CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Reflections Wellness Center, Inc.	**Medicare Reimbursement** **Cost Reporting Period(s) Ending:** **12/31/05**
Provider	
vs.	
Blue Cross Blue Shield Association/ First Coast Services Options, Inc.	**Review of:** **PRRB Dec. No. 2010-D21** **Dated: March 19, 2010**
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 parties were notified of the Administrator's intention to review the Board's decision. CMS' Center for Medicare Management (CMM) commented, requesting reversal of the Board's decision. The Intermediary commented requesting reversal of the Board's decision. Accordingly, the case is now before the Administrator for final administrative decision.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustment disallowing bad debts arising from coinsurance and deductibles for dual eligible Medicare and Medicaid beneficiaries was proper.

The Board, reversing the Intermediary's adjustment, held that the Provider met the requirement for a reasonable collection effort related to the dual eligible beneficiaries pursuant to 42 CFR §413.89 and Section 308 of the Provider Reimbursement Manual. The Board, noting the Intermediary's suggestion that State liability was an absolute bar to Medicare recovery of a bad debt, found that this provision is not identified in statute or regulation, but only in section 322 of the PRM. The Board found that the PRM at §322 is consistent with the regulations in that it describes what constitutes a reasonable collection effort, as that phrase is used in 42 CFR §413.89(e)(2).[1] Where a provider can bill and the State is obligated to pay, the Provider must implement reasonable collection efforts to obtain payment from the State under the PRM. However, to read this PRM as an absolute bar, regardless of the collection effort, would conflict with the statute and regulation. The Board found that, assuming, *arguendo*, that a State's liability constitutes an absolute bar to recovery of a bad debt, the Board found no clear evidence that the State, in this case, had an absolute obligation to pay. The Board stated that a remittance advice is one source of documentary evidence to support a reasonable collection effort, but is not the only reliable source. The Board found, contrary to *Community Hospital of the Monterey Peninsula v Thompson*,[2] that the authorization of an alternative to billing is relevant in this case, because it was not possible for the Provider to bill the Medicaid program. The Board found that, in any event, a Joint Signature Memorandum (JSM), such as JSM 370, is an inappropriate vehicle to set policy and is entitled to less deference than regulations and Manual instructions. However, the Board also stated that a later JSM, (JSM 06345, 03-24-06 (2006)), instructs the Florida Intermediaries to suspend the prior must bill requirement contained in JSM 370. Although the Notice of Program Reimbursement had been issued, the subsequent JSM modification nevertheless shows recognition by CMS that the "must bill" requirements may not be reasonable in some circumstances. Requiring the Provider to bill and to obtain a Remittance Advice is unreasonable and impossible.

SUMMARY OF COMMENTS

CMM commented, requesting, based on its recent comments in *Royal Coast Rehabilitation Center*, PRRB Dec. No. 2010-D13, reversal of the decision of the Board.[3] CMM stated that the Intermediary properly disallowed the bad debts because the Provider did not adhere to the policies requisite to meet the bad debt regulatory criteria, i.e., the must bill policy. In

[1] Formerly designated at 42 C.F.R. §413.80. 69 Fed. Reg. 49,254 (Aug. 11, 2004).
[2] 323 F.3d 782 (9th Cir. 2003).
[3] CMM also referred to the Administrator's decisions in *Village Green Nursing Home (GCI*), PRRB Dec. No. 2000-d59 (2000) and *Port Huron Hos.*, PRRB Dec. No. 2008-D32 (2008) in support of its arguments.

order to comply with 42 CFR 413.89(e), as well as with section 322 of the PRM, Medicare policy requires the Provider to document the State's liability for any cost-sharing amounts related to unpaid Medicare deductible and coinsurance amounts for dual-eligible beneficiaries. CMM reiterated that, to effectuate this program requirement, Medicare has mandated the Provider to bill the State to determine whether the State is liable for payment: the "must bill" policy. CMM maintained that the State's responsibility to determine its cost-sharing liability regarding dual-eligible beneficiaries is critical because individual States maintain complex billing systems and documentation requirements unique to each of their individual programs.

Specifically, CMM noted that this determination is important for the eligibility category known as Qualified Medicare Beneficiary (QMBs), established as part of the Medicare Catastrophic Act of 1988 many years after the last changes to Chapter 3 of the PRM. QMBs are individuals, meeting the definition in section 1905(p)(1) of the Act, who may be eligible for full Medicaid benefits or may have Medicaid eligibility limited to payment of Medicare Part A and B premiums and cost-sharing amounts. They are also Medicare beneficiaries entitled to the full range of Medicare covered services and provider options without regard to whether those services are covered under the Medicaid State Plan. Section 1905(p)(3) of the Act imposes liability for cost-sharing amounts for QMB's on the States, though section 1902(n)(2) allows the States to limit that amount to the Medicaid rate and essentially pay nothing toward dual eligible patients' coinsurance amounts 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 the beneficiary's unpaid deductible amounts. Furthermore, CMM pointed out that, for QMBs, section 3690.14(A)(1) and (2) of the State Medicaid Manual requires the State Agency to provide, through the State Plan, the payment rates applicable for services that are covered or not covered, respectively, by the State Plan to determine the amount of Medicare coinsurance and deductibles that the State is responsible to pay. Section 1903(r)(1) of the Act states that in order for a State to receive payments under section 1903(a) for automated data systems, a State must 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" and "are capable of providing accurate and timely data."

CMM further argued that the must bill policy was outlined clearly for bad debts for dual-eligible beneficiaries in a JSM that was issued on August 10, 2004. The JSM was a reiteration of longstanding Medicare policy, and it was specifically related to Change Request No. 2976 that was issued on September 12, 2006 revising Part II, section1102.3L of

the PRM, relating to Exhibit 5 to Form CMS No. 339.[4] CMM reiterated that in those instances where the State owes none or only a portion of the dual-eligible patient's deductible or co-insurance, 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 as demonstrated with a State remittance advice. Even if the State Plan Amendment limits the liability to the Medicaid rate, a Provider can only verify the current dual-eligible status of a beneficiary and determine whether the State is liable for any portion by billing the State.

CMM argued that the Board failed to comprehend the nature of a JSM. If a JSM is transmitted into the clearance process, but is found not in accordance with applicable program criteria, a JSM will be returned to the originating component for a manual instruction prepared and submitted via the formal Change Management/Change Request process. In this case, JSM 370, as with any JSM, has met the criteria of what constitutes a JSM. CMM further argued that the Board's reading of a later JSM as suspending the instructions at JSM 370 is in error. The JSM 06345 applied only to freestanding psychiatric hospitals, not the type of hospital of the Provider in this case, and implements a temporary hold on settling cost reports to affected Providers in Florida. Thus, CMS did not implement a change to its "must bill" policy in JSM 06345, but rather only implemented a temporary hold on settling cost reports of the affected providers. CMM noted that, since issuance of JSM 06345, the State amended its statute to comply with the Federal statue to clarify its responsibility for the payment of Medicare coinsurance and deductible amounts for dual-eligible beneficiaries. Finally, CMM argued that, neither the Secretary, nor the Board has the authority to excuse the State from complying with the Federal requirements to determine cost-sharing liability, even if the Medicaid State Plan was approved in error. CMM reiterated that the State maintains the most current and accurate patient and financial information to determine the dual-eligible status of the beneficiaries at the time of service and to determine its State cost-sharing liability for all covered stays of such dual-eligible beneficiaries, including Qualified Medicare Beneficiaries. Thus, the Provider must bill the State and the State must process the bill or claim to produce a Remittance Advice for each beneficiary. Even if the Provider believes it has calculated that the State possesses no liability for outstanding deductible and coinsurance amounts, the Provider must bill the State and receive, in return, a Remittance Advice, before claiming a bad debt as worthless.

The Intermediary commented, requesting, based on its recent comments in *Royal Coast*, reversal the Board's decision. The Intermediary argued that the bad debts at issue were the deductible/coinsurance for dual eligible Medicaid/Medicare beneficiaries for services

[4] *Community Hospital of the Monterey Peninsula v Thompson*, 323 F.3d 782 (9th Cir. 2003).

provided by the Provider. The State's effort to avoid payment of these coinsurance/deductible amounts was a violation of Federal law and allowing these bad debts would result in cost shifting of a responsibility that should be borne in part by the State. In addition, the Intermediary noted that the Board was overly concerned with use a JSM as a communications tool. However, the JSM communicated a policy supported by the Ninth Circuit as a reasonable reading of existing regulations and instructions. The Board also misread another JSM to discredit the JSM 03-24-06. The Intermediary noted that JSM 06345 served as a stay on recoveries and not as a cancellation of the "must bill" policy.

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.

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 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...." 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. Specifically, the regulation at 42 C.F.R. 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 C.F.R. 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 in the regulation at 42 C.F.R. 413.9,[5] which provides that the determination of reasonable cost must be based on

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[5] The regulation at 42 C.F.R. 413.1 explains that: "This part sets forth regulations governing Medicare payment for services furnished to beneficiaries." Paragraph (3) explains that: "Applicability. The payment principles and related policies set forth in this part are binding on CMS and its fiscal intermediaries, on the Provider Reimbursement Review Board, and on the entities listed in paragraph (a)(2) of this section. (b) Reasonable cost reimbursement. Except as provided under paragraphs (c) through (h) of this section, Medicare is generally

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.

Consistent with these reasonable cost principles and payment requirements, the regulatory provision at 42 C.F.R. 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 C.F.R. 413.89(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. In particular, the regulatory provision at 42 C.F.R. §413.89(d) explains that:

> *Requirements for Medicare.* 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. Uncollected revenue related to services furnished to beneficiaries of the program generally mean the provider has not recovered the cost of services covered by that revenue. <u>The failure of beneficiaries to pay the deductibles and coinsurance amounts could result in the related costs of covered services being borne by others. The costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs.</u> Bad debts arising from other sources are not an allowable cost. (Emphasis added.)

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

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required, under section 1814(b) of the Act (for services covered under Part A) and under section 1833(a)(2) of the Act (for services covered under Part B) to pay for services furnished by providers on the basis of reasonable costs as defined in section 1861(v) of the Act.…"

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.
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> 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.

Furthermore, 42 C.F.R. 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. (Emphasis added.)

To comply with 42 C.F.R. 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.) (Emphasis added.)

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, §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:

> [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[6] notes 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 section 312 or, if applicable, section 310 are met. (Emphasis added.)

For instance, 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

[6] Sections 1905(p)(1) and 1905(p)(3) of the Act requires State participation in payment of coinsurance and deductibles for QMBs although it may be limited. Thus, the first paragraph of section 322 in that respect does not reflect the latest version of the Medicaid Act regarding QMBs when it states: "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...."

> 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 section 312, or if applicable, section 310 are met.

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, thus, to determine its 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.

The Administrator, through adjudication, further addressed this policy in *Community Hospital of the Monterey Peninsula,* PRRB Dec. No. 2000-D80. As a result of that litigation, CMS issued a memorandum on August 10, 2004 regarding bad debts of dual-eligible beneficiaries.[7] The Joint Signature Memorandum (JSM-370) 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.

[7] JSM 370 (Aug. 10, 2004).

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.[8] The memorandum noted that in, *Community Hospital of the Monterey Peninsula v. Thompson, supra*, (2008), the Ninth Circuit upheld the must bill policy of the Secretary.[9] The memorandum also stated that regarding dual-eligible beneficiaries, 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.[10] 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 the must bill policy.[11] The Ninth Circuit panel found that section 1102.3L was inconsistent with the Secretary's must – bill 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 effect 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-eligibles' co-pays and deductibles before claiming Medicare bad debts.[12]

The CMS JSM also provided a limited "hold harmless provision." This memorandum 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

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[8] *Id*.
[9] *Id*., citing 323 F.3d 782.
[10] *Id*.
[11] *Id*.
[12] *See*, Change Request 2796, issued September 12, 2003.

documentation for such cost reporting periods. This hold harmless policy affects only those providers with cost reports that were open as 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.[13]

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. Accordingly, revised section 1102.3L of the PRM, Part II (Exhibit 5 to Form CMS-339)[14] 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 has a partial hospitalization program is certified to participate in Medicare. The record does not demonstrate that the Provider ever had a Medicaid Provider Number. The Provider furnished services under the partial hospitalization program, which was not a service covered under the State plan. The Provider claimed that it did not possess a Medicaid number; hence, it could not bill the State Medicaid program.

Relevant to this case, by a letter dated November 24, 1997, CMS issued guidance to all State Medicaid Directors explaining the implementation of the effects of the Balanced Budget Act of 1997 on QMBs. The letter pointed out that the requirement for Medicaid to pay Medicare cost-sharing for QMBs was originally enacted in the Medicare Catastrophic Coverage Act of 1988. The State Medicaid Manual, addressing that requirement, provided that States have the option to pay Medicare cost-sharing in amounts based either on the full Medicare-approved amount, or on the amount that the State pays for the same service on behalf of a Medicaid recipient not entitled to Medicare. Because some Federal courts had interpreted the Medicaid law as not giving States this choice, the section 4714 of the BBA was enacted

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[13] *Id*.

[14] Rev. 6 (April 2006)(changes originally issued pursuant to a Change Request 2796, issued September 12, 2003).

that clarified that States have flexibility in establishing the amount of payment for Medicare cost-sharing in their Medicaid State plans. The letter explained specifically that section 4714 of BBA amended section 1902(n) of the Social Security Act to clarify that a State is not required to provide any payment for any expenses incurred relating to Medicare deductibles, coinsurance, or copayments for QMBs to the extent that payment under Medicare for the service would exceed the amount that would be paid under the Medicaid State plan if the service were provided to an eligible recipient who is not a Medicare beneficiary.

However, contrary to the CMS letter and the law, in 1998, the State legislature passed an Act which, *inter alia*, provided that the State Medicaid program would not make any payment towards deductibles and coinsurances for any services not covered by the State Medicaid program.[15] Contrary to the plain language of section 1905 of the Act as incorporating the provisions of the Medicare Catastrophic Act and the BBA of 1997 and CMS pronouncements, the State changed its law so it would no longer be responsible for any coinsurance/deductibles for QMBs for services not covered under its State Plan. Such services included partial hospitalization services. In error, the CMS regional office approved the State plan amendment that incorporated the State law. The State eventually passed House Bill 55085 that became effective July 1, 2008 and brought the State plan into compliance with Federal law. The legislation also established that: "the rate applies to payments by Medicaid for items and services before the effective date of this act if such payment is the subject of a lawsuit that is based on the provisions of this section and that is pending as of or is initiated after the effective date of the Act."

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, regardless of any errors in the State plan, the Medicaid statute provides for a State's obligation to payment QMBs deductible and coinsurance amounts regardless of whether the service is covered under the plan. The eligibility category known as a Qualified Medicare Beneficiary or QMB, i.e., a dual eligible, which was enacted by the Medicare Catastrophic Act of 1988, represents individuals who meet the definition in section 1905(p)(1) of the 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

[15] *See* also *Royal Coast*; *supra*, 13-14

Medicaid payment of their Medicaid cost-sharing expenses. Section 1905(p)(3)[16] 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 eligible cost-sharing if the Medicaid rate is lower than what Medicare would pay for the service. Thus, the record does not support the finding that the State had no clear obligation to pay the uncollectible coinsurances and deductibles in this case.

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 met the necessary criteria for Medicare payment of bad debts related to these claims. In order to determine the State's liability and, likewise, the amount of coinsurance and deductible amounts attributable to Medicare bad debt, the Provider is required to bill the State for these claims. However, it is only through the State's records and claims system that the amount of any payment can be determined; and in most cases, the State will always be liable to pay for a beneficiary's unpaid deductible amounts. This necessity is recognized by the statute at section 1903(r)(1) as it requires automated facilitation of cross-over claims between State Medicaid programs and the Medicare program for dual eligible patients. 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 C.F.R. 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 the debt was actually uncollectible when claimed.

Additionally, 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

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[16] *See also*, section 3490.14 of the State Medicaid Manual, CMS Pub. 45 ("Payment of Medicare Part A and Part B Deductibles and Coinsurances—State Agency Responsibility.").

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, since well before the cost year in this case.[17] The final decisions of the Secretary have consistently held that the bad debt regulation and the documentation requirements for payment set forth in the law and regulation require providers to bill the Medicaid programs for payment. 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 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. 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. 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.

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[17] *See, e.g., California Hospitals Crossover Bad Debts Group Appeal*, PRRB Dec. No. 2000-D80; *See also, California Hospitals* at n.16 (listing cases). To the extent any CMS statements may be interpreted as being inconsistent with the "must bill" policy, such an interpretation would be contrary to the OBRA moratorium. In addition, the Ninth Circuit Court of Appeals decision in *Community Hospital of Monterey Peninsula*, discusses at length the various PRRB/Administrator decisions setting forth the must bill policy. One of the earliest cases was decided in 1993 and involved a 1987 cost year. *See, Hospital de Area de Carolina*, Admin. Dec. No 93-D23.

As noted for the reasons set forth in CMM's comments, the Board also incorrectly dismissed the JSM 370 as a valid means of communicating established, longstanding policy. The Board also incorrectly interpreted the subsequent JSM-06345 as being inconsistent with CMS longstanding policy where in fact it but restates such a policy and only issues a temporary instruction regarding tentative settlement. A subsequent JSM/TDL-10172, dated March 12, 2010, instructs intermediaries on settling the final notices of program reimbursement and instructs the intermediary to disallow the dual eligible bad debts not billed to the State of Florida.

In light of the foregoing, the Provider has not demonstrated that the bad debts claimed by the Provider were actually uncollectible and worthless when written off on the FYE 2005 cost report. The Provider did not bill the State and receive a remittance advice contemporaneous with 2005, as needed to meet the reasonable collection effort requirements of the regulation and manual provisions for the claims at issue in this case for the cost reporting period at issue. While 42 C.F.R. 413.89 explains the criteria needed to be met to claim a bad debt, the regulation at 42 CFR 413.89(f) addresses the timing of when a bad debt can be claimed consistent with the general Medicare documentation requirements.[18] 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. This provision is not a replacement

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[18] 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 an essential and 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 C.F.R. 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 "contemporaneous" records and documentation 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. Here the Provider has not submitted claims to the State, received and "maintained" the required remittance advices contemporaneous with the cost reporting period and furnished such documents to the Intermediary, contrary to this principle.

or substitute for the reasonable collection effort, as once the debt is paid by Medicare, there is no incentive or requirement or need to continue collection efforts (i.e., bill the State), thus nullifying the likelihood for any later recoveries.

In accordance with section 314 of the PRM and 42 C.F.R. 413.89(f), uncollectible Medicare deductible and coinsurance amounts are recognized, and only recognized, in the reporting period in which they are deemed worthless. As the court discussed in *Palms of Pasadena v. Sullivan*, 932 F.2d 982 (D.C. 1991), regarding when a bad debt may be claimed:

> Bad debts relating to Medicare patients can arise when these patients fail to pay their deductible or coinsurance despite the hospital's bona fide attempts at collection….If Medicare does not reimburse providers for these losses, this "could result in the related costs of covered services being borne by other than Medicare beneficiaries." … Medicare therefore steps in and compensates the provider for its losses, but it does so only after the Medicare patients' accounts actually become worthless…. Pursuant to this method, Medicare paid [the provider] a single amount for each bad debt relating to a Medicare patient, regardless of which hospital services gave rise to the debt.
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> The basic effect of these provisions is to bar providers from reporting bad debts on an accrual accounting basis. Rather, some bad debts-those arising from the failure of Medicare patients to pay their deductible or coinsurance amounts-are to be treated as if the provider were on a cash basis. That is, the provider reports (and is then reimbursed for) such Medicare bad debts only in the accounting period when the particular account receivable actually becomes worthless.[19]

These provisions, like that of 42 C.F.R. 413.89(f), ensure the proper recovery of bad debts by preventing the premature claiming of debts and preventing double dipping, or duplicative recoveries. In addition, the period in which a bad debt is claimed can affect the amount of the bad debt to be allowed, either because of the offset of recovered debts, or the affect of certain new provisions affecting the percentage of bad debts which will be paid in a specific cost year.[20] Because the Provider has not billed the State and the State had not issued

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[19] *Palms of Pasadena v. Sullivan*, 932 F.2d 982, 983 (D.C. 1991). However, while Medicare reimbursement regulation requires health care providers to maintain standard financial records, it does not require the Secretary to make reimbursement determinations according to generally accepted accounting principles.

[20] *See, e. g.,* 42 C.F.R. 413.89(h)(2008).

remittance advices for these services contemporaneous with this FY 2005 cost reporting period, the bad debts cannot be demonstrated as "actually uncollectible when claimed as worthless" and that "there is no likelihood of recovery at any time in the future" and that sound business judgment has established no likelihood of recovery in the future. In addition, as there is a third party, the State who is responsible for coinsurance and deductibles, the Provider has not shown that it has used reasonable collection efforts as the State has a legal obligation to pay the bad debts and the claims have not been submitted for processing to the State. As such, the elements of the bad debt regulation are not met for this cost reporting period.[21] For the cost reporting period during which contemporaneous remittance advices are received, bad debts may at that time be claimed for that cost reporting period; that is, if the criteria of 42 C.F.R. 413.89 is otherwise met.

[21] The Medicaid and Medicare programs are authorized by different provisions of the Social Security Act and financed under different mechanisms. The reasonable cost payment is made from the Medicare Trust Fund/Supplemental Medical Insurance, while Medicaid is a joint State and Federal program financed, *inter alia*, under State and Federal appropriations with its own separate and distinct rules and authorizations. Consequently, the remittance advices are critical as they document the proper payments that should be made from the respective programs. Moreover, a fundamental principle of the program is that payment be fair to the providers, the "contributors to the Medicare trust fund" and to other patients. In this instance the program is reasonably balancing the accuracy of the bad debt payment, the timing of when these bad debts can and should be paid, the need to ensure the fiscal integrity of Medicare, and the fact that the providers' claims for payment can be made under two different programs for which Medicare is the payor of last resort.

DECISION

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

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

Date: 5/10/2010

/s/
Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

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