, 2000), *rev'g*, PRRB Dec. No. 2000-D80 (Sept. 6, 2000).

Providers' policy of not billing the State does not constitute a reasonable collection effort as required by the regulations.[37]

The Intermediary further asserts that the Provider was notified of the "must bill" policy. First, it points to the PRM 15-2 transmittal that CMS issued on September 12, 2003 in response to the decision in *Monterey*. The Intermediary asserts that this transmittal changed the language in PRM 15-2 § 1102.3(L) to revert back to pre-1995 language which required providers to bill the individual states for dual-eligible beneficiary co-payments before claiming a Medicare bad debt.[38] The Intermediary communicated this to all providers in a Newsletter dated October 15, 2003.[39]

The Intermediary also asserts that the "hold harmless" policy for cost reports beginning before January 1, 2004 was communicated to all providers in a Newsletter dated October 1, 2004.[40] As the cost reports at issue pertain to FY 2005, the Intermediary concludes that they are not covered by the hold harmless period allowed by CMS for claiming dual eligible bad debts and, therefore, the hold harmless provisions do not apply to the Providers.[41]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered Medicare law and guidelines, the parties' contentions and the evidence presented in the record. Set forth below are the Board's findings and conclusions.

The Board agrees that, in order to claim a bad debt on the cost report, the criteria 42 C.F.R. §413.89(e) must be met and that the "must bill" policy is applicable.[42] As early as the Intermediary's Newsletter dated October 1, 2003, the Providers were notified that they had to submit crossover claims to the Pennsylvania Medicaid program even when no payment was expected from the Pennsylvania Medicaid program:

> 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 and 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. We cannot accept other forms of documentation such as a provider's calculations of the agency's

[37] *See* Intermediary's Final Position Paper at 7-11.
[38] *See* Intermediary Exhibit I-6.
[39] *See* Intermediary Exhibit I-7.
[40] *See* Intermediary Exhibit I-8.
[41] *See* Intermediary's Final Position Paper at 11-12.
[42] The Board notes that, because the Providers are skilled nursing facilities, the moratorium which prohibits the Secretary from making changes to the bad-debt policy in effect as of August 1, 1987 (the "Bad Debt Moratorium,") is not applicable to the Providers. *See* OBRA 1987, Pub. L. No. 100-203, § 4008(c), 101 Stat. 1330, 1355 (1987), *as amended by* Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8402,102 Stat. 3342, 3798 (1988), *as amended by* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6023, 103 Stat. 2106, 2167 (1989) (reprinted in 42 U.S.C. § 1395f note).

> liability for the debt or an affidavit from the provider's employee that they were instructed not to bill the agency. Moreover, we will not accept a letter from the welfare agency informing providers that it will no longer pay Medicare deductible and coinsurance amounts because a State payment ceiling or budget shortfall.[43]

Similarly, the Intermediary's October 1, 2004 Newsletter notified the Providers of the "must bill" policy as described in JSM 370. As a result, the Board finds that the Provider was fully notified of the Medicare Program's "must bill" policy through the Intermediary's publication of its Newsletter dated October 1, 2003. The Board is not persuaded by the Intermediary's argument that the transmittal issued on September 12, 2003 to revise PRM 15-2 § 1102.3(L) provided any notification on the "must bill" policy because no such policy statement was added to that section.

Further, the Board finds that the hold harmless provisions of JSM 370 are not applicable because the fiscal years at issue (as well as the dates of service at issue) all begin after the time period covered by the hold harmless provisions (*i.e.,* on or after January 1, 2004).[44] However, the Board lacks jurisdiction to decide whether billing a crossover claim to the Pennsylvania DPW may violate the state statute governing false claims, particularly if such a violation of state statute would conflict with federal laws and/or regulations governing bad debts. Notwithstanding, the Board finds that, even if it had jurisdiction to decide the issue, the Providers have failed to submit sufficient evidence to establish that such claims, if submitted, would be in fact be false under the state statute. For example, the Medicare program provides specific instructions to providers on how to bill the Medicare program for denial charges for services that are not covered by the Medicare program.[45]

Regardless of the alleged false claim issue, it is clear that any patients with an eligible QMB code should be covered by the Pennsylvania State Medicaid plan, unless that plan specifically eliminates any coverage responsibility for Medicare deductible and coinsurance amounts for QMBs. As a result, the Board asked the Providers to confirm whether the Pennsylvania State Medicaid plan was amended to eliminate any coverage responsibility for QMBs, and describe how the Providers account for patients with QMB coverage. The Board also encouraged the Intermediary to submit a substantive brief responding to these Board's request for additional information.[46]

Both the Providers and the Intermediary responded to the Board's request for additional information. The Providers and the Intermediary were in agreement that the Pennsylvania's State Medicaid plan was not amended to eliminate any coverage responsibilities for QMBs.[47] The Intermediary further stated that state statutes, 55 Pa. Code § 1187.14, specify that QMBs in

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[43] *See* Intermediary Exhibit I-7 at 3 (excerpt from the October 15, 2003 Medicare Newsletter).
[44] All of the dates of service for the bad debts at issue are in 2004 or 2005. *See* Provider Exhibit P-3.
[45] *See* Medicare Claims Processing Manual, CMS Pub. No. 100-04. Transmittal No. 25 (Oct. 31, 2003) (providing notification requirements for billing noncovered charges to the Medicare program).
[46] *See* letter from the Board to the Provider and Intermediary Representatives (Dec. 5, 2012).
[47] *See* letter from the Provider Representative to the Board (Jan. 3, 2013); letter from the Intermediary Representative to the Board (Jan. 2, 2013).

Pennsylvania receiving nursing facilities services may be eligible for State payment of Medicare coinsurance and deductible amounts for services provided under the MA program.[48]

The Board finds that, based on the evidence submitted into the record, the Providers do not appear to have a methodology in place to account for patients with QMB coverage and, as a result, some or all of bad debts at issue in this appeal may involve QMBs. The Providers could have taken the Bad Debt list that has been appealed and isolated the QMBs from the non-QMB's, since the non-QMB's may have met the criteria for allowable Bad Debts under 42 C.F.R. § 413.89(e), specifically "[t]he debt was actually uncollectible when claimed as worthless." However, further steps were required to prove that the QMB crossover claims were worthless. The Board has not identified any evidence in the record showing that the Providers performed further steps to prove whether any of the bad debts at issue involved QMBs. As a result, the Board finds that the Providers have failed to confirm that none of the bad debts at issue pertained to QMBs.

Pursuant to the "must bill" policy, the Provider clearly would have been required to identify and bill the Pennsylvania Medicaid program for the Medicare coinsurance and deductible for any QMB because these QMB claims could have been paid under the State statute, 55 Pa. Code § 1187.14. Moreover, if the only way to identify the QMB claims from the non-QMB was to submit all crossover claim to the Pennsylvania DPW, then the Board would have to conclude that the Provider would not have been in jeopardy of violating the state billing statute because other state statutes specify that QMBs in Pennsylvania receiving nursing facilities services may be eligible for State payment of coinsurance and deductible amounts for services provided under the MA program.

DECISION AND ORDER:

The Intermediary's exclusion of unbilled crossover bad debts from the cost report was proper, since the Provider failed to demonstrate, that the debt was uncollectible when claimed as worthless.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, C.P.A
Clayton J. Nix, Esq.

[48] *See* 55 Pa. Cons. Stat. Ann. § 1187.14 (2012) (adopted Jan. 1, 1996) (copy included at Intermediary Exhibit I-4 to the Intermediaries response to Board Questions)).

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: APR 10 2014

Attachment A:

Schedule of Providers in Group (Schedule A)

Group Name: Accord Health Services, Inc.

Page No.: 1 of 1

Representative: Kennedy, PC Law Offices
John N. Kennedy, Esq.

Date Prepared: April 30, 2007

Case No.: 07-0604, 07-0605, 07-0606

Issue: Whether Intermediary's disallowance of Providers' Medicare Part A bad debt was proper.

Provider Number	Provider Name	FPE	Intermediary	A Date of Final Deter.	B Date of Hearing Req.	C No. of Days	D Audit Adj. No.	E Amt. of Reimbursement	F Original Case No.	G Date(s) of Add/Transf.
1) 39-5680	Kutztown Manor (Kutztown, Berks Co., PA)	6/30/05	Mutual of Omaha Insurance Co.	11/27/06	1/2/07	N/A	4	$104,104	07-0604	N/A
2) 39-5047	Greenleaf Nursing (Doylestown, Bucks Co., PA)	6/30/05	Mutual of Omaha Insurance Co.	11/27/06	1/2/07	N/A	7	$57,638	07-0605	N/A
3) 39-5409	Briarleaf Nursing (Doylestown, Bucks Co., PA)	6/30/05	Mutual of Omaha Insurance Co.	11/27/06	1/2/07	N/A	4 & 5	$77,885	07-0606	N/A