PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D29

PROVIDER-

Select Medical 2011 Dual Eligible Medicare Bad Debts CIRP Group

Provider No.: Appendix I

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

HEARING DATE –

April 19, 2018

Cost Reporting Period Ended –2011

CASE NO. 13-0122GC

INDEX

ISSUE STATEMENT:

Whether the Medicare Contractors' must-bill policy applies to the Providers' dual eligible bad debts when the Providers did not participate in the Medicaid program.[1]

DECISION:

After considering Medicare law, regulations and program instructions, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") makes the following findings:

1. It affirms the portion of the Medicare Contractors' dual eligible bad debt adjustments at issue that pertain to dual eligible bad debt claims associated with the following state Medicaid programs in which the Providers chose not to enroll: Arkansas, California, Colorado, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi (except for Harrison County), North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; and

2. It reverses the portion of the Medicare Contractors' dual eligible bad debt adjustments at issue that pertain to dual eligible bad debt claims associated with the following state Medicaid programs which would not enroll long term care hospitals ("LTCHs") and, accordingly, remands this subset of claims to the Medicare Contractors to determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims: Alabama, Delaware, Mississippi (for Harrison County only), New Jersey and Pennsylvania.

INTRODUCTION:

Select Medical Corporation ("Select") owns and operates the Medicare-certified LTCHs in this group appeal (the "Select LTCHs").[2] The Select LTCHs are located in 26 states.[3] The Select LTCHs claimed certain Medicare bad debts related to dual eligibles (*i.e.*, Medicare beneficiaries who were also eligible for a state Medicaid program). The dual eligible bad debts at issue involve 24 state Medicaid programs in which the Select LTCHs were not enrolled as a Medicaid provider.[4] Four Medicare contractors[5] (including Novitas Solutions, Inc., First Coast Service Options, Palmetto GBA, and CGS Administrators (collectively, the "Medicare Contractors")) denied the dual eligible bad debt claims at issue because they involved dual elibigles and the

[1] Hearing Transcript ("Tr.) at 5-6.
[2] *See* Appendix 1 for Schedule of Providers.
[3] Providers' Final Position Paper at 6.
[4] *See* Provider's Post-Hearing Brief at 8-9 identifying the bad debt amount by state.
[5] Fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") will be referred to interchangeably as Medicare contractors.

Select LTCHs failed to obtain remittance advices ("RAs") from the relevant state Medicaid program to document their bad debt claims.[6]

The Select LTCHs timely appealed their bad debt reimbursement to the Board and met the jurisdictional requirements for a hearing. The Board held a live hearing on April 19, 2018. The Select LTCHs were represented at the hearing by Jason M. Healy, Esq. of The Law Offices of Jason M. Healy PLLC. The Medicare Contractors were represented by Joseph Bauers, Esq. of Federal Specialized Services.

STATEMENT OF THE FACTS:

A. MEDICARE'S BAD DEBT POLICY

Federal regulations at 42 C.F.R. § 413.89(e) (2010) specify the criteria that must be met for a provider to claim bad debt reimbursement on its Medicare cost report. Specifically, § 413.89(e) states:

> (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.[7]

CMS has provided extensive guidance on its bad debt policy in the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), §§ 308, 310, 312 and 322. PRM 15-1 § 308 requires that the provider make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible. PRM 15-1 § 310 states that a "reasonable collection effort" involves sending a bill on or shortly after discharge or death. However, this section by its own terms is not applicable to indigent patients and specifically refers to § 312 which allows providers to "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, respectively." While this language absolves the providers from taking further steps to prove the dual eligible patient indigent, subsection C of § 312 nonetheless requires providers to "determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian."

Finally, PRM-I § 322 states that a provider may not claim Medicare bad debt reimbursement for that portion of the deductible and copayment amounts that "the State is obligated either by

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[6] Providers' Final Position Paper at 1.
[7] Copy at Exhibit P-53.

statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts," but a provider may claim the "portion of such deductible or coinsurance amounts that the State is not obligated to pay . . . provided that the requirements of § 312 or, if applicable, § 310 are met."

On August 10, 2004, CMS issued the Joint Signature Memorandum ("JSM") JSM-370 to Medicare contractors to clarify and explain its "must bill" policy. The JSM explained that a provider must bill and obtain an RA from the relevant state Medicaid program whenever a bad debt involves a dual eligible beneficiary, regardless of whether that program may owe nothing or only a portion of the dual eligible's Medicare deductible or co-payment.[8] The Ninth Circuit, in *Community Hosp. of the Monterey Peninsula v. Thompson* ("*Monterey*"),[9] found CMS' must-bill policy to be a reasonable implementation of the bad debt reimbursement system and not inconsistent with the statute and regulations governing fiscal years 1989 through 1995.[10] In a subsequent case, *Cove Associates Joint Venture v. Sebelius*, the federal District Court for the District of Columbia again upheld the agency's must-bill policy, but noted that a provider that was unable to bill the state Medicaid program because it could not be enrolled as a Medicaid provider was in a "Catch-22," and remanded the case back to the agency to determine whether the providers were justified in relying on CMS' prior failure to enforce the must-bill policy with respect to dual-eligible reimbursement claims from non-participating Medicaid providers.[11]

B. MEDICARE BAD DEBTS ASSOCIATED WITH STATE COST SHARING OBLIGATIONS FOR DUAL ELIGIBLES

State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost-sharing (Medicare deductibles and copayments) on behalf of poor and low-income Medicare-eligible individuals. While a state may limit payment of cost sharing amounts for most dual eligible patients,[12] a state may be obligated to pay full cost sharing amounts for patients who

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[8] JSM-370 may be found at Provider Exhibit P-33. Specifically, JSM 370 states:

> The "must bill" policy states that if a patient is determined by the provider to be indigent or medically indigent, the provider does not need to attempt to collect from the patient. However, the 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. [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).
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> (citation omitted.)

[9] 323 F.3d 782, 785 (9th Cir. 2003).

[10] However, with respect to the time under review, the Court declined to apply § 1102.3L which was added to PRM 15-2 in 1995 to allow for certain documentation as an alternative to RAs. *Id.* at 797-99. In CMS Memorandum, JSM-370, CMS withdrew § 1102.3L and reverted back to the pre-1995 language which required providers to bill state Medicaid programs before claiming Medicare bad debt.

[11] 848 F.Supp.2d 13, 30 (D.D.C. 2012).

[12] 42 U.S.C. § 1396a(n)(2) allows states to limit the cost-sharing amount to the Medicaid rate and essentially pay nothing toward the dual eligibles' cost sharing if the Medicaid rate is lower than what Medicare would pay for the service.

qualify for Medicaid as Qualified Medicare Beneficiaries ("QMBs").[13] In general, to receive Medicaid reimbursement, a provider must enroll as a Medicaid provider. Some state Medicaid agencies do not allow enrollment of certain types of providers (*e.g.*, CMCHs, LTCHs, inpatient rehabilitation facilities) and, in those situations, the providers are unable to bill the state Medicaid program for Medicare cost sharing amounts.

The Select LTCHs were not enrolled as Medicaid providers in the relevant state Medicaid programs[14] during the time periods at issue. In some states, the state Medicaid program did not permit LTCHs to enroll as Medicaid providers. Other states allowed enrollment of LTCHs, but the Select LTCHs chose not enroll.[15] In either case, the state Medicaid programs would refuse to process claims submitted by the Select LTCHs and issue Medicaid RAs, because the Select LTCHs were not enrolled as Medicaid providers.

DISCUSSION, FINDINGS OF FACT, CONCLUSIONS OF LAW:

The Select LTCHs contend that, prior to 2007, the Medicare Contractors did not require non-Medicaid-participating providers to bill the state for Medicare cost-sharing amounts and obtain an RA from the state in order to be reimbursed for bad debt.[16] The Medicare Contractors reversed this policy when settling the FY 2005 cost reports,[17] using the "must bill" policy to require that both participating and non-participating Medicaid providers bill the state Medicaid programs, and obtain an RA before claiming Medicare bad debt. Following a remand of the FY 2005 case in 2012, the Select LTCHs responded by billing 102 claims to 6 state Medicaid programs and reported that they received letters stating that the state Medicaid program was unable to process these claims and could not issue RAs.[18] Later, in 2013, the Select LTCHs filed 83 Medicaid claims to 23 different state Medicaid programs and received similar letters from the state Medicaid programs.[19] Citing responses from the state Medicaid programs, the Select

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[13] However, 42 U.S.C. § 1396d(p)(3), at least for a time, required state Medicaid programs to pay cost-sharing amounts for QMBs.

[14] Tr. at 59. *See also* Providers' Post Hearing Brief at 7-9 (providing the bad debt amounts by state indicating roughly 25 percent relates to hospitals that were eventually enrolled in Medicaid, roughly 25 percent relates to out-of-state Medicaid programs, and roughly 50 percent relates to hospitals that were not allowed to enroll in Medicaid).

[15] *See id.*; Tr. at 242-243.

[16] Providers' Final Position Paper at 4. In further support of their position that CMS did not require non-Medicaid-participating providers to obtain RAs, the Select LTCHs cite to the 1995 instructions for completing CMS Form 339 (copy included at Provider Exhibit P-7). In particular, the 1995 instructions addressing bad debts required only that the provider furnish documentation of Medicaid eligibility and proof that non-payment would have resulted from the billing. *See* Providers' Post Hearing Brief at 5-6.

[17] Select Specialty FY 2005 cost year became a separate appeal which was decided by the Board on April 13, 2010. *See Select Specialty '05 Medicare Dual Eligible Bad Debts Grp. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2010-D25 (Apr. 13, 2010), *rev'd*, Adm'r Dec. (June 9, 2010). The Administrator's decision was appealed to the U.S. District Court for the District of Columbia ("Court") in *Cove Associates Joint Venture v. Sebelius*, 848 F.Supp.2d 13 (D.D.C. 2012). The Court found in favor of the Secretary that the must-bill policy was not new and did not require notice and comment rulemaking. The Court remanded the case to the Secretary on the limited issue of whether the Providers were justified in relying on the Secretary's prior failure to enforce the must-bill policy. On remand, the Administrator issued a decision on March 15, 2016 and found that such "reliance was not reasonable."

[18] Providers' Post-Hearing Brief at 13; Provider Exhibit P-5 at 82.

[19] Providers' Post-Hearing Brief at 13; Provider Exhibit P-5 at 88.

LTCHs maintain that they were unable to obtain Medicaid RAs with payment determinations for these claims.[20] The Providers undertook an additional effort to submit 44 claims to the state Medicaid programs for the bad debts amounts at issue in this group appeal.[21]

The Select LTCHs argue that applying CMS' "must bill" policy (*i.e.*, the requirement to bill the state Medicaid program *and* obtain an RA in order to claim Medicare bad debt) to this case violates the "Bad Debt Moratorium."[22] The Select LTCHs maintain that the Medicare Contractors' denial of the bad debt claims at issue is unsupported by statute or regulation, and that the Medicare Contractors' application of the "must bill" policy is arbitrary and capricious.[23] The Select LTCHs assert that they relied on the longstanding agency practice that allowed non-Medicaid-participating providers to claim bad debts without obtaining Medicaid RAs. Accordingly, the Select LTCHs conclude that they should be allowed to claim the Medicare bad debts.[24]

The Select LTCHs also assert that CMS has recognized some exceptions to its "must bill" policy. Specifically, in briefs filed in connection with the *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–00142 VRW (N.D. Cal. Oct. 11, 2001), the Secretary recognized the following "two unique instances where the Secretary permits providers to claim Medicare crossover bad debt without billing the State Medicaid agency." [25]

1. Community mental health centers ("CMHCs").—CMHCs "are allowed to claim Medicare crossover bad debt without billing the State agency because CMHC's *cannot* bill the State agency given that they are not licensed by the State and, therefore, have no Medi-Cal provider number."[26]

2. Institutions for mental diseases ("IMDs").—IMDs "are permitted to claim Medicare crossover bad debts without billing the State agency where the services are provided to an individual aged 22-64. This is because the Medicaid statute and regulations categorically preclude payment for services provided to patient aged 22-64 in IMD's, and the State

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[20] Providers' Post-Hearing Brief at 13.
[21] Providers' Post-Hearing Brief at 16. This sample included claims that were crossed-over automatically from the Medicare program and claims that were submitted electronically or in paper by the Provider. Provider Exhibit P-104 indicates the state would not process the claims because the providers were not participating in the state's Medicaid program. This is confirmed by the Affidavit of Wade Snyder at Provider Exhibit P-142 at ¶¶ 17-20. (Note: P-104 claim # 42 was processed by the state as the provider was participating in Medicaid on the date of service. The remit was received after the cost report was filed. *See* Tr. at 92-94)
[22] Providers' Final Position Paper at 31-32.
[23] *Id.* at 35-36.
[24] *Id.* at 38-39.
[25] Defendant's Memorandum in Reply to Plaintiffs' Opposition to Defendant's Motion for Summary Judgment at 9 n.5, *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–00142 VRW, 2001 WL 1256890 (N.D. Cal. Oct. 11, 2001) (copy included at Provider Exhibit P-45).
[26] *Id.* (citations omitted) (emphasis in original).

> accordingly has absolutely no responsibility for the coinsurance/deductibles associated with those particular services."[27]

The Select LTCHs argue that the rationale for CMHCs and IMDs is equally applicable in this case because, similar to CHMCs and IMDs, many state Medicaid programs do not recognize and certify LTCHs as providers and, therefore, will neither enroll them, process their Medicaid claims, nor issue RAs to them.[28]

Finally, the Select LTCHs contend that they satisfied the requirement of *submitting* claims for the fiscal year at issue, and that they could not obtain RAs because the state Medicaid program simply refused to process the claims of a non-Medicaid participating provider. As a result, the Select LTCHs contend that they were forced to bear the costs of allowable Medicare bad debts, in violation of Medicare's statutory prohibition on cost shifting.[29] Further, they assert that, in connection with state Medicaid programs for which they did not enroll, the Medicare Contractors violated the Bad Debt Moratorium by requiring the Select LTCHs to obtain RAs from such state Medicaid programs prior to a claiming Medicare bad debt for a dual eligible or QMB.[30]

For their part, the Medicare Contractors state that one of the core justifications for the "must bill" policy is found in the statute at 42 U.S.C. § 1396(p)(3) which imposes certain cost sharing on states for the Medicare coinsurance and deductibles of dual eligible Medicare patients. The Medicare Contractors assert that the need for CMS' must-bill policy as it relates to dual eligibles is plainly evident because a patient's Medicaid status may change over the course of a very short period, and states are entitled to change, enhance, or modify provisions of their Medicaid state plans. It is the state Medicaid program that maintains the most accurate and up-to-date patient information to make a determination of a patient's Medicaid eligibility status at the time of service, and the state that must determine its cost sharing responsibility, if any, for any unpaid Medicare deductibles and coinsurance based upon the state plan in effect at that time.[31]

Having considered the positions of the parties, the evidence presented and the statutory and regulatory authority, the Board finds that pre-1987 the bad debt policy in the PRM clearly established that providers have an obligation to bill "the responsible party" as explained below. This is similar to the Board's 2016 decision for Select's FY 2006-2010 cost years.[32] As noted in

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[27] *Id.* (citations omitted).
[28] Providers' Final Position Paper at 84-87.
[29] *Id.* at 75-76; 42 U.S.C. § 1395x(v)(1)(A)(i) (copy included at Provider Exhibit P-51).
[30] Providers' Final Position Paper at 31-32.
[31] Medicare Administrative Contractor's Final Position Paper at 7-8.
[32] *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups v. Novitas Solutions, Inc.*, PRRB Dec. No. 2016-D22 (Sept. 27, 2016), *modified by*, Adm'r Dec. (Nov. 28, 2016).

that decision, the Board considered three federal appeals court decisions on this matter,[33] as well as the Administrator's decision upon remand of Select's FY 2005.[34]

While none of the three federal appeals court decisions applied the Bad Debt Moratorium, they are still instructive as to CMS' policy, The First Circuit concluded that "some version" of a "must bill" policy has generally been enforced and that a general requirement (as opposed to a per se requirement) to obtain a Medicaid remittance advice for crossover claims is entitled to deference where "[t]he Secretary has made exceptions and accepted alternative documentation *from the State* where circumstances warranted the exception."[35] Similarly, the D.C. Circuit found that it is "sensible for the Secretary to require that the state determine in the first instance the Medicaid eligibility of the claims and the appropriate amount of state payment owed. . . ."[36] Finally, the Ninth Circuit deferred to the Secretary's reasonable determination that "the must-bill policy is a 'fundamental requirement to demonstrate' . . . 'that reasonable collection efforts [have been] made' and that 'the debt was actually uncollectible when claimed [as worthless].'"[37]

With this backdrop, the Board analyzed the pre-1987 PRM provisions for the bad debts at issue based on the dual eligible's state Medicaid program: (1) states in which the Select LTCHs could have been certified as Medicaid providers but did not enroll; and (2) states in which the Select LTCHs could not be certified as Medicaid providers.

A. STATES IN WHICH THE SELECT LTCHS COULD BE CERTIFIED AS MEDICAID PROVIDERS BUT DID NOT ENROLL.

The Board's review of the record (including, but not limited to, Provider Exhibit P-100) shows that, the Select LTCHs could have enrolled in the state's Medicaid programs in the following states: Arkansas,[38] Colorado,[39] Florida,[40] Georgia,[41] Indiana,[42] Iowa,[43] Louisiana,[44] Michigan,[45]

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[33] *Maine Med. Ctr. v. Burwell*, 775 F.3d 470, (1st Cir. 2015); *Grossmont Hosp. Corp. v. Burwell*, 797 F.3d 1079 (D.C. Cir. 2015), rehearing en banc denied (D.C. Cir. 2015); *Community Hosp. of Monterey Peninsula v. Thompson*, 323 F.3d 782, 792 (9th Cir. 2003).
[34] *Select Specialty '05 Medicare Dual Eligible Bad Debt Group v Blue Cross Blue Shield Association*, Decision of the Administrator, March 15, 2016, on remand from, *Cove Associates Joint Venture v Sebelius*, 848 F. Supp. 2d 13 (D.D.C. 2012).
[35] 775 F.3d at 473, 480 (emphasis in original).
[36] 797 F.3d at 1085.
[37] 323 F.3d at 792, 796 (citation omitted).
[38] Provider Exhibit P-100 at 8 with a Medicaid enrollment effective date of 4/27/2009.
[39] *Id.* at 12 with a Medicaid enrollment effective date of 2/26/2010.
[40] *Id.* at 19 indicating various Medicaid enrollment effective dates in 2007 and 2008.
[41] *Id.* at 24 with a Medicaid enrollment effective date of 6/1/2009.
[42] *Id.* at 37 and 45 with Medicaid enrollment effective dates in 2009.
[43] *Id.* at 54 with a Medicaid enrollment effective date of 1/1/2007.
[44] *Id.* at 55 indicating Medicaid enrollment in 2005.
[45] *Id.* at 64 with Medicaid enrollment effective dates in 2005-2008.

Mississippi (except for Harrison County),[46] North Carolina,[47] Oklahoma,[48] Tennessee,[49] Texas,[50] and West Virginia[51] (the "first grouping"). This review also shows that there is no evidence confirming whether LTCHs could or could not enroll in the Medicaid programs in the following states: California, Illinois, Kansas, Kentucky, Ohio, South Carolina, and Virginia (the "second grouping"). Without any evidence to the contrary, the Board must assume that the Select LTCHs could have enrolled in the state's Medicaid programs for the second grouping. For purposes of this subsection, the Board will refer to the first and second grouping of state Medicaid programs collectively as "the States Allowing LTCH Enrollment."

For the States Allowing LTCH Enrollment, the Board finds the Select LTCHs had no bar to enrolling as a Medicaid provider and obtaining a Medicaid billing number. As previously discussed, PRM 15-1 § 322 confirms that, if the Medicaid State plan provides for payment of Medicare coinsurance and deductibles (in whole or in part), then the amount of the State payment cannot be allowable as Medicare bad debt. Significantly, this is a blanket requirement that is not predicated on whether the provider does or does not participate in the relevant Medicaid program.[52] Second, this excerpt cross-references the requirements of § 310, confirming that, *at a minimum*, the § 310 requirement to "bill . . . the party responsible" is applicable to crossover claims.[53]

Notwithstanding the § 322 requirement to determine whether the relevant state Medicaid program was "responsible," the Select LTCHs made business decisions not to enroll in the Medicaid programs in the states Allowing LTCH Enrollment, and have not submitted documentation (whether in the form of RAs or other evidence[54]) that confirms the state Medicaid

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[46] The record shows that, if an LTCH was located outside of Harrison County, Mississippi, it could enroll in Mississippi's state Medicaid program. In particular, the LTCH in Jackson was able to enroll backdated to 9/1/2008 when they applied. *See* Provider Exhibit P-100 at 102. *See also* Provider's Post-Hearing Brief at 44-45.
[47] Provider Exhibit P-100 at 109 with a Medicaid enrollment effective date of 2/1/2010.
[48] *Id.* at 111-113 with Medicaid enrollment effective dates in 2007 and 2008.
[49] *Id.* at 146 with Medicaid enrollment effective dates in 1997- 2000.
[50] *Id.* at 151 indicating Medicaid enrollment in 2008.
[51] *Id.* at 165 with a Medicaid enrollment date in 2010.
[52] *See also Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2.d 13, 25 (D.D.C. 2012).
[53] The Board recognizes that CMS issued a transmittal in November 1995 revising cost reporting instruction on bad debt documentation to allow providers "in lieu of billing" to submit alternative documentation to establish that nonpayment would have occurred if the crossover claim had been billed. *See* PRM 15-2, Ch. 11, Transmittal No. 4 (Nov. 1995) (revising PRM 15-2 § 1102.3). However, the Board notes that this decision does *not* opine on whether this 1995 transmittal does or does not violate the Bad Debt Moratorium (*i.e.*, whether that portion of CMS' "must bill" policy that requires billing of crossover claims even when nonpayment would have occurred if the crossover claim had been billed violates the Bad Debt Moratorium) because neither this sub-issue nor this transmittal are relevant to deciding the issues in this case.
[54] The Select LTCHs point to the 1995 bad debt instructions for the CMS Form 339 (copy at Provider Exhibit P-7) to support their position that an RA is not required, yet they did not comply with those instructions. Providers' Final Position Paper at 5-6. These instructions specify that, to "establish that Medicaid is not responsible for payment," the provider may, in lieu of billing, furnish documentation of Medicaid eligibility and proof that "non-payment would have occurred if the . . . claim had actually been filed with Medicaid." However, the Select LTCHs have not furnished any evidence that the States Allowing LTCH Enrollment are not responsible for payment for any portion of the claims for dual-eligible beneficiaries including QMBs under the state Medicaid plan had a claim been filed.

program is not responsible for Medicare coinsurance and deductibles of either dual eligibles or QMBs. Further, as previously noted, PRM § 322 pre-dates and complies with the Bad Debt Moratorium.[55]

Further, the Board notes that the record indicates that, in October 2004, the Medicare Contractors advised the Select LTCHs that they would be required to bill the state Medicaid programs for dual eligible and QMBs[56] although through April 2007 some Medicare Contractors reimbursed some of the Select LTCHs for bad debts without requiring them to bill Medicaid and obtain RAs.[57] Nonetheless, the record indicates that the Select LTCHs did not participate in the Medicaid programs in all of the states that correspond to their Medicaid patients for the years under appeal.[58] As a result, the Select LTCHs cannot demonstrate their compliance with the requirement to determine that "no other source other than the patient would be legally responsible for the patient's medical bill" as is required by Medicare bad debt policy.[59] The fact that the Select LTCHs were informed of the Medicare Contractors' directive in 2004, but did nothing to become a Medicaid provider for all of the states corresponding to their Medicaid patients, indicates that the Select LTCHs made business decisions to not apply for Medicaid certification, until it became obvious that they had no other recourse but to become a Medicaid provider in order to receive Medicare bad debt reimbursement.[60] The Board concludes that the Medicare Contractor's disallowance of the Select LTCHs' bad debt was proper as it relates to the States Allowing LTCH Enrollment.

As the Select LTCHs have not submitted evidence outside of RAs to demonstrate that the States Allowing LTCH Enrollment had no responsibility for coinsurance and deductibles, the Board need not address: (1) whether this other documentation would be acceptable; or (2) whether the CMS' position that the "must bill" policy necessarily includes obtaining an RA from a state even when that state has no responsibility violates the Bad Debt Moratorium.

[55] In support of its position, the Board notes the following examples of pre-1987 agency statements and Board cases applying CMS' bad debt policy: HCFA Action No. HCFA-AT-77-73 (MMB) (July 5, 1977) (responding to questions about a change in federal law in January 1968 which made payment of Medicare deductible and copayments by the state Medicaid program optional); *Geriatric and Med'l Ctrs., Inc. v. Blue Cross Ass'n*, PRRB Dec. No. 82-D62 at 5 (Mar. 3, 1982) (finding that "the cost of these services were not included in payments for services covered by the State of Pennsylvania"), *decl'd* review, HCFA Adm'r (Apr. 23, 1982); *Concourse Nursing Home v. Travelers Ins. Co.*, PRRB Dec. No. 1983-D152 at 18 (Sept. 27, 1983) (finding that "the Provider has furnished no documentation which would support its contentions that it had established collection policies and procedures or that actual collection efforts were made to obtain payments from the patients or the Medicaid authorities before an account balance was considered . . . bad debt[.]"), *decl'd review*, HCFA Adm'r (Nov. 4, 1983); *St. Joseph Hospital v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 84-D109 at 4 (Apr. 16, 1984) (finding that "the Provider did not attempt to bill the State of Georgia for its Medicaid patients."), *decl'd review*, HCFA Adm'r (May 14, 1984).

[56] Provider Exhibit P-35.

[57] Providers' Final Position Paper at 33; Provider Exhibit P-9 at 4.

[58] Providers' Post-Hearing Brief at 8.

[59] PRM 15-1, Ch. 3, § 312.

[60] Tr. at 110-111.

B. STATES IN WHICH THE SELECT LTCHS COULD NOT BE CERTIFIED AS MEDICAID PROVIDERS.

At the hearing, Select indicated that, in some instances, they were unable to submit claims to the state Medicaid program because the state Medicaid program would not enroll or certify LTCHs as Medicaid providers.[61]

The Board reviewed the documentation submitted by the parties and determined that, in several states, for the cost reports under appeal, the Select LTCHs were unable to enroll as Medicaid providers[62] and, therefore, were unable to bill the relevant state Medicaid programs. Based on its review, the Board determined that, in the following 5 states: Alabama,[63] Delaware,[64] Mississippi for Harrison County Only,[65] New Jersey,[66] and Pennsylvania,[67] providers were unable to enroll in the relevant state Medicaid program and obtain a Medicaid provider number as a LTCH. The Board will refer to these states as the "States Not Allowing LTCH Enrollment."

Based on the evidence in the record, the Board finds that the States Not Allowing LTCH Enrollment do not recognize nor reimburse LTCHs, including, but not limited to, the Select LTCHs. This is similar to the exception to the must bill policy that CMS recognized for CMHCs in the *Monterey* case.

Moreover, the Select LTCHs are clearly caught in a "Catch-22," as identified by the D.C. District Court in 2012 in *Cove Assocs. Joint Venture v. Sebelius ("Cove").*[68] Like the LTCHs in *Cove*, the Select LTCHs were told to comply with the Medicare "must bill" policy even though they were unable to do so because billing privileges for these state Medicaid programs were contingent on enrollment in those programs and, as LTCHs, they could not enroll in the relevant state Medicaid programs. Consistent with the *Cove* Court rationale, the Select LTCHs "are left in the untenable position of either refusing to treat dual-eligible patients or absorbing the bad debt associated with those patients."[69]

In *Cove*, the Secretary's position was that "states are required to issue RAs (regardless of a provider's participation status)," although the agency's counsel conceded "it is in a better position than the providers to ensure that the states comply with the applicable regulations of the Medicaid program." However, the *Cove* Court was "not willing to place a stamp of judicial

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[61] *Id.* at 112.
[62] Providers' Final Position Paper at 17-18.
[63] Provider Exhibit P-100 at 1. *See also* Providers' Post-Hearing Brief at 33 (explaining that Alabama revised its list of valid hospitals in July 2014 to include LTCHs).
[64] Provider Exhibit P-100 at 16. *See also* Tr. at 169 (explaining that Delaware still does not enroll LTCHs).
[65] Provider Exhibit P-100 at 68. *See also* Tr. at 175 (explaining that LTCHs in Harrison County still could not enroll in Medicaid).
[66] Provider Exhibit P-100 at 106. *See also* Tr. at 195 (stating New Jersey still does not enroll LTCHs in Medicaid).
[67] Exhibit P-100 at 122 – 125 (showing Medicaid enrollment effective 12/11/2011 and 7/31/2012). *See also* Tr. at 218-222 (describing a March 2012 meeting with the state of Pennsylvania and various LTCHs).
[68] 848 F. Supp. 2d 13 (D.D.C. 2012).
[69] *Id*. at 28.

approval on a policy that puts non-participating providers in the position of not being paid due to the delinquency of federally-funded state programs."[70] Neither is the Board.

Based on *Cove*, the Board finds that the Medicare Contractors improperly disallowed bad debt reimbursement for the claims at issue involving the States Not Allowing LTCH Enrollment. Accordingly, the Board remands the claims involving the States Not Allowing LTCH Enrollment to the Medicare Contractors to determine the appropriate amount of bad debt reimbursement for those claims.

The Board recognizes that the Administrator has disagreed with the Board on this issue in two similar bad debt reimbursement cases. In both *Life Care Hospitals v. Novitas Solutions Inc.*, PRRB Decision No. 2016-D25 and *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups v. Novitas Solutions Inc.*, PRRB Decision No. 2016-D22,[71] the CMS Administrator specifically rejected the Board's determination that the excerpt from the *Monterey* brief created an "exception" from billing a state Medicaid program and obtaining an RA for providers that could not be certified as Medicaid providers. Rather, the Administrator took the position that the reference in the *Monterey* brief was to a very limited settlement agreement and "settlements are not admissible as evidence and would not be properly considered in the case."[72] Further, the Administrator noted that, if such an exception existed, it should only be applied to non-Medicaid CMHCs located in California and not to non-Medicaid long term care hospital providers in Pennsylvania and North Carolina.[73]

The Board respectfully disagrees with the Administrator's characterization of the language from the *Monterey* brief, and believes that this excerpt reflects the Secretary's policy because the Secretary made this statement in the brief without qualification and, in particular, neither cited to nor referenced any settlement agreement in that statement.

Likewise, the Administrator rejected the Board's position related to the "Catch 22" situation in which a provider finds itself when the state will not enroll that provider type. The Administrator in his decision stated:

> 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 Federal statute and the state must be forced to comply.

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[70] *Id.*
[71] *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups v. Novitas Solutions, Inc.*, CMS Adm'r Dec. at 19 (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D22 (Sept. 27, 2016). *See also LifeCare Hosps. v. Novitas Solutions, Inc.*, CMS Adm'r Dec. at 19 (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016).
[72] *LifeCare Hosps. v. Novitas Solutions, Inc.*, CMS Adm'r Dec. at 19 (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016).
[73] *Id.* at 19-20.

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> Where States are made aware of their duty and still refuse to enroll Providers for the purpose of billing and receiving remittance advices, or otherwise refuse to process non-enrolled providers' claims, then the appropriate course would be for the Providers to take legal action with their states."[74]

However, the Board is not convinced that requiring an individual provider to take legal action against its State is a viable means for the provider to obtain Medicare bad debt reimbursement. Rather, the Board highlights the concession of the agency's counsel in *Cove*, stating that "it is in a better position than the providers to ensure that the states comply with the applicable regulations of the Medicaid program."[75] The *Cove* Court was "not willing to place a stamp of judicial approval on a policy that puts non-participating providers in the position of not being paid due to the delinquency of federally-funded state programs."[76]

Finally, the Administrator, in his recent decisions, also rejected any determination that the Medicare contractors' past practice of allowing bad debt claims for non-Medicaid providers "constitutes an explicit or affirmative agency action on policy," stating that such an allowance could happen only because of the constraints on the Medicare contractors to timely and correctly audit undocumented claims.

Given the unique circumstances of this case, the Board finds that an exception to the "must bill" policy should be applied to the Select LTCHs for claims that could not be billed to the States Not Allowing LTCH Enrollment. Further, regardless of the application of the exception in this case, the Board concludes that the Select LTCHs' bad debts were uncollectible when claimed as worthless, and that sound business judgment established that there was no likelihood of recovery at any time in the future. The Select LTCHs bad debt claims in the States Not Allowing LTCH Enrollment have met the requirements of the regulation, 42 C.F.R. § 413.89(e), for Medicare bad debt reimbursement.

DECISION AND ORDER:

After considering Medicare law, regulations and program instructions, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") makes the following findings:

1. It affirms the portion of the Medicare Contractors' dual eligible bad debt adjustments at issue that pertain to dual eligible bad debt claims associated with the following state

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[74] *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups. v. Novitas Solutions, Inc*., CMS Adm'r Dec. at 17 (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D22 (Sept. 27, 2016). *See also LifeCare Hosps. v. Novitas Solutions, Inc.*, CMS Adm'r Dec. (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016).
[75] *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).
[76] *Id.*

Medicaid programs in which the Providers chose not to enroll: Arkansas, California, Colorado, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi (except for Harrison County), North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; and

2. It reverses the portion of the Medicare Contractors' dual eligible bad debt adjustments at issue that pertain to dual eligible bad debt claims associated with the following state Medicaid programs which would not enroll long term care hospitals ("LTCHs") and, accordingly, remands this subset of claims to the Medicare Contractors to determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims: Alabama, Delaware, Mississippi (for Harrison County only), New Jersey and Pennsylvania.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Charlotte F. Benson, C.P.A.
Gregory H. Ziegler, C.P.A., CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

6/26/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

APPENDIX I
Schedule of Providers

[redacted]

Schedule of Providers in Group

Case No.: 13-0122GC
Group Name: Select Medical 2011 Dual Eligible (DE) Bad Debt CIRP Group
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in the Medicaid program.

Date Prepared: 6/21/2017

					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case No(s).	Date of Direct Add / Transfer(s) to Group
1	45-2022	Select Specialty Hospital - Dallas Carrollton, Dallas, TX	12/31/11	Novitas Solutions, Inc	12/17/2013	12/23/2013	6	800	$35,771	Direct Add	12/23/2013
2	34-2018	Select Specialty Hospital - Durham Durham, Durham, NC	01/31/11	Novitas Solutions, Inc	6/21/2012	12/5/2012	167	FI did not adj*	$51,036		12/5/2012
3	04-2000	Select Specialty Hospital - Little Rock Little Rock, Pulaski, AR	02/28/11	Novitas Solutions, Inc	6/28/2012	12/5/2012	160	805	$11,427		12/5/2012
4	16-2001	Select Specialty Hospital - Quad Cities Davenport, Scott, IA	01/31/11	Novitas Solutions, Inc	7/5/2012	12/5/2012	153	800	$18,095		12/5/2012
5	39-2039	Select Specialty Hospital - Central PA Camp Hill, Cumberland, PA	01/31/11	Novitas Solutions, Inc	7/5/2012	12/5/2012	153	800	$88,147		12/5/2012
6	39-2047	Select Specialty Hospital - Danville Danville, Montour, PA	01/31/11	Novitas Solutions, Inc	7/5/2012	12/5/2012	153	804	$75,532		12/5/2012
7	43-2002	Select Specialty Hospital - Sioux Falls Sioux Falls, Minnehaha, SD	02/28/11	Novitas Solutions, Inc	7/5/2012	12/5/2012	153	804	$2,470		12/5/2012
8	23-2033	Select Specialty Hospital - Saginaw Saginaw, Saginaw, MI	02/28/11	Novitas Solutions, Inc	7/5/2012	12/5/2012	153	805	$193		12/5/2012
9	25-2007	Select Specialty Hospital - Jackson Jackson, Hinds, MS	02/28/11	Novitas Solutions, Inc	7/5/2012	12/5/2012	153	804	$9,476		12/5/2012
10	11-2014	Regency Hospital of South Atlanta East Point, Fulton, GA	02/28/11	Novitas Solutions, Inc	7/16/2012	12/5/2012	142	805	$138,683		12/5/2012
11	11-2013	Select Specialty Hospital - Augusta Augusta, Richmond, GA	03/31/11	Novitas Solutions, Inc	7/5/2012	12/5/2012	153	804	$69,931		12/5/2012
12	10-2020	Select Specialty Hospital - Tallahassee Tallahassee, Leon, FL	02/28/11	Novitas Solutions, Inc	8/1/2012	12/5/2012	126	800	$19,828		12/5/2012
13	10-2022	Select Specialty Hospital - Gainesville Gainesville, Alachua, FL	07/31/11	First Coast Service Options	8/3/2012	12/5/2012	124	11	$5,151		12/5/2012
14	39-2036	Select Specialty Hospital - Laurel Highlands Latrobe, Westmoreland, PA	03/31/11	Novitas Solutions, Inc	9/5/2012	12/5/2012	91	805	$1,755		12/5/2012

15	67-3036	Select Rehabiliation Hospital of Denton Denton, Denton, TX	05/31/11	Novitas Solutions, Inc	7/23/2014	12/15/2014	145	10	$6,263	Direct Add	12/15/2014
16	34-2020	Select Specialty Hospital - Greensboro Greensboro, Guilford, NC	04/30/11	Palmetto GBA	3/7/2013	8/6/2013	152	7	$2,310	Direct Add	8/6/2013
17	11-2011	Select Specialty Hospital - Savannah Savannah, Chatham, GA	04/30/11	Novitas Solutions, Inc	6/27/2013	8/6/2013	40	12	$5,609	Direct Add	8/6/2013
18	44-2011	Select Specialty Hospital - Nashville Nashville, Davidson, TN	04/30/11	Novitas Solutions, Inc	6/27/2013	8/6/2013	40	800	$770	Direct Add	8/6/2013
19	52-2008	Select Specialty Hospital - Madison Madison, Dane, WI	05/31/11	Novitas Solutions, Inc	4/22/2013	8/6/2013	106	800	$991	Direct Add	8/6/2013
20	39-2037	Select Specialty Hospital - Erie Erie, Erie, PA	05/31/11	Novitas Solutions, Inc	5/9/2013	8/6/2013	89	800	$37,619	Direct Add	8/6/2013
21	18-2003	Select Specialty Hospital - Lexington Lexington, Fayette, KY	05/31/11	Novitas Solutions, Inc	6/21/2013	8/6/2013	46	12	$963	Direct Add	8/6/2013
22	23-2035	Select Specialty Hospital - Kalamazoo Battle Creek, Calhoun, MI	05/31/11	Novitas Solutions, Inc	6/27/2013	8/6/2013	40	8	$10,395	Direct Add	8/6/2013
23	15-2016	Select Specialty Hospital - Fort Wayne Fort Wayne, Allen, IN	06/30/11	Novitas Solutions, Inc	4/19/2013	8/6/2013	109	803	$7,508	Direct Add	8/6/2013
24	28-2001	Select Specialty Hospital - Omaha Omaha, Douglas, NE	06/30/11	Novitas Solutions, Inc	7/18/2013	8/6/2013	19	15	$7,915	Direct Add	8/6/2013
25	44-2012	Select Specialty Hospital - Knoxville Knoxville, Knox, TN	07/31/11	Novitas Solutions, Inc	3/21/2013	8/6/2013	138	806	$1,782	Direct Add	8/6/2013
26	01-2008	Select Specialty Hospital - Birmingham Birmingham, Jefferson, AL	08/31/11	Novitas Solutions, Inc	7/19/2013	8/6/2013	18	14	$208,377	Direct Add	8/6/2013
27	10-2024	Select Specialty Hospital - Pensacola Pensacola, Escambia, FL	09/30/11	First Coast Service Options	3/25/2013	8/6/2013	134	13	$20,146	Direct Add	8/6/2013
28	06-2015	Select Specialty Hospital - Denver Denver, Denver, CO	09/30/11	Novitas Solutions, Inc	4/10/2013	8/6/2013	118	12	$963	Direct Add	8/6/2013
29	31-2019	Select Specialty Hospital - Northeast New Jersey Rochelle Park, Bergen, NJ	10/31/11	Novitas Solutions, Inc	5/2/2013	8/6/2013	96	808	$263,292	Direct Add	8/6/2013
30	44-2014	Select Specialty Hospital - Memphis Memphis, Shelby, TN	11/30/11	Novitas Solutions, Inc	4/29/2013	8/6/2013	99	800	$75,235	Direct Add	8/6/2013
31	42-2007	Regency Hospital of Florence Florence, Florence, SC	12/31/11	Novitas Solutions, Inc	7/17/2013	8/6/2013	20	15	$64,877	Direct Add	8/6/2013
32	39-2044	Select Specialty Hospital - Pittsburgh UPMC Pittsburgh, Allegheny, PA	06/30/11	Novitas Solutions, Inc	8/8/2013	12/23/2013	137	800	$32,225	Direct Add	12/23/2013
33	25-2006	Regency Hospital Meridian	07/31/11	Novitas Solutions, Inc	8/27/2013	12/23/2013	118	10	$44,466	Direct Add	12/23/2013

34	36-2019	Meridian, Lauderdale, MS Select Specialty Hospital - Cincinnati Cincinnati, Hamilton, OH	07/31/11	Novitas Solutions, Inc	8/29/2013	12/23/2013	116	805	$10,236	Direct Add	12/23/2013
35	34-2016	Select Specialty Hospital - Winston-Salem Winston-Salem, Forsyth, NC	07/31/11	Novitas Solutions, Inc	8/30/2013	12/23/2013	115	805	$1,783	Direct Add	12/23/2013
36	08-2000	Select Specialty Hospital - Wilmington Wilmington, Newcastle, DE	07/31/11	Novitas Solutions, Inc	8/30/2013	12/23/2013	115	14	$93,798	Direct Add	12/23/2013
37	15-2013	Select Specialty Hospital - Beech Grove Beech Grove, Marion, IN	08/31/11	Novitas Solutions, Inc	8/9/2013	12/23/2013	136	13	$43,621	Direct Add	12/23/2013
38	37-2007	Select Specialty Hospital - Tulsa Tulsa, Tulsa, OK	08/31/11	Novitas Solutions, Inc	8/19/2013	12/23/2013	126	805	$140,354	Direct Add	12/23/2013
39	39-2045	Select Specialty Hospital - McKeesport McKeesport, Allegheny, PA	08/31/11	Novitas Solutions, Inc	8/30/2013	12/23/2013	115	6	$2,372	Direct Add	12/23/2013
40	51-2002	Select Specialty Hospital - Charleston Charleston, Kanawha, WV	08/31/11	Novitas Solutions, Inc	9/4/2013	12/23/2013	110	805	$8,470	Direct Add	12/23/2013
41	26-2013	Select Specialty Hospital - St. Louis St. Louis, St. Louis, MO	10/31/11	Novitas Solutions, Inc	8/20/2013	12/23/2013	125	9	$42,865	Direct Add	12/23/2013
42	11-2016	Regency Hospital of Macon Macon, Bibb, GA	10/31/11	Novitas Solutions, Inc	9/24/2013	12/23/2013	90	14	$140,172	Direct Add	12/23/2013
43	44-2016	Select Specialty Hospital - Tri Cities Bristol, Sullivan, TN	10/31/11	Novitas Solutions, Inc	9/25/2013	12/23/2013	89	14	$2,972	Direct Add	12/23/2013
44	52-2006	Select Specialty Hospital - Milwaukee Milwaukee, Milwaukee, WI	10/31/11	Novitas Solutions, Inc	9/30/2013	12/23/2013	84	14	$4,556	Direct Add	12/23/2013
45	03-2001	Select Specialty Hospital - Phoenix Phoenix, Maricopa, AZ	11/30/11	Novitas Solutions, Inc	11/7/2013	12/23/2013	46	14	$792	Direct Add	12/23/2013
46	17-2007	Select Specialty Hospital - Wichita Wichita, Sedgwick, KS	12/31/11	Novitas Solutions, Inc	8/15/2013	12/23/2013	130	13	$396	Direct Add	12/23/2013
47	36-2036	Regency Hospital of Toledo Sylvania, Lucas, OH	12/31/11	CGS	10/30/2013	12/23/2013	54	8	$50,698	Direct Add	12/23/2013
48	25-2005	Select Specialty Hospital - Gulf Coast Gulfport, Harrison, MS	12/31/11	Novitas Solutions, Inc	12/17/2013	12/23/2013	6	14	$64,462	Direct Add	12/23/2013
								Total	**$1,927,750**		

* FI did not remove protested amount.