CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Summer Hill Nursing Home	**Determination for Cost Reporting Period Ending: December 31, 2004**
Provider	
vs.	
Mutual of Omaha Insurance Company	**Review of: PRRB Dec. No. 2008-D5 Dated: November 1, 2008**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The Intermediary and CMS' Center for Medicare Management (CMM) commented, requesting Administrator's review. The parties were then notified of the Administrator's intention to review the Board's decision. The Provider submitted comments requesting that the Board's decision be affirmed. Accordingly, the case is now before the Administrator for final administrative decision.

BACKGROUND

The Provider is a 120-bed skilled nursing facility located in Old Bridge New Jersey. In its cost report for fiscal year ending (FYE) 12/31/04, the Provider claimed $170,537 in Medicare bad debts of which $135,106 was disallowed by the Intermediary. The Intermediary reviewed the Provider's collection and bad debt write-off policies and found that the Provider applied the New Jersey Medicaid payment formula to determine the State's liability for any portion of the coinsurance due from patients who were dually eligible for

both Medicare and Medicaid. The Provider billed the State only in those instances where it determined that a liability existed. Where the calculations determined no liability, the Provider considered the outstanding coinsurance amount uncollectible and claimed a Medicare bad debt in that amount. The Intermediary disputed the propriety of writing off those amounts without billing the State for each patient and receiving contemporaneous documentation of a payment or a denial.

ISSUE AND BOARD'S DECISION

The issue, set forth by the Board, was whether the Intermediary properly adjusted Medicare bad debts. The Board focused its decision-making on whether a finding of uncollectibility on a debt owed by a patient who is dually eligible for Medicare and Medicaid must be supported by an individual billing to the State.

The Board examined the regulation at 42 CFR §413.80 and the program guidance at CMS Pub. 15-1, Sections 308, 310, 312 and 322 of the Provider Reimbursement Manual (PRM), that govern the recognition of Medicare bad debts, as well as the newsletters and agency alerts cited by the parties in their respective position papers. Based on this examination, the Board concluded that the existing bad debt regulation and manual provisions do not contain any billing requirements. Rather, these sections require that a provider make reasonable collection efforts and apply sound business judgment to determine if the debt was actually uncollectible.

The Board did recognize that a particular Newsletter was the only evidence in the record that substantiated that such billing is required. However, the Board found that the Newsletter, while explicit, is unsupported by a statute or regulation and is insufficient to impose an additional major requirement for bad debt reimbursement, since it goes beyond the scope of the existing regulation and manual provisions.

SUMMARY OF COMMENTS

The Intermediary submitted comments, requesting reversal of the Board's decision. The Intermediary asserted that the regulatory criteria at 42 CFR 413.80(e) for Medicare bad debt payment were not met because there was no collection effort since the Providers did not bill the State. The Provider claimed the bad debts as worthless prior to determining the State would not pay the outstanding deductible and coinsurance amounts. Therefore, the Administrator should reverse the decision by the Board.

CMM explained that before a provider can be paid for bad debts relating to unpaid Medicare deductibles and coinsurance amounts for dual-eligible beneficiaries, Medicare policy requires a determination and documentation of the State's liability for those cost-shareing amounts. To effectuate this, Medicare required the provider to bill the State to determine that the State is not liable for payment – referred to as the "must bill" policy as required by chapter 3 of the PRM. This policy allows a claim by claim adjudication of the State's cost-sharing liability.

CMS outlined the "must bill" policy in a Joint Signature Memorandum (JSM)-370 issued August 3, 2004 which stated that "in 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 if the current dual-eligible status of a beneficiary and can determine whether or not the State is liable for any portion thereof.

CMM maintained that, in order for bad debts to be reimbursable under Medicare, they must meet the criteria set forth in 42 CFR 413.89(e), and the guidelines in the PRM. Specifically, CMM stated, *inter alia*, that under the section 322 of the PRM, any portion of Medicare deductible or coinsurance amounts that a State is not obligated to pay can be included as a bad debt provided that the requirements of section 312 of the PRM are met. Further, Section 312 of PRM states that the provider must determine that no source other than the patient would be legally responsible for the patient's medical bill.

In this case, it is undisputed that the State bears liability for some portion of the coinsurance and deductible amounts for services rendered to dually-eligible beneficiaries. However, the provider did not comply with specific requirements under section 1102.3L of the PRM (Part II), which requires the provider to submit specific documentation such as evidence that the patient is eligible for Medicaid; copies of bills for Medicare deductibles and coinsurance that were sent to the State; and copies of the remittance advice from the State showing the amount of the provider's claims for deductibles and coinsurance. Thus, since the Provider failed to bill the State, and did not comply with these requirements, the Provider's bad debts are not reimbursable under Medicare.

Finally, CMM supports consistent application of the "must bill" policy by stating that CMS' "must bill" policy for dual-eligible beneficiaries has been upheld in the decision of the Ninth Circuit federal court in Community Hospital of the Monterey Peninsula v. Thompson, 323 F.3d 782 (9th Cir. 2003).

The Provider commented, requesting affirmation of the Board's decision. The Provider maintained that the Board correctly held that Medicare law does not mandate the State's remittance advice as the only documentation to support crossover bad debt. The Provider argued that the Board correctly determined that the regulation and manual provisions do not contain a "must bill" requirement. The Provider asserted that it had established that the bad debts were actually uncollectible "when claimed as worthless" through its own straight-forward determination which was later confirmed by the remittance advices received from Medicaid.

The Provider further argued that in this case all of the patients for which bad debts were claimed were previously determined by the State to be "categorically needy" or "medically needy". As a result, these individuals were deemed indigent, their debts were deemed uncollectible and no "must bill" policy applies under the provisions of Section 312 of the PRM.

Finally, the Provider asserted that the required remittance advices were received from Medicaid which conclusively establishes the debts to be "actually uncollectible when claimed" and therefore acknowledges the validity of the bad debts that were claimed. Since this point was never challenged by the Intermediary, this point was effectually conceded and accordingly the Board's decision should be affirmed.

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. After a review of the record, applicable regulations and manual instructions, the Board's decision should be reversed.

The Medicare program primarily provides medical benefits to eligible persons over the age of 65, and consists of two parts: Part A [42 U.S.C. §1395(c)-1395(i)], which provides reimbursement for inpatient hospital and related post-hospital, home health and hospice care; and Part B [42 U.S.C. §1395(j)-1395(w)], 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 fiscal intermediaries for Part A and carriers for Part B, under contract with the Secretary.

To be covered by Part B, a Medicare-eligible person must pay limited cost-sharing in the form of premiums, and deductible and coinsurance amounts. Where a Medicare beneficiary is also a Medicaid recipient, (i.e., "dually eligible"), a State Medicaid agency may enter into a buy-in agreement with the Secretary. Under such an agreement, the State enrolls the poorest Medicare beneficiaries, those eligible for Medicaid, in the Part B program by entering into an agreement with the Secretary and by paying the Medicare premiums and deductibles and coinsurance for its recipients as part of its Medicaid program.

Under Section 1861(v)(1)(a) of the Act, providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. That section defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included...." 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.

The principles set forth in the Act are reflected and further explained in the regulations. One of the underlying principles 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. This principle is reflected at 42 CFR 413.9(c), which provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries. However, if the provider's costs include amounts not reimbursable under the program, those costs will not be allowed.

Consistent with this principle, 42 CFR 413.80(a)[1] 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 413.80(b)(1) defines "bad debts" as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are defined as designations for claims arising from the furnishing of services, and are collectable in money in the relatively near future.

However, the regulation at 42 CFR 413.80(d)(1) explains that to ensure that the cost of Medicare services are not borne by others, the costs attributable to the Medicare deductible and coinsurance amounts which remain unpaid are added to the Medicare share of allowable costs. The circumstances under which providers may be reimbursed for the bad debts

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[1] The regulation at 42 CFR 413.80 *et. seq.* has been redesignated to 42 CFR 413.89 *et. seq.* *See* 69 Fed. Reg. 49254 (Aug. 11, 2004).

derived from uncollectible deductibles and coinsurance amounts are set forth at paragraph (e). The regulation at 42 CFR 413.80(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.

To comply with section 42 CFR 413(e)(2), the Provider Reimbursement Manual or PRM provides further guidance with respect to the payment of bad debts. Section 310 of the PRM provides the criteria for meeting reasonable collection efforts. A reasonable collection effort, *inter alia*, includes:

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

Moreover, Section 310.B states that the provider's collection effort is to be documented "in the patients 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, §312.C requires that:

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

Finally, section 312 also states that:

> once 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 notes that:

> Effective with the 1967 amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically needy or medically needy persons....
>
> Where the State is obligated either by statute or under the terms of its plan to pay all, *or any part of* the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare provided that the requirements of §312 or, if applicable, §310 are met. (Emphasis added.)

For cases 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.* (Emphasis added.)

Section 322 of the PRM concludes by explaining that:

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

The patient's Medicaid status at the time of service should be used to determine their eligibility for Medicaid to satisfy the requirement of Section 312 and to determine the

State's cost sharing liability. A patient's financial situation and Medicaid eligibility status may change over the course of a very short period of time. The State maintains the most accurate patient information to make the determination of a patient's Medicaid eligibility status at the time of service and, thus, determine its cost sharing liability for unpaid Medicare deductibles and coinsurance. Thus, CMS issued Joint Signature Memo (JSM-370) which restated Medicare's longstanding bad debt policy that:

> [I]n those instances where the state owes none or only a portion of the dual-eligible patient's deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State remittance advice). Even if the State Plan Amendment limits the liability to the Medicaid rate, by billing the state, a provider can verify the current dual-eligible status of the beneficiary and can determine whether or not the State is liable for any portion thereof.

In fulfilling the requirements of sections 312 and 322 of the PRM, Medicare requires a provider to bill the State and receive a remittance advice that documents the Medicaid status of the beneficiary at the time of service, and the State's liability for unpaid deductibles and coinsurance as determined and verified by the State.[2] Accordingly, 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.

In this case, the Provider claimed $170,537 in Medicare bad debts of which $135,106 was disallowed by the Intermediary. The Intermediary reviewed the Provider's collection and

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[2] The Secretary's "must bill" policy for dual-eligible beneficiaries has been upheld by the Ninth Circuit Federal Court in the decision of Community Hospital of the Monterey Peninsula v. Thompson, 323 F.3d 782 (9th Cir. 2003). In *Community Hospital*, the court, rendered its decision on a motion for Summary Judgment in favor of the Secretary, and found that the "must-bill" policy was a reasonable implementation of the reimbursement system and not inconsistent with the statute and regulations. *Id*.

bad debt write-off policies and found that the Provider applied the New Jersey Medicaid payment formula to determine the State's liability for any portion of the coinsurance due from patients who were dually eligible for both Medicare and Medicaid. The Provider billed the State only in those instances where it determined that a liability existed. Where the calculations determined no liability, the Provider considered the outstanding coinsurance amount uncollectible and claimed a Medicare bad debt in that amount. The Intermediary disputed the propriety of writing off those amounts without billing the State for each patient and receiving contemporaneous documentation of a payment or a denial.

After a review of the record and the applicable law and Medicare policy, the Administrator finds that the Provider failed to meet all the regulatory requirements and the Manual guidelines for reimbursement of the subject amounts as Medicare bad debts. The Administrator finds that the State Medicaid program provides for the payment of dual eligible beneficiaries' deductible and coinsurance amounts. Thus, in order to determine the State's liability and, likewise, the amount of coinsurance and deductible attributable to Medicare bad debt, the Provider is required to bill the State for these claims. The Administrator finds that, as the Provider did not bill the State for the claims at issue in this case, it has not demonstrated that it has meet the necessary criteria for Medicare payment of bad debts related to these claims.

The policy requiring a provider to bill the State, 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 413.80(d)(1), the costs of Medicare deductible and coinsurance amounts which remain unpaid 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 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. Reading the sections together, the Administrator concludes that, in

situations where a State is liable for all or a portion of the deductible and coinsurance amounts, the State is the responsible party and is to be billed 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.[3] The final decisions of the Secretary have consistently held that the bad debt regulation and 42 CFR §413.20 require providers to bill the Medicaid programs for payment.[4] These decisions have denied payment when there is no documentation that actual collection efforts were made to obtain payments from the Medicaid authority before an account is considered uncollectible and when the provider did not even attempt to bill the State for its Medicaid patients.

Moreover, the must-bill 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. For instance, an eligibility category known as a qualified Medicare beneficiary (QMB) which was enacted by the Medicare Catastrophic Act of 1988 represents individuals who meet the definition in Section 1905(p)(1) of the Social Security Act for Medicaid. All QMBs are Medicare beneficiaries, entitled to the full range of Medicare-covered services and Medicare provider options, without regard to whether those services are covered under the Medicaid State Plan, and are eligible for Medicaid payment of their Medicaid cost-sharing expenses.

Section 1905(p)(3) of the Act imposes liability for cost-sharing amounts for QMBs on the States, though Section 1902(n)(2) allows States to limit that amount to the Medicaid rate and essentially pay nothing toward dual eligibles' cost-sharing if the Medicaid rate is lower than what Medicare would pay for the service. However, in most cases the State will always be liable to pay for a beneficiary's unpaid deductible amounts. 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 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. Even in cases where the

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[3] *See, e.g.*, California Hospitals Crossover Bad Debts Group Appeal PRRB Dec. No. 2000-D80; *See also* California Hospitals at n.16 (listing cases).

[4] *Id.*

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.[5]

In light of the foregoing, the Administrator finds that the Board's decision is incorrect. The bad debts claimed by the Provider were not worthless when written off as Medicare bad debts on their FYE December 31, 2004 cost report. The Provider did not bill the State and receive a remittance advice to meet the reasonable collection effort requirements of the regulation and manual provisions for the claims at issue in this case. Accordingly, the Board's decision is reversed.

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[5] In addition to verifying the validity of the provider's bad debt, submission of the claim to the State and preservation of the remittance advice is essentially a required record keeping criteria for Medicare reimbursement. Under Section 1815 of the Act, no Medicare 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. Consistent with the statute, the regulations require that providers maintain verifiable and supporting documents to justify their requests for payment under Medicare. The regulation at 42 CFR 413.20 provides that:

> The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for provider determination of costs payable under the program.... Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained....

As used in the context of the regulation at §413.20, "maintain" means that the provider is required to keep records and data throughout the cost year and to then make available those records to the intermediary in order to settle the cost report in the normal course of business. The provider's failure to submit claims to the State, receive and "maintain" the required remittance advices, and furnish such documents to the Intermediary violates this principle.

DECISION

In accordance with the foregoing opinion, the decision of the Board is reversed.

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

Date: **12/20/07** **/s/**
Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services

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