CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Ashton Hall Nursing & Rehabilitation Center	**Provider Cost Reimbursement Determination for Cost Year Ending: June 30, 2005**
Provider	
vs.	**Review of:**
BlueCross BlueShield Association/ Novitas Solutions, Inc.	**PRRB Dec. No. 2014-D5**
Intermediary	**Dated: April 9, 2014**

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 mandated 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. The Intermediary submitted comments, requesting that the Administrator reverse the Board's decision. The Center for Medicare (CM) submitted comments, requesting that the Administrator reverse the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE

The issue was whether the Intermediary's[1] adjustment to disallow Medicare Bad Debts on the Medicare Cost Report was proper.

[1] Formerly known as Fiscal Intermediaries (FIs), CMS's payment and audit functions under the Medicare program are now contracted to organizations known as Medicare Administrative Contractors (MACs). However, for the cost year at issue in this case, the term "Intermediary" will be used.

BOARD'S DECISION

The Board found that the Intermediary's adjustments to bad debts with dates of service on or after January 3, 2004 were proper. However, the Board found that adjustments for the claims on the bad debt list with service dates prior to January 3, 2004 were improper, and the Board remanded to the Intermediary to recalculate the allowable bad debts for the dual eligible claims on the June 30, 2005 bad debt list.

The Board found that the Provider was fully notified of the "must bill" policy through the Intermediary's publication of its Newsletter dated October 1, 2003. The Board noted it was not persuaded by the Intermediary's argument that the transmittal issued on September 12, 2003 to revise Provider Reimbursement Manual (PRM) 15-2 § 1102.3(L) provided any notification on the "must bill" policy because no such policy statement was added to that section. Rather, the Board noted, CMS simply cross-referenced other previously-existing sections of PRM 15-1 without making any policy statements, for example stating "See the criteria in Provider Reimbursement Manual – 1 §§312 and 322 and 42 C.F.R. § 413.80 for guidance on billing requirements for indigent and welfare recipients."

Regardless of the date of notification, the Board held that the records established that the Provider could not bill the Pennsylvania Medicaid program for denials as the program was not properly set up to process denials and zero bills until July 1, 2004. In support of this finding, the Board cited to the minutes from the April 14, 2004 meeting of Long Term Care Subcommittee, an advisory committee for the Pennsylvania Medicaid program; and newsletters from the other intermediary servicing skill nursing facilities (SNFs) in Pennsylvania. The Board noted that in addition to the "Clarification of Medicare Bad Debt Payments" issued on July 19, 2004 by Veritus Medicare, Novitas Solutions Inc. (which was previously Veritus Medicare) had posted on its website the following guidance concerning bad debts:

> Skilled Nursing Facility (SNF) Providers that can demonstrate that they followed the instructions that were previously laid out at PRM 15-2 1102.3L * (*select chapter 11, open pr2_1100-_to_1102.3 doc, then scroll to section 1102.3L*) for open cost reporting periods beginning prior to January 1, 2004, will be held harmless for those periods. Section 11 02.3L, which was added in November 1995, permitted SNF providers to show other documentation in lieu of billing the states. This language was in conflict with the billing requirements in Chapter 3 of the PRM 15-1, and due to a moratorium on changes in bad debt reimbursement policies imposed by Congress in August 1987, the Secretary lacked authority in November 1995 to effect a change in policy. CMS has reverted back to the pre 1995 language, which

> requires all providers to bill the individual states for dual-eligible co-pays and deductibles before claiming Medicare bad debts. SNF providers were instructed via Provider Notice 04-116 to begin billing the state effective for services rendered on or after July I. 2004.
>
> Intermediaries who followed the now-obsolete Section 1102.3L instructions for cost reporting periods prior to January 1, 2004, may reimburse SNF providers for dual-eligible bad debts with respect to unsettled cost reports that were deemed allowable using other documentation in lieu of billing the state.
>
> Therefore. for cost reporting periods beginning January l, 2004, and forward, we will require that all providers have a processed State Medicaid remittance advice before allowing dual eligible bad debts.[2]

The Board further found that the claim submission rules for the Pennsylvania Medicaid program would only have permitted the Provider's required claims to be filed within 180 days of the date of service. Thus, as a result of the time limits for submitting Pennsylvania Medicaid claims and the capability limitations of the Pennsylvania Medicaid billing system, the Board concluded that it was not possible for the Provider to bill the Pennsylvania Medicaid program for the coinsurance claims on the bad debt list with dates of service prior to January 3, 2004 (i.e., 180 days prior to July 1, 2004) and receive a denial from the State.

Based on these findings, the Board concluded that the Intermediary's adjustment for the claims on the bad debt list with a service date prior to January 3, 2004 was improper. The Board noted that it is not bound by the PRM manual guidance but must only give great weight to it. The Board found that it is not bound by the bad debt provisions in the PRM as they are applied to SNFs (including the application to SNFs of the so called "must bill" policy to the extent, if any, that such policy conflicts with the Board's finding) because the Bad Debt Moratorium which prohibits the Secretary from making changes to the bad-debt policy in effect as of August 1, 1987 pertains only to hospitals and not to SNFs.[3]

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[2] Novitas Solutions Inc. webpage entitled "Provider Audit & Reimbursement (Part A): Bad Debts" (available online at: *www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00003685* (last accessed on May 16, 2014)). The Board noted that Novitas Solutions Inc. assumed the responsibility for the Provider, which was previously serviced by Mutual of Omaha.

[3] The Board noted that the moratorium which prohibits the Secretary from making changes to the bad-debt policy in effect as of August 1, 1987 (the "Bad Debt

However, the Board found, the Provider could have obtained the required remittance advice (RA) documentation from the Pennsylvania State Medicaid program for any claim for a date of service for any claim on or after January 3, 2004, since as of July 1, 2004, the Pennsylvania Medicaid program had the capability to generate a RA for denial and zero bills. The Board noted that it is unclear whether the hold harmless provisions delineated in JSM 370 would have been applicable to dates of service prior to January 1, 2004 because the record did not establish whether the Provider followed the Form CMS-339 instructions located in the pre-2003 version of PRM 15-2 § 1102.3(L). Rather, the record only established that it was impossible to bill the State in the first instance for dates of service covered by the hold harmless provisions of JSM 370.

Thus, the Board concluded that the Intermediary should review any dual eligible claims on the June 30, 2005 bad debt list that have dates of service prior to January 3, 2004 in order to determine if the claims would qualify as bad debts, under the statute and regulations without adhering to the "must bill" policy and adjust those bad debt claims accordingly in favor of the Provider. The Board affirmed the Intermediary's adjustment to disallow bad debts with a date of service on or after January 3, 2004 because the Provider did not have on file a Medicaid RA denying payment for these dates of service.

SUMMARY OF COMMENTS

The Intermediary commented, requesting that the Administrator reverse the Board's decision in so far as it reverses the Intermediary's denial of the Provider's bad debt cross over claims of dual eligible patients prior to January 3, 2004.

The Intermediary argued that in granting an "exception" to CMS's "must bill" requirement where the State Medicaid program could not issue a remittance advice (RA), the Board is granting equitable relief, citing the "impossibility" of obtaining the requisite RA as a basis for relief. However, the applicable regulation and CMS policy, rules, and instructions provide for no such exception. The Intermediary pointed out that the Board does not have the authority to grant any such exception or to grant equitable relief, and that this fact has been recognized in various

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Moratorium") is not applicable to the Provider because the Provider is a SNF, rather than a hospital. *See* OBRA 1987, Pub. L. No. 100-203, § 4008(c), 10I Stat. 1330, 1355 (1987), as amended by Technical and Miscellaneous Revenue Act of I988, Pub. L. No. 100-647, § 8402,102 Stat. 3342,3798 (1988), as amended by Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 10I-239, § 6023, 103 Stat. 2106, 2167 (1989).

circumstances.[4] The Intermediary noted that Federal courts[5] hearing cases challenging CMS' "must bill" requirement have uniformly upheld the requirement and have endorsed the agency's rationale justifying the receipt of a RA in order to document the liability of a state's Medicaid program for the unpaid co-insurance and deductible of dual eligible patients.

The Center for Medicare (CM) commented, noting that it disagreed with the Board's decision to remand the issue to the Intermediary to recalculate the bad debts for dual eligible claims with dates of service prior to January 3, 2004. CM stated that it agreed with the Board's finding that the adjustments to the bad debts with dates of service on or after January 3, 2004 were proper.

CM pointed out that the Board based its decision on the finding that the Pennsylvania Medicaid program was not set up to process denials and zero payment remittance advices until July 1, 2004 and also that the claim submission rules for the Pennsylvania Medicaid program only permitted the Provider to file claims within 180 days of the date of service. Thus, the Board concluded it was not possible for the Provider to bill for the coinsurance on the bad debt list with dates of service prior to January 3, 2004 and receive a denial from the State.

CM noted that in order to comply with 42 C.F.R. § 413.89(e)(3) and PRM § 322, Medicare requires a provider to document the State's liability for any cost sharing amounts related to unpaid Medicare deductible and coinsurance amounts for dual eligible beneficiaries. Thus, Medicare has required the provider to make certain that no source, other than the patient, would be legally responsible for the patient's medical bill. To effectuate this requirement, CM pointed out, a provider must submit a bill to its fiscal intermediary, who then initiates the Medicaid crossover billing process with the State. This process allows a claim by claim adjudication necessary to determine the State's cost sharing liability. CM stated that CMS clearly reinforced this requirement in JSM-370 issued to all fiscal intermediaries on August 10, 2004, and that JSM-370 was a clear and concise reiteration of the instructions that were issued in Change Request 2796 on September 12, 2003. Change Request 2796 was issued as a direct result of the Ninth Circuit Federal Court decision in *Community*

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[4] The Intermediary cited to *LivinRite Home Health Services v. BCBSA*, PRRB Dec. No. 2013-D30 (Aug. 27, 2013)("the Board cannot consider the Provider's request for equitable relief. The Board's authority is limited to the statutory and regulatory requirements…").

[5] *See, e.g., Community Hospital of Monterey Peninsula v. Thompson*, 323 F.3d 782 (9th Cir. 1983); *Cove Associates Joint Venture v. Sebelius*, 848 F.Supp.2d 13 (D.D.C. 2012); *CGI Health Care Ctrs. V. Thompson*, 209 F.Supp. 2d 63 (D.D.C. 2002); *Grossmont Hospital Corp. v. Sebelius*, 903 F.Supp.2d 39 (D.D.C. 2012).

Hospital of the Monterey Peninsula v. Thompson[6] upholding the Secretary's discretion to apply the must bill policy for dual eligible beneficiaries.

CM stated that the Provider's argument that the hold harmless directive in JSM-370 pertains to any bad debt with a date of service prior to January 1, 2004, regardless of the cost reporting period in which it was reported and claimed as a bad debt is incorrect. CM argued that protection under the JSM-370 hold harmless provision is only applicable to bad debts claimed in cost reporting periods open as of August 10, 2004 and filed before January 1, 2004, not to claims with dates of service prior to January 1, 2004. Therefore, CM noted, the Provider is not entitled to protection under the hold harmless provision of JSM-370.

CM reasoned that a beneficiary's financial status may change quickly. States maintain complex billing systems and documentation requirements unique to each State, and it is the State's responsibility to determine its cost sharing liability concerning dual eligible beneficiaries. CM pointed out that § 1903(r)(1) of the Social Security Act provides that in order for a State to receive payments under § 1903(a) for automated data systems, a State must have, in operation, a 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". Neither CMS, the Board, nor providers are able to make cost-sharing liability determinations.

Thus, the provider must submit a bill for a dual eligible beneficiary to its fiscal intermediary to begin the Medicaid crossover billing process with the State. Thereafter, the State must process these crossover bills/claims to produce a remittance advice (RA) for each beneficiary to determine a patient's Medicaid status at the time of service and to also determine the State's liability for payment of Medicare deductible and coinsurance amounts. CM asserted that under 413.89(e)(3) and for the reasons provided in its comments, it is unacceptable for a provider to write off a Medicare dual eligible beneficiary bad debt as worthless without the State determining its share of liability.

Thus, CM stated, after reviewing the Board's decision and all relevant facts, the bad debts claimed by the Provider on its cost report for the cost reporting period ending June 30, 2005 should be disallowed in its entirety because the Provider failed to provide the remittance advices from the State to first determine whether the State was legally responsible for its share of the dual eligible patients' coinsurance amounts. CM noted that while it recognized that the Pennsylvania Medicaid program was not

[6] 323 F.3d 782 (9th Cir. 2003)

properly set up to process denials and remittance advices until July 1, 2004, the State was statutorily required to process crossover claims to determine its liability for dual eligible beneficiaries and to further provide the required remittance advice documentation to the Provider. Thus, CM stated, the Provider must seek a remedy from the State as a direct result of the State's shortcomings in failing to perform a statutorily mandated duty.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. The Administrator has reviewed the Board's decision. All comments timely submitted have been taken into consideration.

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 § 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, § 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*. (Emphasis added.)

In addition, consistent with the requirements of § 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 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 at 42 C.F.R. § 413.9[7], which provides that the determination of reasonable cost must

[7] 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 required, under § 1814(b) of the

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.

Consistent with these reasonable cost principles and payment requirements, the regulatory provision at 42 C.F.R. § 413.89(a)[8] 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, 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. *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.* Bad debts arising from other sources are not an allowable cost. (Emphasis added.)

Act (for services covered under Part A) and under § 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 § 1861(v) of the Act.…"

[8] Formerly 42 C.F.R. § 413.80. The regulation addressing "Bad Debts, Charity, and Courtesy Allowances" was redesignated at 69 Fed. Reg. 49,254 (Aug. 11, 2004).

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 C.F.R. § 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.

Further, 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 section 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, § 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, § 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, § 322 of the PRM 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 §312 or, if applicable, §310 are met. (Emphasis added.)

For instances in which a State payment "ceiling" exists, § 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.

The patient's Medicaid status at the time of service should be used to determine their eligibility for Medicaid to satisfy the requirement of § 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 § 322 of the PRM that the amount that can be claimed as bad debts is the amount the State "does not pay" presumes that the State has been billed and the State has rendered a determination on such a claim.

In fulfilling the requirements of §§ 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)[9] requires the submission of the following documentation:

> 1. Evidence that the patient is eligible for Medicaid, e.g., Medicaid card or I.D. number
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> 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.

The Administrator further addressed this policy in *California Hospitals Crossover Bad Debts Group Appeal*.[10] In that case, rendered October 31, 2000, the Administrator again repeated the requirement that providers must bill the Medicaid program for payment. This "must bill" policy enunciated in *California Hospitals* was upheld by the federal Ninth Circuit Court of Appeals.[11] As a result of that litigation, CMS issued a Joint Signature Memorandum (JSM-370) on August 10, 2004

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[9] Rev. 6 (Apr. 2006)(changes originally issued pursuant to a Change Request 2796, issued Sept. 12, 2003).

[10] Admin. Dec. No. 2000-D80

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

regarding bad debts of dual-eligible beneficiaries. 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. [12]

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.[13] JSM-370 also stated that, regarding dual-eligible beneficiaries, § 1905(p)(3) of the Act imposes liability for cost-sharing amounts for Qualified Medicaid Beneficiaries (QMBs) on the States through § 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.[14] 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, JSM-370 also indicated that, in November 1995, language was added to the PRM at § 1102.3L, which was inconsistent with the must bill policy.[15] The Ninth Circuit found that § 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 § 1102.3L to revert back to pre-1995 language, which required providers to bill the individual States for dual-eligibles' co-pays and deductibles before claiming Medicare bad debts.[16]

JSM-370 also provided a limited "hold harmless provision", which noted:

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[12] JSM 370 (Aug. 10, 2004).
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *See* Change Request 2796, issued September 12, 2003.

> **This memorandum is to serve 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 1102.3L 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 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 § 1102.3L in providing documentation.[17] (Emphasis in original).

In this case, the Provider is a skilled nursing facility (SNF) located in Philadelphia, Pennsylvania. On November 27, 2006, the Intermediary issued a Notice of Program Reimbursement (NPR) for the Provider's cost report for the fiscal year ending June 30, 2005 (FY 2005). In the NPR, the Intermediary disallowed a portion of the bad debts associated with deductible and coinsurance amounts for dual eligible. The Provider filed a timely request for a hearing, disputing CMS' "must bill" policy.[18]

The Provider contended that it relied on PRM 15-2 § 1102.3(L) as it existed prior to September 2003 revisions and the subsequent JSM 370 instructions. The Provider argued that the pre-2003 PRM provisions allowed it to be reimbursed for bad debts for dual eligibles even though it did not bill the State Medicaid program. Thus, the Provider reasoned, reasonable collection efforts may be waived for dual eligible patients because they may be deemed indigent, and bad debts for an indigent patient may be written off and claimed upon discharge or upon the determination of indigency, whichever is later.

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

[18] The Provider previously withdrew a second issue regarding an adjustment made for $342 due to lack of documentation.

The Provider claimed that the Intermediary's insistence on applying the "must bill"' policy to crossover claims for services provided before January 1, 2004 and reported as bad debts for cost reporting periods beginning on or after January 1, 2004 was incorrect, as the hold harmless directive in JSM 370 pertains to any bad debt with a date of service prior to January 1, 2004 regardless of the cost reporting period in which it was reported and claimed as a bad debt.

The Provider argued that the Intermediary's Newsletter dated October 1, 2004 announcing the "must bill" policy based on the *Community Hospital of Monterey Peninsula v. Thompson*[19] decision placed the Provider in an "impossible situation", as Pennsylvania State Medicaid Policy required providers to bill the program within 180 days from the patient's date of service. Because the Intermediary's Newsletter announcing the new "must bill" policy was not issued until October of 2004, had the Provider attempted to bill the Pennsylvania Medicaid program for any claims for services furnished prior to May 1, 2004, the Pennsylvania Medicaid program would have denied those claims as untimely because the 180-day filing deadline for those claims had already tolled when the Newsletter was issued.

The Provider also asserted that the Pennsylvania Medicaid program could not accept any bills for Medicare coinsurance prior to July 1, 2004.[20] Pennsylvania had set up a new billing system called the Promise Billing System, on March 1, 2004, but because providers had never had to bill the Pennsylvania Medicaid program in the past, it was not set up to handle the coinsurance bills. [21] Thus, the Provider noted, it

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[19] 323 F.3d 782 (9th Cir. 2003)

[20] As evidence of this claim, the Provider submitted Provider Notice 04-116, issued on July 19, 2004 by another intermediary, Veritus Medicare, which the Provider contended was the intermediary for the majority of SNFs in Pennsylvania. This notice required all Pennsylvania SNFs for which it was the designated intermediary to begin sending claims to the State for dates of service after July 1, 2004. The Provider argued that this intermediary must have received permission from CMS to use the July 1, 2004 date because it was impossible for facilities to bill the Pennsylvania Medicaid program for Medicare deductible and coinsurance prior to that date. The Provider claimed that allowing a waiver of the application of the "must bill" policy for facilities serviced by one intermediary, while holding other facilities serviced by other intermediaries to the policy, is unfair.

[21] As evidence that Pennsylvania's Promise Billing System was unable to handle coinsurance bills, the Provider pointed to a statement that the Director of Provider Relations at Pennsylvania's Department of Public Welfare made at the April 14, 2004 meeting of Long Term Care Subcommittee, an advisory committee for the Pennsylvania Medicaid program. When asked if the Department could respond to a zero bill and generate a denial that nursing facility providers could then use for

was impossible for the Provider to obtain RAs for any claims filed prior to this date as required by CMS.

The Intermediary claimed that the regulations and manual provisions clearly stated that providers must prove that a bad debt was uncollectible when claimed and that reasonable collection efforts using sound business judgment were employed. This "must bill" policy is a reasonable reading of the regulations and has been upheld by the CMS Administrator and the courts.[22] In this case, the Intermediary argued, the Provider's policy to not bill the State of Pennsylvania fails to demonstrate that the Provider determined that "no source other than the patient would be legally responsible for the patient's medical bills" as required by the regulation and program guidance. Further, the Provider's method for writing off dual eligible bad debts without billing the State Medicaid program does not constitute a reasonable collection effort as contemplated by the regulations or the manual provisions

The Intermediary noted that the Provider was notified of the "must bill" policy before October 1, 2004, first on September 12, 2003 in the PRM 15-2 transmittal that CMS issued in response to the decision in *Community Hospital of the Monterey Peninsula v. Thompson*. The Intermediary stated that this transmittal changed the language in PRM 15-2 § 1102.3(L) to revert back to pre-1995 language which required providers to bill the individual states for dual eligible beneficiary co-payments before claiming a Medicare bad debt. The Intermediary further communicated the "must bill" requirement to all providers in a Medicare Newsletter dated October 15, 2003 which stated:

> A provider must demonstrate that a debt was uncollectible when claimed as worthless. With respect to a dual-eligible, this can only be done by billing the welfare agency for each deductible and coinsurance

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claiming the Medicare bad debt, the Director stated that the system does have the capability to handle a zero bill and the Department would probably need to develop procedures for that process. *See* Provider Exhibit P-6 at 4 (copy of the minutes from the April 14, 2014 Long Term Care Subcommittee meeting of the Pennsylvania Medicaid Advisory Board (available online at *http://listserv.dpw.state.pa.us/Scripts/wa.exe?A2=ind10&L=ltc-meeting-minutes&T=0&F=&S=&P=20120*)).

[22] *Community Hospital of Monterey Peninsula v. Thompson*, 323 F.3d 782 (9th Cir. 2003); *Cove Associates Joint Venture v. Sebelius*, 848 F.Supp.2d 13 (D.D.C. 2012); *CGI Health Care Ctrs. V. Thompson*, 209 F.Supp. 2d 63 (D.D.C. 2002); *Grossmont Hospital Corp. v. Sebelius*, 903 F.Supp.2d 39 (D.D.C. 2012); *Maine Medical Center v. Sebelius*, 2:13-cv-00118-JAW (D.Me. Mar. 25, 2014) (order on motion and cross-motion for judgment on administrative record).

> amount and receiving a partial or total denial of the claim. The denial must be documented and made available to the auditor upon request. We cannot accept other forms of documentation such as a provider's calculations of the agency's liability for the debt or an affidavit from the· provider's employee that they were instructed not to bill by the agency. Moreover, we will not accept a letter from the welfare agency informing providers that it will no longer pay Medicare deductible and coinsurance amounts because of a State payment ceiling or budget shortfall.[23]

Another Medicare Newsletter dated October 1, 2004 further clarified the "must bill" policy and described a "hold harmless" policy for cost reports beginning before January 1, 2004, noting:

> In order to fulfill the requirement that a provider make a "reasonable" collection effort with respect to deductibles and coinsurance amounts owed by dual-eligible patients, CMS bad debt policy requires the provider to bill the patient or entity legally responsible for the patient's bill before the provider can be reimbursed for uncollectible amounts. . .
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> ...[I]n those instances where the state owes none or only a portion of the dual- eligible patient's deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State Remittance Advice)…
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> On August 10, 2004, CMS issued a directive to fiscal intermediaries 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 1102.3L 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 allowable using other documentation in lieu of billing the state.[24]

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[23] *See* Intermediary Exhibit I-9 (excerpts from the October 15, 2003 Medicare Newsletter).

[24] *See* Intermediary Exhibit I-10 (excerpts from the October 1, 2004 Medicare Newsletter).

The Intermediary argued that the hold harmless provision was only applicable to bad debts requested in cost reports open as of August 10, 2004 and filed before January 1, 2004, not claims with dates of service prior to January 1, 2004 as the Provider argued.

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 the State's ability to provide the Medicaid remittance advices, the Provider was required to bill for and produce the remittance advice before including crossover bad debt claims on its cost report. Accordingly, the failure to produce the Medicaid remittance advices represents a failure on the part of the Provider to meet the necessary criteria for Medicare payment of bad debts related to these claims and Intermediary was correct to deny the crossover bad debt claims for the cost years at issue.

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 and receive a remittance advice. It is only through the State's records and claims system that the amount of any payment can be determined. This necessity is recognized by the statute at § 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.

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 and a remittance advice issued 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.[25] 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 and receive a remittance advice from the State for its Medicaid patients.

CMS's "must bill" policy requires a determination by the State on a filed claim. 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

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[25] *See, e.g., California Hospitals Crossover Bad Debts Group Appeal*, Admin. Dec. No. 2000-D80; *See also California Hospitals* at n.16 (listing cases). In addition, the Ninth Circuit Court of Appeals decision in *Monterey* discusses at length the various PRRB and 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. 1993-D23. The Administrator has never distinguished between types of providers in applying this policy. See, e.g., *Concourse Nursing Home*, PRRB Dec. No. 83-D152 (1977 and 1978 cost years denied as there was no documentation that actual collection efforts were made to obtain payment from the Medicaid authorities before account balances were considered uncollectable), *Village Green Nursing Home*, Admin. Dec. 2000-D59 (1994 cost year).

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 and receiving the remittance advice from the State.

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*[26] 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.[27]

These provisions, like that of 42 C.F.R. § 413.89(f), ensure the proper recovery of bad debts while safeguarding against 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 effect of certain new provisions affecting the percentage of bad debts which will be paid in a

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[26] 932 F.2d 982, 983 (D.C. 1991).

[27] *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.

specific cost year.[28] Because the Provider has not submitted State issued remittance advices for these services contemporaneous with the 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 process unpaid coinsurance deductibles and issue a remittance advice, the elements of the bad debts regulation are not met for the cost reporting periods. For the cost reporting periods during which contemporaneous remittance advices are received, bad debts may at that time be claimed for that cost reporting period if the criteria of 42 C.F.R. § 413.89 are otherwise met.

The central issue in this case is whether the Provider is obligated to pursue collection from the party responsible for the beneficiary's financial obligations, namely the Pennsylvania Medicaid Program. The Administrator finds that, despite the problems alleged regarding the Program's inability to produce the required denials and zero bills, the Provider was required to bill the Pennsylvania Medicaid Program and receive a RA in order to demonstrate reasonable collection efforts. The Administrator finds that the Provider in this case did not satisfy this requirement, and as such, the bad debt claims were properly disallowed by the Intermediary. As the State has a legal obligation to process unpaid coinsurance deductibles and issue a remittance advice, the elements of the bad debts regulation are not met for the cost reporting periods.

The Administrator finds that the bad debts claimed by the Provider on its cost report should be disallowed because the Provider failed to submit the claims to the State and obtain a remittance advice to determine if the State was liable for any cost sharing amounts for purposes of claiming the bad debts in these periods. The Provider failed to determine that the debt was actually uncollectible when claimed as worthless as required under 42 C.F.R § 413.89(e)(3) and Chapter 3 of the PRM. Providers are required to bill the State and the State process the bills/claims to produce a remittance advice for each beneficiary to determine a patient's Medicaid status at the time of service, and to determine the State's liability for payment of Medicare deductible and coinsurance amounts. Under the regulations cited above, it is unacceptable for a provider to write off a Medicare dual eligible beneficiary bad debt as worthless without first billing and receiving a RA from the State.

While the Provider argued that the Pennsylvania Medicaid program was not properly set up to process denials and remittance advices until July 1, 2004, the State was

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

statutorily *required* to process crossover claims to determine its liability for dual eligible beneficiaries and to further provide the required remittance advice documentation to the Provider. Thus, the Provider should seek a remedy from the State as a result of the State's shortcomings in failing to perform a statutorily mandated duty.

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 and the timing of when these bad debts can be paid and the need to ensure the fiscal integrity of the Medicare funding, with the providers claims for payment which can be made under two different program for which Medicare is the payor of last resort.

Additionally, the Administrator notes that the Provider is not entitled to protection under the "hold harmless" provision of JSM-370, as protection under this provision is only applicable to bad debts claimed in cost reporting periods beginning prior to January 1, 2004, and that were open as of the date of issuance of JSM-370, not to claims with dates of service prior to January 1, 2004. In this instance, the cost reporting period at issue is for July 1, 2004-June 30, 2005, after the January 1, 2004 date specified in JSM-370.[29]

In light of the foregoing, the Administrator finds that the Board's decision regarding dual eligible claims on the June 30, 2005 bad debt list with dates of service prior to January 3, 2004 is incorrect. The Provider did not demonstrate that the bad debts claimed by the Provider were actually uncollectible and worthless, as the Provider did not bill the State and receive a remittance advice as needed to meet the reasonable collection effort requirements of the regulation and manual provisions for the claims at issue in this case.

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[29] Moreover, the Provider did not demonstrate that it or the Intermediary relied upon the instructions set forth in PRM-II § 1102.3L. Further, the Provider can not reasonably argue that it relied upon §1102.3L yet could not be expected to rely on the change request to that section issued in 2003.

DECISION

The Administrator modifies the decision of the Board in accordance with the foregoing opinion. The Intermediary's adjustment to disallow Medicare bad debt on the Medicare cost report at issue was proper.

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

Date: 5/30/14

/s/
Marilynn Tavenner
Administrator
Centers for Medicare & Medicaid Services