

**PROVIDER REIMBURSEMENT REVIEW BOARD  
DECISION  
ON THE RECORD  
2017-D14**

**PROVIDER–**  
Portia Bell Hume Behavioral Health & Training  
Center

Provider No.: 05-4662

**vs.**

**MEDICARE CONTRACTOR –**  
Noridian Healthcare Solutions, LLC

**DATE OF HEARING –**  
April 12, 2016

Cost Reporting Period Ended –  
June 30, 2008

**CASE NO.:** 10-1036

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ISSUE:

Whether Portia Bell Hume Behavioral Health & Training Center (“Hume Center”) can be paid by the Medicare program for certain dual eligible Medicare and Medicaid crossover bad debts without billing and obtaining a remittance advice (“RA”) from the appropriate state Medicaid agency?<sup>1</sup>

DECISION:

After considering the Medicare law and regulations, the parties’ contentions, and the evidence submitted, the Provider Reimbursement Review Board (“Board”) concludes that the Hume Center has met the requirement in 42 C.F.R. § 413.89 for a reasonable collection effort related to its dual eligible non-QMB beneficiaries. Accordingly, the Board remands this matter back to the Medicare Contractor to pay the Hume Center for its bad debts related to dual eligible non-QMB beneficiaries.

INTRODUCTION:

The Hume Center is a community mental health center (“CMHC”) located in Concord, California and operates a free-standing partial hospitalization program (“PHP”).<sup>2</sup> On November 20, 2009, the Medicare contractor, Noridian Healthcare Solutions, LLC (“Medicare Contractor”), issued a Notice of Program Reimbursement (“NPR”) to the Hume Center for its fiscal year ending June 30, 2008 (“FY 2008”).<sup>3</sup> In particular, the Medicare Contractor disallowed all of the Hume Center’s bad debt expense for individuals who are eligible for Medicare and Medi-Cal, California’s Medicaid program (“dual eligibles”).<sup>4</sup>

The Hume Center requested a hearing before the Board challenging whether a provider must first submit a claim to Medi-Cal and obtain a Medi-Cal remittance advice (“RA”) to receive Medicare reimbursement for crossover bad debts derived from unpaid Medicare deductibles and coinsurance of dual eligible patients.<sup>5</sup> The Hume Center met all of the jurisdictional requirements, and the Board held a record hearing on April 12, 2016.

STATEMENT OF FACTS:**A. MEDICARE’S BAD DEBT POLICY**

Federal regulations at 42 C.F.R. § 413.89 (e) (2009) 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.

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<sup>1</sup> See Stipulations at ¶ 1.

<sup>2</sup> See *id.* at ¶ 2.

<sup>3</sup> The appeal period at issue is July 2007 through February 2008.

<sup>4</sup> Provider’s Final Position Paper at 3; Provider Exhibit P-9 at 1.

<sup>5</sup> Provider’s Individual Appeal Request, Tab 3, at 1.

- (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.<sup>6</sup>

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.<sup>7</sup> 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 to be 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 declare Medicare bad debt for that portion of the deductible and copayment amounts that “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” but may include the “portion of 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 that the provider must bill and obtain an RA from the relevant state Medicaid program whenever a bad debt involves a dual eligible regardless of whether that program may owe nothing or only a portion of the dual eligible’s Medicare deductible or co-payment.<sup>8</sup> The Ninth Circuit in *Community Hosp. of the Monterey Peninsula v. Thompson* (“*Monterey*”), 323 F.3d 782, 785 (9<sup>th</sup> Cir. 2003), found CMS’ must-bill policy to be a reasonable implementation of the bad debt reimbursement system and

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<sup>6</sup> Provider Reimbursement Manual, CMS Pub. No. 15-1 (“PRM 15-1”), § 308 restates these requirements.

<sup>7</sup> For copies of the PRM sections, see Medicare Contractor Exhibit I-3.

<sup>8</sup> Specifically, JSM-370 (copy included at Provider Exhibit P-10) outlines CMS’ “must bill” policy as follows:  
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 debts 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).

(citations omitted.)

not inconsistent with the statute and regulations governing fiscal years 1989 through 1995.<sup>9</sup> In addition, in 2012, the federal district court in the District of Columbia 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.<sup>10</sup>

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

State Medicaid agencies have a legal obligation to reimburse providers for Medicare cost-sharing (*i.e.*, 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,<sup>11</sup> a state may be obligated to pay the full cost sharing amounts for patients who qualify for Medicaid as qualified Medicare beneficiaries ("QMBs").<sup>12</sup> In general, to receive Medicaid reimbursement, a provider must enroll as a Medicaid provider. Some state Medicaid agencies do not allow enrollment of certain providers (*e.g.*, CMCHs, long term care hospitals, inpatient rehabilitation facilities) and, in those situations, the providers are unable to bill the state Medicaid program for Medicare cost sharing amounts.

In the present case, the Hume Center was one of those providers who could not enroll in the Medi-Cal program because the Medi-Cal program did not cover services provided in a CMHC and, therefore, would not enroll and give the Hume Center a Medi-Cal provider number.<sup>13</sup> As a result, the Hume Center could not bill Medi-Cal for the dual eligible crossover bad debts and did not receive remittance advices ("RAs") from Medi-Cal.<sup>14</sup> The Hume Center claimed some of these deductible and co-insurance amounts on its cost report as "bad debts." The Medicare Contractor disallowed the Hume Center's bad debts based on the Centers for Medicare & Medicaid Services' ("CMS") "must bill" policy.

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<sup>9</sup> 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. In CMS Memorandum, JSM-370, CMS withdrew § 1102.3L and reverted back to the pre-1995 language and required providers to bill state Medicaid programs before claiming Medicare bad debt. See Provider Exhibit P-10.

<sup>10</sup> *Cove Assocs. Joint Venture v. Sebelius*, 848 F.Supp.2d 13, 30 (D.D.C. 2012).

<sup>11</sup> 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."

<sup>12</sup> However, 42 U.S.C. § 1396d(p)(3), at least for a time, required state Medicaid programs to pay cost-sharing amounts for QMBs. See Stipulations at ¶ 2.4.

<sup>13</sup> See Stipulations at ¶ 2.5, Attachment 1; Provider Exhibit P-2; Provider's Individual Appeal Request, Tab 3, at 1. The Hume Center introduced into evidence a February 9, 2000 response letter to it from the California Department of Health Services ("CDHS") stating that, because Medi-Cal does not recognize PHP services, Medi-Cal has no way to process claims for payment. *Id.* at Attachment 1. The Hume Center also introduced into evidence a June 2, 2009 letter that it sent to the Electronic Data System Corporation ("EDS"), which was the Medi-Cal claims processing contractor at that time, to request a method for EDS to process dual eligible claims during the appeal period. *Id.* at Attachment 2. However, EDS did not respond to this request. Stipulations at ¶ 2.5.

<sup>14</sup> Stipulations at ¶¶ 2.8-2.9.

Until 2007, four prior Medicare Contractors for the Hume Center allowed the bad debt claims for these unpaid deductible and co-insurance amounts based on a CMS letter allowing the bad debt claims as long as the provider could provide documentary evidence of its patients' Medicaid eligibility.<sup>15</sup> The Hume Center was assigned a new Medicare Contractor for its FY 2008 cost report. The new Medicare Contractor refused the bad debt documentation and disallowed all dual eligible Medicare bad debts for which the Hume Center had no Medi-Cal RA.<sup>16</sup>

To address the Contractor's concerns, the Hume Center revised its bad debt claim "by eliminating all Medi-Cal Aid Code 80 QMB patient accounts and by eliminating all unmet SOC [share of costs] amounts". The Hume Center contends the Medi-Cal Eligibility Verification System provides all the needed information on dual eligible patients except the amount of the state's liability on a QMB patient.<sup>17</sup> However, the Hume Center claims it has omitted QMB patients in its revised listing so "any such remittance advice information would only be academic."<sup>18</sup>

The record also shows that, in March 2008, the Hume Center used its federal National Provider Identification ("NPI")<sup>19</sup> number for its non-PHP services, to register with Medi-Cal claims processing. With this NPI number, the Hume Center was able to file Medicare copayment crossover claims to Medi-Cal and receive a RA. While this satisfied the must bill documentation issue beginning March 2008, it did not remedy the Hume Center's inability to submit claims and generate "no pay" RAs for the preceding period July 2007 through February 2008.<sup>20</sup>

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<sup>15</sup>See Provider Exhibit P-3 at ¶ 1 (acknowledgement by the Director of Audit and Reimbursement at First Coast Options, Inc., a Medicare Contractor, that "the previous intermediaries were instructed by the regional office to allow reimbursement if the only reason for disallowing was that fact that you could not bill the state"). See also Provider Exhibit P-7; September 4, 1998 letter from HCFA (CMS) to Professional Medical Adjusters, Inc. c/o La Cheim Schools, Inc. (the provider is located in Alameda County, California). CMS stated:

[W]e believe it is reasonable to conclude that La Cheim has no means of obtaining a provider number to bill the State for the coinsurance and deductible amounts related to dually eligible patients. We will instruct the intermediary to allow the related bad debts without your billing the State. However, the following conditions apply:

- All allowed bad debts must otherwise meet the criteria as defined in Chapter 3 of the Provider Reimbursement Manual.
- For unpaid coinsurance/deductible related to dually eligible patients, the provider must fully document the Medicaid eligibility of the patients to the intermediary's satisfaction. If the provider is unable to do this, the intermediary will expect collection efforts as described in Section 310 of the Provider Reimbursement Manual.

<sup>16</sup> Provider's Final Position Paper at 3.

<sup>17</sup> See Provider's Final Position Paper at 1-3; Provider Exhibit P-9. The Hume Center obtains key information from California's Eligibility Verification System ("EVS") related to the status of a dual eligible beneficiary including share of costs ("SOC") and special aid code 80 QMB status. The only data the Hume Center cannot obtain is the specific amount of the State's QMB share of cost.

<sup>18</sup> See Provider's Final Position Paper at 5.

<sup>19</sup> CMS adopted the National Provider Identifier ("NPI") in 2005 as the standard unique health identifier for health care providers to file health care claims. Medicare has required NPI reporting since May 23, 2008. Providers were required to provide their NPI on Medicaid claims effective on July 6, 2010. 42 C.F.R. § 424.506(b); 77 Fed. Reg. 25284, 25287 (Apr. 27, 2012).

<sup>20</sup> Provider's Final Position Paper at 1-2. See also Provider Exhibit P-9. The Hume Center recognizes that Medi-Cal may be responsible for the cost-sharing liabilities of QMBs during this period and states that the Hume Center has represented that it would revise its claim for Medicare bad debts by eliminating all "Special Aid Code 80 QMB patient accounts and any other CMS categorically non-allowed accounts, such as Share of Cost amounts. See

DISCUSSION, FINDINGS OF FACT AND CONCLUSION OF LAW:

The Medicare Contractor maintains that the Hume Center’s collection efforts do not meet the reasonable collection effort criteria for allowable bad debts stated in PRM-I §§ 308, 310 and 312(C); and 42 C.F.R. § 413.89.<sup>21</sup> The Medicare Contractor argues that the Hume Center did not properly bill the Medi-Cal program and did not obtain a state remittance advice prior to claiming the bad debt from Medicare<sup>22</sup> The Medicare Contractor argues that the state agency’s refusal to issue the Hume Center a Medi-Cal provider billing number does not relieve the Hume Center of its obligation to submit claims to Medi-Cal in order to claim bad debt reimbursement. The Medicare Contractor asserts that, unless the Hume Center files the related claims, Medi-Cal has no basis to determine its payment obligation (including its obligation for QMBs)<sup>23</sup> under the state’s approved plan and, therefore, the Hume Center has not met its obligation to determine third party liability.

The Board’s review of the record shows that Medi-Cal did not allow CMHCs to enroll in the Medicaid program for the time period at issue.<sup>24</sup> Based on its review of similar cases, the Board is aware that the Hume Center’s inability to obtain RAs is similar to the two exceptions to the “must bill” policy that the Secretary recognized in a brief that she filed in connection with *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–0142 (N.D. Cal. Oct. 11, 2001) (“*Monterey*”). Specifically, the following excerpts from that brief describes “two unique instances where *the Secretary* permits providers to claim Medicare crossover bad debt without billing the State Medicaid agency”<sup>25</sup>

1. Community mental health centers (“CMHCs”).—CMHCs “are allowed to claim Medicare crossover bad debts without billing the State agency because CMHCs cannot bill the State agency given that they are not licensed by the State and, therefore, have no Medi-Cal provider numbers.”<sup>26</sup>
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 patients aged 22-64. This is because the Medicaid statute and regulations categorically preclude payment for services provided to patient aged 22-64 in IMDs, and the state accordingly has absolutely no responsibility for the coinsurance/deductibles associated with those particular services.”<sup>27</sup>

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Provider Exhibit P-6 (showing California Medicaid codes that indicate whether the State is required to pay a share of the costs (“SOC”)).

<sup>21</sup> Medicare Contractor Supplemental Final Position Paper at 4.

<sup>22</sup> *Id.* at 7.

<sup>23</sup> See Provider Exhibit P-8.

<sup>24</sup> *Id.* at 4; Provider Exhibit P-2.

<sup>25</sup> 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–01–0142, 2001 WL 1256890 (N.D. Cal. Oct. 11, 2001) (emphasis added). An example of prior Board decisions referencing these exceptions is *LifeCare Hosps v. Novitas Solutions, Inc.*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016), *modified by*, CMS Adm’r Dec. (Nov. 28, 2016).

<sup>26</sup> *Id.* (citations omitted).

<sup>27</sup> *Id.* (citations omitted).

Accordingly, consistent with the Secretary-recognized exceptions to the “must bill” policy, the Board concludes that the Hume Center’s inability to obtain RAs from the Medi-Cal Program qualifies as an exception to the “must bill” policy.

In further support of this conclusion, the Board notes that the Hume Center clearly was caught in the same “Catch-22” described by the D.C. District Court in *Cove Assocs. Jt. Venture v. Sebelius* (“*Cove*”).<sup>28</sup> Like the long term care hospitals in *Cove*, the Hume Center was unable to enroll in the Medi-Cal program until March 2008 and, accordingly, could not bill the program and obtain Medicaid RAs in compliance with Medicare’s “must bill” policy. As the *Cove* Court stated, in these situations providers “are left in the untenable position of either refusing to treat dual-eligible patients or absorbing the bad debts associated with those patients.”<sup>29</sup>

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,<sup>30</sup> the CMS Administrator specifically rejected the Board’s determination that the excerpt from the *Monterrey* 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 *Monterrey* brief was to a very limited settlement agreement, and “settlements are not admissible as evidence and would not be properly considered in the case.”<sup>31</sup> 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.<sup>32</sup> The Board respectfully disagrees with the Administrator’s characterization of the language from the *Monterrey* 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. Further, the Board points out the provider in this case *is* a CMHC located in the State of California. As a result, the Board finds that the “exception” identified by the Secretary can and should be applied to the Hume Center.

Likewise the Administrator rejected the Boards position related to the “Catch-22” situation a provider finds itself in 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 a dual eligible beneficiary claims, for all types of Medicare providers, then the State is out of

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<sup>28</sup> *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).

<sup>29</sup> *Id.*

<sup>30</sup> The Administrator’s decisions for these cases were issued on November 28, 2016.

<sup>31</sup> *Life Care Hosps. v. Novitas Solutions, Inc.*, CMS Adm’r Dec. at 19 (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016).

<sup>32</sup> *Id.* at 19-20.

compliance with Federal statute and the state must be forced to comply. 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."<sup>33</sup>

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.<sup>34</sup> Rather, the Board points to *Cove*, where 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."<sup>35</sup> The *Cove* Court was "not willing to place a stamp of judicial approval on a policy that would put non-participating providers in the position of not being paid due to the delinquency of federally-funded state programs."<sup>36</sup>

Finally, the record in this case contains emails, from the Director of Audit and Reimbursement for the Medicare contractor, First Coast Service Options, Inc., affirming that "previous intermediaries were instructed by the regional office to allow reimbursement if the only reason for disallowing was the fact that you could not bill the state."<sup>37</sup> The Board finds that this statement suggests that prior to the year at issue in this case, the CMS Regional Office policy for this region was to allow Medicare contractors to accept bad debt claims for providers that could not be certified by the state as a Medicaid provider.

Given the unique circumstances of this case, the Board finds that an exception to the "must bill" policy should be applied to the Hume Center. Further, regardless of the application of the exception in this case, the Board concludes that the Hume Center's 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 Hume Center's bad debt claims have met the requirements of the regulation, 42 C.F.R. § 413.89(e).

#### DECISION AND ORDER:

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board concludes that the Hume Center has met the requirement for a reasonable collection effort related to its dual eligible non-QMB beneficiaries as required by 42 C.F.R. § 413.89. Accordingly, the Board remands this matter back to the Medicare Contractor to pay

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<sup>33</sup>*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 Life Care Hosps. v. Novitas Solutions, Inc.*, CMS Adm'r Dec. (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016).

<sup>34</sup>It should be noted that, in February, 2011, CMS required all state Medicaid programs to require providers to use NPI numbers on all Medicaid claims—even for providers who "order and refer" but do not bill (or could not bill) the Medicaid program. *See* Final Rule, Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, 76 Fed. Reg. 5862 (Feb. 2, 2011).

<sup>35</sup> *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).

<sup>36</sup> *Id.*

<sup>37</sup> Provider Exhibit P-3 (copy of email dated Feb. 16, 2009).

the Hume Center's for its bad debts related to dual eligible non-QMB beneficiaries.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

/s/  
L. Sue Andersen, Esq.  
Chairperson

DATE: March 29, 2017