CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the cases of:	**Claim for:**
SELECT MEDICAL 2011 DUAL ELIGIBLE BAD DEBTS CIRP GROUP **Provider** **vs.**	**Cost Reporting Period Ending:** **2011**
NOVITAS SOLUTIONS, INC. **Intermediary**	**Review of:** **PRRB Dec. No. 2019-D29** **Dated: June 26, 2019**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in section 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). CMS' Center for Medicare (CM), Chronic Care Policy Group (CCPG), and the Medicare Administrative Contractor (MAC) commented, requesting a partial reversal of the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. The Providers commented requesting that Board's decision be reversed, in part, and modified, in part. Accordingly, the case is now before the Administrator for final administrative decision.

ISSUE AND BOARD'S DECISION

The issue is whether the MAC's must-bill policy applies to the Providers' dual eligible bad debts when the Provider did not participate in the Medicaid program.

The Board held that pre-1987 bad debt policy in the PRM clearly established that providers have an obligation to bill "the responsible party." The Board pointed to its prior decision in 2016 for Select's FY 2006-2010 cost years in which the Board considered three federal appeals court decisions on this matter,[1] as well as the Administrator's decision upon remand of Select's FY 2005.[2] The Board held that the various Courts have upheld that the Secretary has had a

[1] *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 Monterrey Peninsula v. Thompson*, 323 F.3d 782, 792 (9th Cir. 2003).

[2] *Select Specialty'05 Medicare Dual Eligible Bad Debt Group*, 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).

longstanding "must bill" policy and that it is not unreasonable to require the state to first determine any cost sharing liability. [3]

Recognizing prior Board, Administrator and Federal court decisions, the Board addressed this case as two separate issues by dividing the Providers into two groups: 1) Providers in states in which the Providers could have enrolled but chose not to enroll[4] and 2) Providers in states in which the Providers claim they were unable to enroll in the respective state Medicaid program. [5]

In the first group of Providers, the Board affirmed the MAC's dual-eligibility adjustment for those Providers who were in states in which the Providers could have, but chose not to, enroll. The Board held that a review of the record shows that Select long term care hospitals (LTCHs) had no bar to enrolling as a Medicaid provider and obtaining a Medicaid billing number. The Board held that PRM 15-1 section 322, which pre-dates the Bad Debt Moratorium, 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 a Medicare bad debt. The Board further held that the Manual section 322 requirement is not predicated on whether the provider does or does not participate in Medicaid. Additionally, the Board noted that section 322 cross references section 310 which confirms, at a minimum, the requirement to "bill….the party responsible" for crossover claims. The Board determined that Select LTCHs made a business decision not to enroll in the respective Medicaid programs in states allowing LTCH enrollment and have not provided evidence that demonstrates that the state Medicaid program is not responsible for Medicare coinsurance and deductibles of either dual eligible patients or QMBs. Additionally, the Board pointed out that in October 2004 the MACs advised the Providers that they would be required to bill the state Medicaid programs for dual eligible and QMBs. Thus the Board held that MAC's disallowance was proper as it relates to States allowing LTCH enrollment because the debt could not be claimed as worthless.

Regarding the second group of Providers, those Providers located in states in which the Providers claimed that LTCHs could not be certified as Medicaid Providers, the Board reversed the MAC's adjustment and remanded these claims to the Medicare Contractors to determine the appropriate amount of bad debt reimbursement due under the Medicare program. The Board determined, based upon a review of the record, that, in several states, the Providers were unable to enroll as Medicaid providers (Final Position paper at 17-18) because of their LTCH status, and, therefore, were unable to bill the relevant state Medicaid programs. The Board held that these Providers qualified for a "must-bill" exception. The Board applied the evidence in the record with the facts in *Community Hosp. of Monterrey Penninsula v. Thompson*[6] to reach the determination that, in these states where the State will not enroll LTCHs, the Secretary has an exception to the "must-bill" policy. Furthermore, the Board also pointed to the "catch-22" rationale raised in *Cove Assocs. Joint*

[3] *See* PRRB Decision No. 2019-D29 at 8.

[4]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.

[5]Alabama, Delaware, Mississippi (Harrison County only), New Jersey and Pennsylvania.

[6] Case No. C-01-00142 VRW, 2001 WL 1256890 (N.D. Cal. Oct. 11, 2009).

Venture v. Sebellius[7] to find in favor of a "must-bill" exception for Providers located in states where the respective Medicaid program will not enroll LTCHs. The Board, respectfully disagreed with the Administrator's previous findings on the "catch-22" issue. Lastly, the Board provided that, arguendo, an exception to the "must-bill" policy is determined not to exist, that the Providers 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.

SUMMARY OF COMMENTS

The Providers commented requesting that the Administrator 1) affirm the portion of the Board's decision that reversed the MAC's bad debt adjustment for the states where the Medicaid program would not enroll LTCHs with the modification that it also applies to the Providers located in Arkansas and North Carolina, 2) reverse the portion of the Board's decision that affirmed the MAC's dual eligible bad debt adjustments for the remaining Providers, and 3) modify the Board's decision to clarify that the MAC's dual eligible bad debt adjustments are reversed for out-of-state beneficiaries.

The Providers claimed that the MAC's must-bill policy has no foundation in law and that the application of the must-bill policy when the Providers do not participate in Medicaid programs is improper. The Providers alleged that there has never been a court decision that addresses whether the must-bill policy applies to non-Medicaid-participating providers. The Providers applied rationale from the *Cove* remand which stated the Court's reluctance to give approval to the must-bill policy in the instance of non-participating Providers who are caught in a "catch-22" where the respective States refuse to issue a Medicaid remittance advice (RA). Additionally, the Providers asserted that all non-participating providers are caught in this "catch-22," not just those located in states where states refuse to enroll them in Medicaid.

The Providers also raised the issue of detrimental reliance based on the discussion in the *Cove* remand to CMS in which the District Court questioned the lack of enforcement of the "must-bill" policy for bad debts prior to fiscal year 2005. The Providers noted that the Court instructed the Administrator, on remand, to address whether "CMS' enforcement of the must-bill policy to Plaintiff's claims may 'constitute a change that does not take into account [] legitimate reliance on prior interpretation.'" The Providers asserted that in states where there is no mechanism for non-Medicaid-participating providers to bill and receive a RA, the Provider does have a legitimate reliance and that the Administrator's findings in the *Cove* remand decision[8] that the Provider did not prove a detrimental reliance was inconsistent with the administrative record in that case. The Providers also argued that the Board's reliance on Federal case law and the Administrator's decision upon remand in the *Select Specialty FY 2005* remand is inconclusive because no court has issued a final decision on the specific issue of whether the CMS must-bill policy applies to dual-eligible bad debts for providers that did not participate in Medicaid.

The Provider asserted that the closest thing to a court opinion on the subject is the "catch-22" discussion found in *Cove*, arising from the Provider's appeal of the *Select Medical FY 2005*

[7] 848 F.Supp. 2d 13 (D.D.C. 2012).
[8] *Select Medical FY 2005*, Administrator Remand Decision at n. 3 (March 15, 2016)

Administrator's decision. The Providers claimed that the Administrator does not address, in its remand decision, the core issue that Providers are caught in the alleged "catch 22." The Provider asserted that the regulations at 42 C.F.R. 413.89 and PRM sections 308, 310, 312, and 322 do not require that non-Medicaid-participating Providers must enroll into the program to be eligible for dual eligible bad debt reimbursement. The Providers claimed that a reading of both sections 312 and 322 does not apply to non-participating Medicaid providers because the "state clearly would not pay because the Providers were not enrolled in Medicaid" and that "no other source than the patient would be legally responsible for the patient's medical bill." Therefore, the Providers claimed that the Providers in this case are not legally recognized as parties that could submit bills to the state Medicaid programs, and that the respective states were not legally permitted to process or pay bills submitted by the Providers. Based on the this rationale, the Providers also argued that, even in the states which allowed LTCH enrollment in Medicaid, the Providers were also legally unable to bill state Medicaid programs, have their claims processed, or receive Medicaid RAs.

The Providers also claimed that the Joint Signature Memorandum (JSM)-370 and MAC newsletters cannot be used as a reason to continue to deny Medicare payments for the Providers dual eligible bad debts. The Providers stated that the JSM-370 was not a notice to providers as it is only distributed to MACs and that the MAC newsletter[9] did not notify Providers that the CMS must-bill policy applied to non-Medicaid-participating Providers. Furthermore, the Provider pointed to communication from the CMS Kansas City Regional Office after the release of the newsletters which stated that "[I]f a provider is not Medicaid certified, they shouldn't be required to bill the state before we allow the bad debt as the state does not have any liability to non-Medicaid-certified providers."[10] The Provider noted that the MACs continued to reimburse non-Medicaid-participating Providers for nearly three additional years after the newsletter and it was three years later when the CMS Central Office instructed MACs to stop reimbursing Providers' bad debts without Medicaid RAs. The Providers also pointed out that *Monterrey* was issued in 2003 which was four years prior to the first payment adjustment to the Providers and, thus, it did not communicate a policy change. Thus, the Providers noted that there was no guidance from CMS or treatment from the Federal courts regarding the must-bill policy in relation to non-Medicaid-participating providers.

The Providers stated that a state's legal obligation to pay Medicare cost-sharing amounts for dual-eligible patients is trigged by both a state Medicaid plan requirement and a Medicaid participating provider. The Providers argued that the Board's holdings in PRRB Dec. No 2010 D-25 stated that a "common sense" reading of the guidance provides a "universal requirement to collect [bad] debt from responsible third parties"[11] before it can be allowable under Medicare. However, in that decision, the Board added that the requirement was "not intended to apply to dual eligible bad debt claims on non-participating providers."[12] Thus, the Providers insisted that the Board's 2010 decision in the *Select Specialty FY 2005* case, that Medicaid is not a "responsible third party" from whom the Providers were required to pursue collections was correct.

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[9] Provider's Exhibit P-35.
[10] Provider's Exhibit P-9 at 4.
[11] PRRB Dec. No. 2010 D-25 at 8.
[12] *Id.* at 8-9.

Moreover, the Providers claimed that the Administrator's decision on remand did not address the inability of LTCHs in certain states to enroll in Medicaid whereas the Board correctly recognized the similarities between the facts in this case and the Providers in *Monterrey* and correctly applied an exception to the must-bill policy where enrollment is precluded by the State. The Providers also stated that the Board correctly disagreed with the Administrator's finding that the *Monterrey* must-bill "exceptions" were not admissible as evidence since there was no qualification to the discussion of the exceptions, nor a reference to a settlement agreement, by the Secretary.

The Providers also supported the Board's acceptance of the *Cove* "catch-22" theory and rejection of the suggestion that a Providers should have to take legal action against a state that does not provide the Medicaid RAs necessary to comply with the Medicare must-bill policy. The Provider agreed with the Board's reversal of the MAC's disallowance of dual eligible bad debts for these Providers located in states where LTCHs were not permitted to enroll in Medicaid. However, the Providers noted that the Board erred in excluding Arkansas and North Carolina from the group of Providers that were not allowed to enroll in their state Medicaid program and requested that the Administrator modify the decision to include these States in that group of Providers.

The Providers disagreed with the MAC's argument that there are no exceptions to the must-bill policy and that, if there is any exception, based on *Monterrey*, it was limited to non-licensed CMHCs and IMDs in California. The Providers argued that an exception should be found to exist because the reasons are similar to the Providers in *Monterrey* and not because they are CMHCs or IMDs.

Finally, regarding the second group of Providers, the Providers asserted that CM's argument that Providers should lobby or litigate against states that do not allow LTCH enrollment is unreasonable. The Providers pointed to *Cove* in which the District Court found that CMS "conceded that it is in a better position than the providers to ensure that states comply with the applicable regulations of the Medicaid program."[13]

As the final matter of the Providers' request for review, the Providers requested that the Administrator modify the PRRB Decision to clarify that the MAC's dual eligible bad debt adjustments are reversed for out-of-state beneficiaries. The Providers alleged that this issue was fully briefed but not addressed in the Board's decision. The Providers argued that it would be entirely unreasonable to require Medicare providers to enroll in 51 different Medicaid programs to be able to satisfy the must-bill policy.

The CM's Chronic Care Policy Group (CCPG) commented requesting that the Administrator affirm the Board's decision to uphold the MAC's dual eligible bad debt adjustments in the states where the Providers could enroll in the state Medicaid program and reverse the Board's decision to reverse and remand for calculation the disallowed bad debts in the states that did not permit LTCH enrollment. CM pointed out numerous Administrator decisions in which the Administrator has previously upheld the longstanding Medicare bad debt "must-bill" policy and reversed the Board's decision. Additionally, CM pointed to other cases concerning the interplay between the Medicare "must bill" policy and a state's statutory responsibility to determine its cost sharing

[13] 848 F. Supp. 2d at 28.

liability for Qualified Medicare Beneficiary (QMBs), where the Administrator also reversed the Board's decision to reimburse the claimed bad debt.

Furthermore, CM pointed to the plain language in the regulation at 42 C.F.R. 413.89(e) and the corresponding sections of the PRM that provide the foundation for the must bill policy. CM first pointed to Manual 310 which requires the issuance of a bill to a party responsible for the patient's financial obligations, then applied section 312 which addresses indigent or medically indigent patients who are eligible for Medicaid and lastly section 322 which addresses the mandatory compliance for Medicare bad debts for patients who qualify under state welfare programs. CM's review of section 322 supported that where a state is obligated, either by statute or under terms of the State Medicaid plan, to pay all or any part of the Medicare deductible and coinsurance amounts those amounts are not allowable as bad debts under Medicare. CM noted that any portion of such deductible and coinsurance amounts the state is not obligated to pay can be included as a bad debt under Medicare, provided the requirements of section 312 or, if applicable, section 310 are met.

CM also pointed out that section 312, indigent payments, requires Providers to submit a bill to Medicare for the QMB and the bill is subsequently "crossed-over" to the respective Medicaid program to bill the state for the QMB's cost sharing. As part of the crossover billing process, a Medicaid remittance advice (RA) is generated which indicates the state's Medicaid cost sharing liability for QMBs so that the amounts a provider can subsequently claim as Medicare bad debt can be determined. All QMBs are eligible for Medicare as well as being entitled to either full Medicaid benefits or limited Medicaid benefits covering deductibles and coinsurance amounts.[14]

CM further pointed to section 1903(r)(1) of the Social Security Act, which requires that States have, in operation, mechanized claims processing and informational retrieval systems that CMS determines "are compatible with the claims processing and information retrieval systems used in the administration of title XVIII" (i.e., for determination of the Medicare cost sharing amounts) and "are capable of providing accurate and timely data." CM explained that a QMBs financial situation and Medicaid eligibility status my change over the course of a short period of time and the State is required to maintain the most current patient eligibility and financial information as the State is in the best position to fulfill its statutory requirement and make the most accurate determination of its cost sharing liability for any unpaid Medicare deductibles and coinsurance.

CM also pointed to JSM-370 which restated the CMS "must bill" policy requiring that a Provider must bill the state to determine any financial liability as well as to determine the current dual eligible status of a beneficiary and can determine whether or not the state is liable for any portion thereof. CM explained that if a State does not fulfill its statutory obligation to have a claims processing system in place to determine its cost sharing liability then a provider can not claim any amounts of the unpaid deductibles and coinsurance amounts as Medicare bad debts for dual eligible beneficiaries. CM explained that the rationale behind the disallowance of Medicare dual eligible bad debts where the state will not provide a RA is that if Medicare were to reimburse providers for unpaid cost sharing amounts it would incentivize Providers not to enroll in the State Mediciad program and simply claim reimbursement from Medicare for the unpaid cost sharing.

[14] Section 1905(p)(1) and (3) of the Social Security Act.

This could lead to excessive cost shifting to the Medicare program for amounts the State is liable to pay and, in essence, runs afoul of Medicare's anti-cross subsidization principles.

CM conteded that the Board incorrectly carved an exception for Providers where the State refused to enroll them using the decision in *Cove*. CM asserts that this logic conflicts with a State's statutory obligation regarding its cost sharing liability. CM specified that a state must be able to process dual eligible beneficiary claims and that, for QMBs, this must occur without regard to whether those services are covered under the Medicaid State Plan. Furthermore, CM stated that if a State doesn't have the ability to process dual eligible beneficiary claims that the state is out of compliance with the Federal statute. CM pointed to *Alpha Comm. Mental Health Ctr. v. Benson,*[15] a case in Florida where the State was mandated to comply with the Federal statute to process crossover claims for dual eligible to determine Florida's cost sharing liability. CM asserted that the Providers in this case should similarly pursue those states that will not process claims for dual eligible beneficiaries directly as the Providers in *Alpha* did.

CM noted that the Board's assertions that CMS has previously recognized "exceptions" to the must-bill policy is misplaced and that there are no exceptions to the must bill policy as reimbursement of Medicare bad debt can only occur after the provider has billed the State Medicaid program and received an RA indicating the State's cost sharing liability.

CM distinguished between the Providers in the *Monterrey* case located in California and the LTCH Providers in this case. CM argued that the Board incorrectly granted a must-bill exception based the outcome of a limited settlement agreement between California and CMHCs where California would not license CMHCs and that the settlement agreement does not obviate the Medicare must-bill policy and does not apply to Providers in this case. CM also disagreed with the Board's finding that there is a must-bill exception for Institutions for Mental Diseases (IMDs). CM differentiated between IMDs and the Providers in this case by pointing out that section 1905(a) of the Act precludes Medicaid payments to providers who provide services in IMDs to patients aged 22 through 64 and that for that group of patients who are covered by the statute, the state Medicaid programs have no cost sharing obligation and hence, should not be billed for these patient specific IMD services. CM further noted that patients retain their Medicaid eligibility and cost sharing resumes once they are discharged. CM asserted that the Providers have mischaracterized this as an exception rather than a statutory requirement relative to IMDs.

CM stated that, even if the Providers believe the State has no liability for the unpaid deductible and coinsurance amounts, the Providers must bill the State and receive an RA before claiming a bad debt as worthless because the state has the most current patient eligibility and financial information and thus, the crossover billing process includes the critical State determination of whether a Medicare beneficiary is eligible for Medicaid, in addition to the State's determination of its cost sharing liability. CM claimed that the Board has previously erred in upholding the Providers' claims for Medicare bad debt and, in those cases, the has Board held that 1) CMS previously created exceptions to the "must-bill" policy, 2) certain States did not cover LTCH services as a Medicaid covered service and fell within this alleged exception to the "must-bill" policy and 3) the District Court decision in *Cove* placed a burden on CMS to resolve a provider's

[15] Case No. 2008 CA 004161 (2nd Cir. 2010).

failure to obtain the necessary RA from the state. CM argued that the Board has likely erroneously relied on these same arguments in allowing the Providers' bad debts in this case. CM disagrees with the decision in *Cove* and states that it was incorrectly decided as the Secretary has not failed to enforce the "must-bill" policy in previous years and that the Providers in the case were notified of the "must-bill" policy requirements through numerous CMS flash communications and Medicare Learning Network Matters articles that were issued as early as November 2004.

The MAC commented requesting that the Administrator modify that portion of the Board's decision related to the MAC's application of the must-bill policy in denying the Providers' bad debts in States not allowing LTCH enrollment. The MAC disagreed with the Board's finding that there is an exception to the must-bill policy that CMS recognized for CMHC's in a footnote to the *Monterrey* decision and the "Catch-22" scenario identified in the *Cove* decision. The MAC also disagreed that any exception exists to the must-bill policy. Furthermore, the MAC contended that if an exception was found to exist it would not apply to the Providers in this case because the exception referenced in *Monterrey* is a limited footnote to a settlement between the Secretary and non-licensed providers in California. The MAC distinguished that the Providers in *Monterrey* were CMHCs and IMDs and that the Providers in this case are all licensed by the applicable State licensing authority and none of them are CMHCs, nor IMDs.

The MAC noted that the Administrator has consistently disagreed with the Board's reference and reliance to the "Catch-22" *dicta* introduced by the District Court in *Cove* and that the Administrator has reaffirmed its position when upholding the must-bill policy and modifying the Board's decision in *Hillcrest Specialty Hospital*, PRRB Dec. No. 2018-D3.

Discussion

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments were received timely and are included in the record and have been considered.[16]

Medicare

The Medicare program primarily provides medical benefits to eligible persons over the age of 65, and consists of two parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care; and Part B, which is a supplementary voluntary insurance program for hospital outpatient services, physician services, and other services not covered under Part A.

Medicare providers are reimbursed by the Medicare program through Medicare administrative contractors (MACs) for Part A and carriers for Part B, under contract with the Secretary. To be

[16] The Administrator notes that exhibits submitted with CM's comments were excluded from consideration as they were not included in the Board's record below. All parties were notified of the exclusion in the Administrator's Notice of Review dated July 26, 2019. No comments were received on that issue.

covered by Part B, a Medicare-eligible person must pay limited cost-sharing in the form of premiums, and deductible and coinsurance amounts.

Under Section 1861(v)(1)(a) of the Act, providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. That section defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included...." An underlying principle set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs. The section does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters. With respect to such payments, section 1815 of the Act states that:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement …..the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

In addition, consistent with the requirements of section 1815 of the Act, the regulation sets forth that providers are required to maintain contemporaneous auditable documentation to support the claimed costs for that period. The regulation at 42 CFR 413.20(a) states that the principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. The regulation at 42 CFR 413.24(a) also describes the characteristics of adequate cost data and cost finding, explaining that providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. Generally, paragraph (b) explains that the term “accrual basis of accounting means that revenue is reported in the period in which it is earned, regardless of when it is collected; and an expense is reported in the period in which it is incurred, regardless of when it is paid.”

Along with the documentation requirements for payment, the regulations further explain the reasonable cost principles set forth in the Act. This principle is reflected at 42 CFR 413.9, which provides that the determination of reasonable cost must be based on costs actually incurred and related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost.

The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. The regulation states that the objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. However, if the provider's costs include amounts not reimbursable under the program, those costs will not be allowed.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices. These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimburse their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on diagnosis related groups or DRG subject to certain payment adjustments.

Acute care hospitals are one type or provider recognized and certified under the Medicare program. A long term care hospital is a type of acute care hospital recognized under Medicare which focuses on patients who average a hospital stay of more than 25 days. The LTCH is exempt from IPPS for payment purposes set forth at section 1886(d) of the Act. A long term care hospital is defined at section 1886(d)(1)(B)(iv) and pursuant to section 1886(m) is paid under a LTCH prospective system effective for cost reporting periods beginning on or after October 1, 2002. Consequently, while a LTCH is an acute care hospital for Medicare certification and licensure by the State, the LTCH is subspecialty of acute care hospital for purposes of payment under Medicare.[17]

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[17] Section 1861 (b) states that: "(b) The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital— (1) bed and board; (2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and (3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements."
Section 1861 (e) states that: "The term "hospital" (except for purposes of sections 1814(d), 1814(f), and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons…"

Section 1886(d)(1)(B) states that: "As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—… (iv)

Medicaid State Plans

Relevant to the issue involved in this case, two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.[18] The program is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines. Medicaid, under Title XIX of the Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[19] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) [42 USC 601 et seq.] and Supplemental Security Income or SSI [42 USC 1381, et seq.] Participating States may elect to provide for payments of medical services to those aged blind or disabled individuals known as "medically needy" whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy (such as an SSI recipient) are insufficient to pay for necessary medical care.[20]

In order to participate in the Medicaid program, a State must submit a plan for medical assistance to CMS for approval. The State plan must specify, *inter alia*, the categories of individuals who will receive medical assistance under the plan and the specific kinds of medical care and services that will be covered.[21] If the State plan is approved by CMS, under section 1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[22] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for "medical assistance" under the State plan. In particular, section 1901 of the Act sets forth that appropriations under that title are "[for the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of

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a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days."

[18] Section 1901 of the Social Security Act (Pub. Law 89-97).
[19] Section 1902(a) (10) of the Act.
[20] Section 1902(a) (1) (C) (i) of the Act.
[21] *Id*. §1902 *et seq.*, of the Act.
[22] *Id*.

necessary medical services…." Section 1902 sets forth the criteria for State plan approval.[23] Section 1902(a)(10)(E)(i) of the Act requires Medicaid State plans to make "medical assistance available for Medicare cost-sharing (as defined in section 1905(p)(3)) for qualified Medicare beneficiaries…."[24] In addition, pursuant to the Secretary's authority to prescribe state plan requirements for furnishing Medicaid to State residents who are absent from the State, the regulation has long provided under 42 CFR 431.52 for the payment of services furnished out of State.[25]

Notably, section 1905(a) states that for purposes of this title "the term 'medical assistance' means the payment of part or all of the costs" of the certain specified "care and medical services" and the

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[23] 42 C.F.R. 200.203 defining a State plan as "a comprehensive written commitment by a Medicaid agency submitted under section 1902(a) of the Act to administer or supervise the administration of a Medicaid plan in accordance with Federal requirement."

[24] Section 1902 (a)(10)(E)(i) states: A State plan for medical assistance must provide— for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1); (ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) for qualified disabled and working individuals described in section 1905(s); (iii) for making medical assistance available for medicare cost sharing described in section 1905(p)(3)(A)(ii) subject to section 1905(p)(4), for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; (iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available [15]for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;

[25] 42 CFR 431.52, Payments for services furnished out of State. (a) Statutory basis. Section 1902(a)(16) of the Act authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State. (b) Payment for services. A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the State, and any of the following conditions is met: (1) Medical services are needed because of a medical emergency; (2) Medical services are needed and the recipient's health would be endangered if he were required to travel to his State of residence; (3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State; (4) It is general practice for recipients in a particular locality to use medical resources in another State. (c) Cooperation among States. The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.

identification of the individuals for whom such payment may be made. Sections 1905(p)(1) specifies that:

> The term "qualified medicare beneficiary" means an individual—
> (A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A),
> (B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and
> (C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D-14(a)(3)(determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be).

In addition, under section 1905(p)(3):

> The term "medicare cost-sharing" means (subject to section 1902(n)(2)) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:
> (A)(i) premiums under section 1818 or 1818A, and
> (ii) premiums under section 1839,
> (B) Coinsurance under title XVIII (including coinsurance described in section 1813).
> (C) Deductibles established under title XVIII (including those described in section 1813 and section 1833(b)).[104]
> (D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".
> Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

Section 1902(n) provides that:

> (1) In the case of medical assistance furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the

amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.
(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost—sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.
(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—
(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, 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;
(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and
(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.
This paragraph shall not be construed as preventing payment of any medicare cost—sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

Medicaid Cost Sharing

As noted, sections 1905(p)(1) and 1905(p)(3) of the Act requires State participation in the payment of coinsurance and deductibles for certain individuals that are Medicare beneficiaries. In addition, section 1902(a)(1)(E) of the Act directs State Medicaid agencies to reimburse providers for QMB cost-sharing amounts [as defined in section 1905(p)(3)], "without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan." Section 1902(n)(2) of the Act does permit the state to limit payment for QMB cost sharing to the amount necessary to provide a total payment to the provider (including Medicare, Medicaid, required nominal Medicaid copayments, and third party payments) equal to the amount a state would have paid for the service under the State Plan. When the crossover claim is for Medicare-covered services that are not included in the Medicaid State Plan, the state is still liable to pay the crossover claim, but may establish reasonable payment limits, approved by CMS, for the service. The actual crossover payment made to a provider by Medicaid (plus the QMB's personal liability for any nominal copayments under Medicaid, if applicable) is considered payment-in-full for Medicare deductibles and coinsurance.

All States maintaining a federally-certified State Medicaid Management Information Systems (MMIS) funded under section 1903(a)(3) of the Act are required–as an express condition of receiving enhanced federal matching funds for the design, development, installation and administration of their MMIS systems—to process Medicare crossover claims, including QMB

cost sharing, for adjudication of Medicaid cost-sharing amounts, including deductibles and coinsurance for Medicare services, and to furnish the provider with an RA that explains the State's liability or lack thereof. Specifically, section 1903(a)(3)(A)(i) of the Act requires State MMIS systems to demonstrate full compatibility with the claims processing and information retrieval systems utilized in administration of the Medicare program. Instructions contained in CMS's State Medicaid Manual (SMM), Part 11, section 11325 reinforce the requirement of the MMIS system to (1) record Medicare deductibles and coinsurance paid by the Medicaid program on crossover claims, (2) provide a prompt response to all inquiries regarding the status of the crossover claim, and (3) issue remittance statements to providers detailing claims and services covered by a given payment at the same time as payment, including remittance statements for zero payment amounts. The State must be able to document that it has properly processed all claims for cost-sharing liability from Medicare-certified providers to demonstrate compliance with sections 1902(a)(10)(E) and 1902(n)(1) and (2) of the Act.

Section 4714 of the Balanced Budget Act of 1997, amended the statute to state that: "the amount of payment made under the title XVIII plus the payment (if any) under the state plan shall be considered to be payment in full for the service." When first enacted, CMS proposed to prohibit Providers from claiming any unpaid portion of the QMBs' Medicare deductibles and coinsurance as bad debts, if Medicaid had determined that payment in full had been made. CMS initially considered that, as the State's actual payment was payment in full for the Medicare deductible and coinsurance, there was no amount to be claimed as Medicare bad debt as no Medicare payment is to be made where an individual has no legal obligation to pay.[26] CMS subsequently reconsidered its policy in 1998 and determined Congress had not spoken directly on this issue and determined that section 4714(A) of the BBA did not preclude the Medicare program from recognizing the unpaid QMB cost sharing as Medicare bad debt. Therefore, effective on the date of the BBA 1997 enactment (August 5, 1997) in a State where Medicaid does not fully pay for the QMBs cost sharing, CMS determined that Medicare may reimburse providers' bad debts.

Whether an individual is a Medicaid eligible and, if so, the amount of the cost-sharing to be paid, is best determined by the State. Section 1902(n) provides the State Medicaid programs with some flexibility in setting their Medicare cost-sharing payment methods specifically for QMBs, but has historically also been applied to QMB Plus and Full Benefit Dual Eligibles. The cost sharing amounts that State can pay are: 1) The Medicare cost-sharing amount (generally called the Medicare rate); 2) The Medicaid State plan rate for the same service when it's provided to a non-Medicare-eligible Medicaid beneficiary; or 3) A negotiated rate that is approved by CM. The State has the option to establish a different payment method for each group of dual eligibles (QMB, QMB Plus, Other Dual Eligibles) and can establish different payment methods for Part A deductible, Part A coinsurance, Part B deductible, or Part B coinsurance within each group. The

[26] Section 1862(a)(2) of Social Security Act states that "no payment may be made under part A or part B for items or services …(2) for which the individual furnished such items or services has no legal obligation to pay, and for which no other person (by reason of such individual membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for except in the case of a Federally qualified health center." Congress determined these payment under these circumstances as payment in full, and therefore, nonpayment by Medicare would not seem to implicate section 1861(v) of the Act prohibition on cost shifting.

State may mix all of the option payment methods as it chooses, as long as the State can assure CMS that the selected payment methods will not adversely affect access to care for the beneficiary. Regarding the negotiated rate, for Medicare services that are not covered in the Medicaid state plan, the State has greater flexibility in setting the negotiated rate, but the rate must be sufficient for the State to assure CMS that it will not adversely affect access to care for the beneficiary.[27]

Consistent with the statute, the State Medicare Manual (SMM) explains that each State has a statutory duty to determine their cost sharing liability. Section 3490.14(B) specifically provides that:

> 3490.14 Payment of Medicare Part A and Part B Deductibles and Coinsurance.--
> A. State Agency Responsibility.--*You are required to pay for Medicare Part A and Part B deductibles and coinsurance for Medicare services, whether the services are covered in your Medicaid State plan*. The actual amount of your payment depends on the payment rates for particular Medicare services, or the payment rates for the Medicare deductibles and coinsurance that you establish in your State plan for QMBs. If the State has set Medicaid payment rates for particular Medicare services, and if the amount actually paid by Medicare exceeds this rate, the State does not make a payment. When the Medicaid rate exceeds the amount paid by Medicare, pay the difference between the amount paid by Medicare and the Medicaid payment rate. Medicare's payment is equal to a percentage (usually 80%) of the Medicare approved charge for the service, less the annual deductible amount (if the deductible was not previously met). If the State has set Medicaid payment rates for Medicare deductibles and coinsurance with respect to particular services covered by Medicare, pay these amounts (minus any Medicaid copayments which are the recipient's liability) when a QMB incurs liability for services which are subject to the Medicare deductible, or which are considered Medicare coinsurance.
>
> In either case, Medicaid's actual payment, plus the QMB's liability for Medicaid copayment under the State plan, if any, is payment in full for Medicare deductibles and coinsurance.
>
> 1. Medicare Services Covered by Medicaid.--For Medicare services which are also covered under your State's Medicaid plan (whether they are within the amount, duration, and scope limitations of that plan), you have several options. Your

[27] The possible types of dual eligible individuals have expanded and are as follows: Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only – also known as QMB "partial benefit"); Qualified Medicare Beneficiaries (QMBs) with full Medicaid (QMB Plus – also known as QMB "full benefit"); Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB only – also known as SLMB "partial benefit"); Specified Low-Income Medicare Beneficiaries (SLMBs) with full Medicaid (SLMB Plus – also known as SLMB "full benefit"); Qualified Disabled and Working Individuals (QDWIs – also known as QDWI "partial benefit"); Qualifying Individuals (1) (QI-1s – also known as "partial benefit")(Effective 1/1/1998 – 3/31/2014) and Other Full Benefit Dual Eligible (FBDE).

payment rates for particular services may be the same as the payment rates applicable for Medicaid recipients who are not Medicare eligible, or you may choose to set separate, higher payment rates up to the Medicare allowable rate for service or the Medicare deductible and coinsurance.

2. Medicare Services Not Covered by Medicaid.--For Medicare services which are not covered under your State's Medicaid plan, you have the following options. Your State plan may provide reasonable payment rates for particular services, up to the Medicare rates for services, or reasonable payment rates under which a portion or the total amount of Medicare deductibles and coinsurance is payable. Any payment rates must be justified as reasonable, and approved by HCFA, where you choose rates that are less than the Medicare rate for a service or less than the Medicare deductibles and coinsurance.

B. Payment to Providers.—[….][28] Medicaid payment of Medicare deductible and coinsurance amounts may be made only to Medicaid participating providers, even though a Medicare service may not be covered by Medicaid in the State plan. A provider agreement necessary for participation for this purpose (e.g., for furnishing the services to the individual as a QMB) may be executed through the submission of a claim to the Medicaid agency requesting Medicaid payment for Medicare deductibles and coinsurance for QMBs. The claim may not be disallowed on the basis that the Medicare service is not covered by Medicaid in the State plan or that the provider accepts the patient as a QMB only. The actual payment made by Medicaid, plus the QMB's Medicaid copayment liability, if any, under the State plan, is payment in full for Medicare deductibles and coinsurance. In this case, the provider is restricted under §1902(a)(25)(C) of the Act, from seeking to collect any amount from a QMB for Medicare deductibles or coinsurance, which is in excess of his/her liability under Medicaid, even if Medicaid's payment is less than the Medicare deductibles and coinsurance.

The State manual sets forth various examples of cost sharing situations and the State's liability in each. CMS has subsequently issued several informative bulletins addressing this issue and reminding the States of their responsibility and offering assistance to process and adjudicate and reimburse providers for QMB cost sharing even if the service or item is not covered by Medicaid irrespective of whether the provider type is recognized in the State plan and whether or not the QMB is eligible for coverage of Medicaid State plan services.[29] For full benefit dual eligible who

[28] The State Medicaid Manual, 3490.14, unrevised states that: "Subject to State law, a provider has the right to accept a patient either as private pay only, as a QMB only, or (if the patient is both a QMB and Medicaid eligible) as a full Medicaid patient, but the provider must advise the patient, for payment purposes, how he/she is accepted." That section was superseded by the statutory change to Medicaid in 1997 that included the clear prohibition on billing people with QMB at Section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997, which prohibits Medicare providers from balance-billing for Medicare cost-sharing.

[29] *See*, June 7, 2013 Joint CMCS, MMCO and CM Memorandum "Payment of Medicare Cost Sharing for Qualified Medicaid Beneficiaries (QMBs)." https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-06-07-2013.pdf;

are not eligible as QMBs, a State may elect to limit coverage of Medicare cost sharing to only those services also covered in the Medicaid state plan. In addition, State's must have a mechanism to ensure that providers who enroll only for the purpose of submitting claims for reimbursement of QMB cost sharing while in compliance with provider screening and enrollment requirements

In the 2012 and 2013 memorandums, CMS emphasized that State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost sharing that is due for QMBs according to the State's CMS-approved Medicare cost-sharing payment methodology. State Medicaid Management Information Systems or MMIS, must process all Medicare "crossover" claims (claims that include primary payment from Medicare) for QMBs, including Medicare-adjusted claims that are submitted by Medicaid-enrolled providers, even if a service or provider category is not currently recognized in the Medicaid State Plan. States must furnish all Medicare-enrolled providers, including out-of-state providers, with a means by which they can enroll in the Medicaid program for purposes of having such claims processed.

CMS emphasized in the 2012 memorandum that the State may require Medicare-certified providers to execute a Medicaid provider agreement and enroll in the State's Medicaid program in order to submit claims for reimbursement of QMB cost sharing, but the State should have a mechanism to ensure that providers who enroll *only* for that purpose are not included in lists of providers available to other beneficiaries.[30] Alternately, a State may utilize a simplified, limited-purpose enrollment process for Medicare providers seeking to enroll in Medicaid for the sole purpose of claiming Medicare cost-sharing reimbursement while in compliance with the provider screening and enrollment requirements included in the CMCS Information Bulletin issue December 23, 2011 (http://www.medicaid.gov/FederalPolicy-Guidance/downloads/CIB-12-23-11.pdf). As noted above, however, regardless of the specific enrollment mechanism chosen, states must enable all Medicare-enrolled providers, including those who are out-of-state, some mechanism by which they can get the state to process their Medicare crossover claims, including claims for QMB cost sharing.

Unpaid Medicare Coinsurance and Deductibles

Consistent with these reasonable cost principles and payment requirements, the regulatory provision at 42 CFR 413.89(a) provides that bad debts, which are deductions in a provider's revenue, are generally not included as allowable costs under Medicare. The regulation at 42 CFR 413.89(b)(1) defines "bad debts" as "amounts considered to be uncollectible from accounts and

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See June 7, 2013 Joint CMCS and MMCO Memorandum "Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs)." https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf.

[30] The fact that cross over claims maybe paid without an executed provider agreement on file is reflected in the comments to the proposed "Medicaid Program and SCHIP Payment Rate Error Rule" at 70 Fed. Reg. 58260 (Oct 2005) where the CMS noted that: "A few commenters stated that it may be difficult to obtain records on Medicare cross over claims and SCHIP claims when Medicaid has no agreement with the provider. Response: We agree with the commenter and Medicare cross-over claims will not be subject to medical review. The Medicare crossover claims will be subject to the data processing review."

notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are defined as designations for claims arising from the furnishing of services, and are collectable in money in the relatively near future. In particular, 42 CFR 413.89(d) explains that:

> Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, cost of services provided for other than beneficiaries are not to be borne by the Medicare program.

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

> 1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
> 2) The provider must be able to establish that reasonable collection efforts were made.
> 3) The debt was actually uncollectible when claimed as worthless.
> 4) Sound business judgment established there was no likelihood of recovery at any time in the future.[31]

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

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

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

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

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

Finally, section 312 also states that:

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

Relevant to this case, section 322 of the PRM[32] provides that:

> Where the State is obligated either by statute or under the terms of its plan to pay all, or any part of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare provided that the requirements of §312 or, if applicable, §310 are met.

For instances in which a State payment "ceiling" exists, section 322 of the PRM states:

> In some instances, the State has an obligation to pay, but either does not pay anything or pays only part of the deductible, or coinsurance because of a State payment "ceiling." For example, assume that a State pays a maximum of $42.50 per day for the SNF services and the provider's cost is $60.00 a day. The coinsurance is $32.50 a day so that Medicare pays $27.50 ($60.00 less $32.50). In this case, the State limits its payment towards the coinsurance to $15.00 ($42.50 less $27.50). In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of §312 are met.

Section 322 of the PRM concludes by explaining that:

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

[32] As acknowledged by the parties, the Board, and the court in *Community*, this provision and policy has been in the Manual since before the Bad Debt Moratorium provision. (*See* for example, Transmittal No. 278 dated January 1983-clarification-effective date not applicable. "Section clarifies the responsibility of States for deductibles and coinsurance for person eligible under both Medicare and Medicaid.") It was also established before the statutory amendment discussed in *Allina Health Services v. Azar*, No. 17-1484 (June 3, 2019).

The foregoing provision asserts the State's obligation to pay as required by statute and under the terms of its State plan that guides this section. The patients' Medicaid status at the time of service should be used to determine their eligibility for Medicaid to satisfy the requirement of section 312. A patient's financial situation and Medicaid eligibility status may change over the course of a very short period of time. *The State maintains the most accurate patient information to make the determination of a patient's Medicaid eligibility status at the time of service and the Medicaid payment rates and, thus, to determine the State's cost sharing liability for unpaid Medicare deductibles and coinsurance. In addition, it is clear from section 322 of the PRM that the amount that can be claimed as bad debts is the amount the State "does not pay" which presumes that the State has been billed and the State had rendered a determination on such a claim. A State determination/adjustment on the claim is always reflected in the Medicaid Remittance Advice. Without a remittance advice there has not been a determination of the amount the State does not pay under its State plan and the Federal cost sharing requirements.*

The policy requiring a provider to bill the State and receive a determination on that claim, where the State is obligated either by statute or under the terms of its plan to pay all, or any part of the Medicare deductible or coinsurance amounts, is consistent with the general statutory and regulatory provisions relating specifically to the payment of bad debts and generally to the payment of Medicare reimbursement. As reflected in 42 CFR 413.89(d)(1), the costs of Medicare deductible and coinsurance amounts which remain unpaid (i.e. were billed) may be included in allowable costs. In addition, paragraph (e) of that regulation requires, inter alia, a provider to establish that a reasonable collection effort was made and that by receiving a determination from the State, the debt was actually uncollectible when claimed. A fundamental requirement to demonstrate that an amount is, in fact, unpaid and uncollectible, is to bill the responsible party. Section 310 of the PRM generally requires a provider to issue a bill to the party responsible for the beneficiaries' payment. Section 312 of the PRM, while allowing a provider to deem a dually eligible patient indigent and claim the associated debt, first requires that no other party, including the State Medicaid program is responsible for payment, Section 322 of the PRM addresses the circumstances of dually eligible patients where there is a State payment ceiling. That section states that the "amount that the State does not pay" may be reimbursed as a Medicare bad debt. This language plainly requires that the provider bill the State as a prerequisite of payment of the claim by Medicare as a bad debt receive a determination on the amount the State does not pay on that claim.

Reading the sections together, in situations where a State is liable for all or a portion of the deductible and coinsurance amounts, the State is the responsible party and is to be billed, and a determination made by the State in order to establish the amount of bad debts owed under Medicare. The above policy has been consistently articulated in the final decisions of the Secretary addressing this issue, since well before the cost year in this case,[33] and CMS policy pronouncements. The Administrator, through adjudication, addressed this policy in many cases

[33] *See, e.g., California Hospitals Crossover Bad Debts Group Appeal*, PRRB Dec. No. 2000-D80 (Oct. 31, 2000); *See also California Hospitals* at n.16 (listing cases). These decisions have denied payment when there is no documentation that actual collection efforts were made to obtain payments from the Medicaid authority before an account is considered uncollectible and worthless and when the provider did not bill the State for its Medicaid patients.

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

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

The memorandum noted that in *Community Hospital of Monterey Peninsula v. Thompson*, 323 F.3d 1079 (9th Cir. 2008), the Ninth Circuit upheld this policy of the Secretary. Section 1905(p)(3) of the Act imposes liability for cost sharing amounts for QMBs on the States through section 1902(n)(2) that allows the States to limit that amount to the Medicaid rate and essentially pay nothing towards dual-eligible cost sharing if the Medicaid rate is lower than what Medicare would pay for the service. Where the State owes none, or a portion of the dual-eligible deductible and coinsurance amounts, the unpaid liability for the bad debt is not reimbursable until the provider bills the State and the State refuses payment, all of which is demonstrated through a Remittance Advice.

Importantly, the memorandum also indicated that, in November 1995, language was added to the PRM at section 1102.3L, which was inconsistent with this policy. The Ninth Circuit panel found that section 1102.3L was inconsistent with the Secretary's policy and also noted that, effective in August of 1987, Congress had imposed a moratorium on changes in bad debt reimbursement policies and, therefore, the Secretary lacked authority in November of 1995 to promulgate a change in policy. As a result of the Ninth Circuit decision, CMS changed the language in PRM—II Section 1102.3L to revert back to pre-1995 language, which requires providers to bill the individual States for dual-eligible co-pays and deductibles before claiming Medicare bad debts. The CMS JSM also provided a limited "hold harmless provision."[34] Accordingly, revised (to pre-1995 language)

[34] This memorandum also served as a directive to hold harmless providers that can demonstrate that they followed the instructions previously laid out at 1102.3L, for open cost reporting periods beginning prior to January 1, 2004. Intermediaries who followed the now-obsolete section 11102.3L instructions for cost reporting periods prior to January 1, 2004, may reimburse providers they service for dual eligible bad debts with respect to unsettled cost reports that were deemed allowed using other documentation in lieu of billing the State. Intermediaries that required the provider to file a State Remittance Advice for cost reporting periods prior to January 1, 2004 may not reopen the provider's cost reports to accept alternative documentation for such cost reporting periods. This hold harmless policy affects only those providers with cost reports that were open as

section 1102.3L of the PRM, Part II (Exhibit 5 to Form CMS-339) requires the submission of the following documentation:

> 1. Evidence that the patient is eligible for Medicaid, e.g., Medicaid card or I.D. number
> 2. Copies of bills for Medicare deductibles and coinsurance that were sent to the State Medicaid Agency.
> 3. Copies of the remittance advice from the State Medicaid Agency showing the amount of the provider's claim(s) for Medicare deductibles and coinsurance denied.[35]

While the policy at issue is referred to as the "must-bill" policy, the policy in fact requires a determination by the State on a filed claim, which is reflected in a remittance advice. The Remittance Advice or RA is a notice of payment provided with final claim adjudication and payment information. This policy concerning dual-eligible beneficiaries continues to be critical because individual States administer their Medical Assistance programs differently and maintain billing and documentation requirements unique to each State program. The State maintains the most current and accurate information to determine if the beneficiary is a QMB, at the time of service, and the State's liability for any unpaid QMB deductible and coinsurance amounts through the State's issuance of a remittance advice after being billed by the provider.

Consistent with the statute, regulation and PRM, a provider must bill the State and the State must process the bills or claims to produce a remittance advice for each beneficiary to determine their Medicaid status, at the time of service and the State's liability for unpaid Medicare deductible and coinsurance amounts. Thus, it is unacceptable for a provider to write-off a Medicare bad debt as worthless without first billing the State and receiving a determination from the State. Even in cases where the provider has calculated that the State has no liability for outstanding deductible and coinsurance amounts, the provider must bill the State and receive a remittance advice before claiming a bad debt as worthless because, as stated above, the State has the most current and accurate information to make a determination on the beneficiaries' status at the time of the services and to determine the State's cost sharing liability for all covered stays of dual eligible beneficiaries.[36]

Bad Debt Moratorium

Relevant to certain Medicare bad debt claims, section 4008(c) of the Omnibus Reconciliation Act of 1987 (OBRA," as amended by the section 8402 of the Technical and Miscellaneous Revenue

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of the date of the issuance of the memorandum relating to cost reporting periods before January 1, 2004 and who relied on the previous language of section 1102.3L in providing documentation. The cost years in this case are all post-the hold harmless cost years. The relevance to the hold harmless provision in this case maybe whether it was applied for some of the Providers' prior cost years raised during the discussion of whether the MAC had made payments prior to 2008. For example, Exhibit 35 is for cost year ending 08/31/2004.

[35] *See* Change Request 2796, issued September 12, 2003

[36] One of the earliest Administrator decisions cases recognizing this policy was decided in 1993 and involved a 1987 cost year. See, *Hospital de Area de Carolina*, Admin. Dec. No. 93-D23.

Act of 1988, and section 6023 of OBRA 1989 imposed a "moratorium" on changes to the Medicare bad debt policy in effect on August 1, 1987, as applied to hospitals. Specifically, the moratorium states, in part that:

> In making payments to hospitals under [the Medicare Program], the Secretary of Health and Human Services shall not make any change in the policy in effect on August l, 1987, with respect to payment under [the Medicare program] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts included under [the Medicare program] (including criteria for what constitutes a reasonable collection effort; including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency). The Secretary may not require a hospital to change its bad debt collection policy if a fiscal inte1mediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency dete1mination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

In addition, the Conference Report accompanying the 1988 legislative amendment states that, "the conferees do not intend to preclude the Secretary from disallowing bad debt payments based on the regulations, PRRB decisions, manuals, and issuances in effect prior to August 1, 1987." the basis of an expectation of a change in the hospital's collection policy. In addition, the Conference Report accompanying the 1988 legislative amendment states that, "the conferees do not intend to preclude the Secretary from disallowing bad debt payments based on the regulations, PRRB decisions, manuals, and issuances in effect prior to August 1, 1987."

Discussion

During the cost reporting periods at issue, the Providers claimed Medicare bad debts on their cost reports for unpaid coinsurances and deductibles for beneficiaries who were also eligible for Medicaid benefits under the respective State's Medicaid program (i.e., dual eligible beneficiaries). The MAC disallowed all the bad debts based upon the "must bill" policy which requires the Provider to bill the State Medicaid program and obtain a remittance advice to support the Medicare claimed costs.

The Providers in this case are Medicare-certified LTCHs in several states. LTCH are acute care hospitals certified by Medicare based on its longer length of patient stays. For the fiscal years at issue (FY 2011), the Providers were not enrolled in any State Medicaid programs. The Providers admittedly chose not enroll in some of the States and alleged that they were not able to enroll in the other State programs because of the Providers' designation as a LTCH.[37]

The Providers claimed bad debts for dual eligible crossover claims and the MAC disallowed such claims for failure to submit a State issued RA. In the past, the Providers alleged that the MAC had

[37] Provider Position Paper 17-18.

paid the Providers for dual eligible bad debts without a State issued RA.[38] The Providers claimed that the prior payments to non-Medicaid-participating providers without a RA created a detrimental reliance and also that CMS had a policy of allowing nonparticipating providers to submit alternative documentation. The Providers also claims that there is no requirement for a non-Medicaid-participating provider to bill and receive an RA.

A review of the record and the submissions made by the parties indicates that remand for further record development would be appropriate. The Board has made factual findings based on the Providers' contentions regarding the opportunity to enroll in several State Medicaid programs. CM disputes certain of these findings (in particular for Alabama, Mississippi and Pennsylvania) and the Provider disputes certain of these findings (in particular Arkansas and North Carolina), for which the further fact finding and or clarification is best addressed by the Board. In addition, the Providers have pointed out that the Board did not specifically address the out-of- state provider claims[39], which is best directly addressed by the Board in the first instance.

Finally, the record would be enhanced if other issues raised in enrolling the LTCHs were clarified. A LTCH is a hospital under section 1861 (e) of the Social Security Act and licensed by the State as an acute care hospital. While an LTCH is paid under a different payment methodology than a section 1886(d) of Act [IPPS] hospital under Medicare, it is an acute care hospital for licensing purposes. The fact the LTCH is an acute care hospital and treated as such by some States was recognized by the Providers' staff who indicated in 2007 that:

> Here's the bottom. line to all of this. We're about to go through a process of requesting Medicaid RA's from State Plans that have no obligation to us. At the end of the day, you will be able to hold in one hand the amount of Medicaid payment that we're going to receive through all the effort. Even in states where we participate such as Ohio and Texas, we almost never receive a payment from Medicare towards a patient's deductible/coinsurance.[40] The reason for this is simple…the Medicare payment on the case is almost always, and I mean 99.5 percent of the time, exceeds what Medicaid would have paid us if Medicaid had been primary. *The reason Medicaid's payment is 99.5 percent of the time lower than Medicare's is because the State plan only reimburses us a IP PPS (short term) DRG payment.*[41] (Emphasis added.)

Consequently where a LTCH provider was enrolled in Ohio and Texas, it appeared to be enrolled as an acute care hospital and paid pursuant to the short term-acute care Medicaid DRG. The Providers also referenced being able to be enrolled as a "hospital" in the Arkansas Medicaid program, which is indicated in its approval letter. The record in several instances refers to the issue being that the provider could not be covered by "fee-for-service" (presumably in lieu of an

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[38] *See* Provider Position Paper at 4.

[39] *See* e.g. Exhibit P-2, showing out of state claims were approximately $542, 859 of the total $1,927,750 claims.

[40] While State's Medicaid payment rate might result in little to no coinsurance obligated to be paid by the State, it is not clear how the Medicaid rate would affect the State's obligations for unpaid deductibles. *See e.g.* State Medicaid Manual, section 3490 et seq.

[41] Provider Exhibit P-9.

inpatient DRG system) or that State had no payment system for its subspecialty. (See, e.g., Providers' Post Hearing Brief at 38, 36). Consequently, it is not clear whether the issue, at least in some instances, with enrollment, was related to the Providers' type of license or whether it was the type of payment sought (non-DRG/Acute care payment) and whether a LTCH could chose to be enrolled as an acute care hospital for cross over claim payments in a State's Medicaid program. It would also be helpful if the parties clarified how the Medicaid rate impacts the State's obligations for unpaid deductibles.

Accordingly, The Board's decision is vacated and the case is remanded for further development of the record with respect to out-of-state claims and also for the enrollment status of LTCHs in States where the Providers claim they were not allowed to enroll, and any other matters that advance the understating of the issues in this case.

Date: Aug. 29, 2019 /s/

Demetrios L. Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services

Decision

The decision of the Board is modified in accordance with the foregoing opinion.

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

Date:_____ _____

Demetrios L. Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services