CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the cases of:	**Claim for:**
North Sunflower County Hospital	**Cost Reporting Period(s) Ending:**
Providers	**FYE 9/30/2007**
vs.	
Novitas Solutions, Inc.	**Review of:** **PRRB Dec. No. 2017-D9**
Intermediary	**Dated: March 2, 2017**

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 (CM) commented, requesting a reversal of the Board's decision. The Medicare Administrative Contractor (MAC) commented requesting a reversal of the Board's decision. The Provider also commented requesting that the Administrator affirm 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 CMS "must-bill" policy applies to the Provider's dual eligible unpaid deductible and coinsurance amounts related to the Provider's geropsychiatric program.

The Board held that a review of the record demonstrated that the Mississippi Medicaid Program did not allow geropsychiatric units to enroll in the State Medicaid program for the fiscal year at issue in this case and, accordingly, the Provider could not obtain Medicaid remittance advices (RAs) from the State. The Board alleged that the Secretary has previously acknowledged special circumstances in which exceptions to the "must-bill" policy existed.[1] Thus, the Board held that similar to the other alleged exceptions for

[1] The Board is referring to a brief filed by the Secretary in connection with *Community Hosp. of Monterey Penninsula v. Thompson*, Case No. C-01-0142 (N.D. Cal. Oct. 11, 2001).

Community Mental Health Centers (CMCHs) and Institutions for Mental Diseases (IMDs), that the Provider in this case also qualified for an exception to the "must-bill" policy.

The Board also held that the Provider in this case appeared to be caught in the "Catch-22" described by the D.C. District Court in *Cove Assocs. Jt. Venture v. Sebelius* (*Cove)*.[2] Where the Provider is unable to receive RAs from the State, the Board found it was not convinced that requiring an individual practitioner to take legal action against its State is a viable means for the Provider to receive reimbursement. Thus, the Board concluded, based upon the "exceptions" recognized by the Secretary and the rationale in *Cove*, that the MAC's disallowance of the bad debt reimbursement at issue should be reversed.

SUMMARY OF COMMENTS

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider noted that, even though the Provider was aware that the Mississippi Medicaid program does not cover geropsychiatric services, the Provider nonetheless billed the State for dual eligible bad debt claims. The Provider noted that upon receipt of the dual eligible claims the State refused to issue RAs and instead issued a letter to the Provider indicating that Mississippi Medicaid would neither issue a Provider number nor issue any RAs for patients in geropsychiatric units. The Provider submitted the State's letter with the bad debt claims to Medicare as an alternative form of documentation. The Provider instead that, although it is not a State issued RA, the letter meets the intended spirit of the "must-bill" policy and should be accepted as proof that the State has no deductible or coinsurance liability for the bad debt claims at issue in this case. The Provider claimed that the "must bill" policy was fulfilled when the Provider submitted the letter as an alternative form of documentation which demonstrated the State was not liable for any cost sharing amounts. Thus the Provider asserted that the Board's decision to reverse the MACs adjustment was proper.

The MAC commented requesting that the Administrator reverse the Board's decision. The MAC claims the Board's reliance on the alleged exceptions from the brief filed in *Community Hosp. of Monterrey Peninsula v. Thompson*[3] does not supersede numerous subsequent court decisions that support Medicare's "must-bill" policy. Additionally, the MAC asserts that the Board incorrectly relied on dicta from *Cove* as a method to issue an equitable remedy in this case and that the Board has no authority to rule in such a manner.[4]

The MAC further asserted that the "must-bill" policy requires that a Provider bill the state Medicaid program and receive a RA before claiming dual eligible bad debts. The MAC stressed that without receiving an RA from the state the bad debt claims have not been fully

[2] *Cove Assocs. Joint Venture v. Sebelious*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).
[3] (N.D. Cal, 2001).
[4] *See MS Healthcare Center, Inc.* PRRB Dec. No. 2013-D33 at 10.

adjudicated and thus reasonable collection efforts are not satisfied as Medicaid is a source that may be liable for the patient's medical bill. Thus, the MAC contended that it is the Provider's responsibility to resolve with the State Medicaid program to obtain a determination consistent with statutory requirements and not shift the burden to Medicare.

CM commented and requested that the Administrator reverse Board's decision. CM asserted that the Board incorrectly determined that there are any exceptions to the "must-bill" policy. CM asserted that there are no exceptions to the "must bill" policy. In the instance of IMDs, CMS differentiated between what the Board alleged was an exception and payments which are precluded by statute.[5] In the instance of CMHCs in California, CM stated that this was the result of a limited settlement agreement in one State and does not obviate the Medicare "must-bill" policy and does not apply to the Provider in this case.

CM further explained that, even if a provider believes that the State has no payment liability for the unpaid deductible and coinsurance amounts, the provider still must bill the state and receive an RA prior to claiming a bad debt as worthless because the state has the most current patient eligibility and financial information to make the most accurate determination of its cost sharing liability through its automated billing system. CM specified that billing and receiving an RA is necessary to determine whether a Medicare beneficiary is eligible for Medicaid. Thus, CM asserted that the State is both statutorily and contractually obligated to issue RAs even where the services are not covered by the State Medicaid program. CM pointed out that providers in a similar situation in Florida successfully sued the State for failure to comply with the Federal statute to process claims for dual eligible beneficiaries so that the state could produce and RA and determine its cost sharing liability.[6] Thus, CM asserted that there are no exceptions to the must-bill policy and that reimbursement of Medicare bad debt for QMBs can only occur after the provider has billed the state Medicaid program and received an RA indicating the state's cost sharing liability.CM pointed out that if Medicare were to reimburse providers for unpaid amounts cost sharing amounts that states were obligated to pay under the State Medicaid program, providers would be incentivized to not enroll in the Medicaid program and simply claim reimbursement from Medicare for the unpaid cost sharing leading to excessive cost shifting to the Medicare program for the amounts the state is liable to pay.

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

[5] Section 1905(a) of the Act precludes Medicaid payment to providers who provide services in IMDs to patients aged 22 through 64.

[6] *See Alpha Comm. Mental Health Ctr. v. Holly Benson, as Secretary of Health Care Admininstration*, Case No. 2008CA004161 (2nd Cir. 2010).

decision. All comments were received timely and are included in the record and have been considered.

Two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to, *inter alia*, low-income persons who are aged, blind or disabled or members of families with dependent children.[7] The program is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines. Medicaid, under Title XIX of the Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[8] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) [42 USC 601 et seq.] and Supplemental Security Income or SSI [42 USC 1381, et seq.] Participating States may elect to provide for payments of medical services to those aged blind or disabled individuals known as "medically needy" whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy (such as an SSI recipient) are insufficient to pay for necessary medical care.[9]

In order to participate in the Medicaid program, a State must submit a plan for medical assistance to CMS for approval. The State plan must specify, *inter alia*, the categories of individuals who will receive medical assistance under the plan and the specific kinds of medical care and services that will be covered.[10] If the State plan is approved by CMS, under §1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as "medical assistance" under the State plan and also based on, *inter alia*, expenditures under §1923 for purposes of the Medicaid DSH payment.

Within broad Federal rules, States enjoy a measure of flexibility to determine "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[11] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for "medical assistance" under the State plan.

Relevant to this case, sections 1905(p)(1) and 1905(p)(3) of the Act requires State participation in the payment of coinsurance and deductibles for certain individuals that are Medicare beneficiaries. All States maintaining a federally-certified State Medicaid

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[7] Section 1901 of the Social Security Act (Pub. Law 89-97).
[8] Section 1902(a) (10) of the Act.
[9] Section 1902(a) (1) (C) (i) of the Act.
[10] *Id*. § 1902 et seq., of the Act.
[11] *Id*.

Management Information Systems (MMIS) funded under section 1903(a)(3) of the Act are required–as an express condition of receiving enhanced federal matching funds for the design, development, installation and administration of their MMIS systems—to process Medicare crossover claims, including QMB cost sharing, for adjudication of Medicaid cost-sharing amounts, including deductibles and coinsurance for Medicare services, and to furnish the provider with an RA that explains the State's liability or lack thereof. Specifically, section 1903(a)(3)(A)(i) of the Act requires State MMIS systems to demonstrate full compatibility with the claims processing and information retrieval systems utilized in administration of the Medicare program. Instructions contained in CMS's State Medicaid Manual (SMM), Part 11, section 11325 reinforce the requirement of the MMIS system to (1) record Medicare deductibles and coinsurance paid by the Medicaid program on crossover claims, (2) provide a prompt response to all inquiries regarding the status of the crossover claim, and (3) issue remittance statements to providers detailing claims and services covered by a given payment at the same time as payment, including remittance statements for zero payment amounts. The State must be able to document that it has properly processed all claims for cost-sharing liability from Medicare-certified providers to demonstrate compliance with sections 1902(a)(10)(E) and 1902(n)(1) and (2) of the Act.[12]

The Medicare program primarily provides medical benefits to eligible persons over the age of 65, and consists of two parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care; and Part B, which is a supplementary voluntary insurance program for hospital outpatient services, physician services, and other services not covered under Part A. Medicare providers are reimbursed by the Medicare program through Medicare administrative contractors (MACs) for Part A and carriers for Part B, under contract with the Secretary. To be covered by Part B, a Medicare-eligible person must pay limited cost-sharing in the form of premiums, and deductible and coinsurance amounts.

Under Section 1861(v)(1)(a) of the Act, providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. That section defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included...." An underlying principle set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare

[12] *See*, June 7, 2013 Joint CMCS, MMCO and CM Memorandum "Payment of Medicare Cost Sharing for Qualified Medicaid Beneficiaries (QMBs)." https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-06-07-2013.pdf; *See* June 7, 2013 Joint CMCS and MMCO Memorandum "Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs)." https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pd.

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.

The regulation at 42 CFR 413.1 explains that: "This part sets forth regulations governing Medicare payment for services furnished to beneficiaries" and continues to state that: "Under reasonable cost reimbursement Medicare is generally 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…." 42 CFR 413.5(c)(6) sets forth under general principles that: "Bad debts growing out of the failure of a beneficiary to pay the deductible , or coinsurance, will be reimbursed (after bona fide efforts at collection.)" 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.

The regulations further explain the reasonable cost principles set forth in the Act. This principle is reflected at 42 CFR 413.9, which provides that the determination of reasonable cost must be based on costs actually incurred and related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. The regulation states that the objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. However, if the provider's costs include amounts not reimbursable under the program, those costs will not be allowed.

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

Consistent with these reasonable cost principles and documentation payment requirements, the regulatory provision at 42 CFR 413.89(a) provides that bad debts, which are deductions in a provider's revenue, are generally not included as allowable costs under Medicare. The regulation at 42 CFR 413.89(b)(1) defines "bad debts" as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are defined as designations for claims arising from the furnishing of services, and are collectable in money in the relatively near future.

In particular, 42 CFR 413.89(d) explains that:

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

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

> 1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
> 2) The provider must be able to establish that reasonable collection efforts were made.
> 3) The debt was actually uncollectible when claimed as worthless.

> 4) Sound business judgment established there was no likelihood of recovery at any time in the future. [13]

To comply with section 42 CFR 413.89(e)(2), the Provider Reimbursement Manual or PRM provides further guidance with respect to the payment of bad debts. Section 310 of the PRM provides the criteria for meeting reasonable collection efforts. A reasonable collection effort, *inter alia*, includes: "the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations.... (See section 312 for indigent or medically indigent patients.)" (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, section 312.C requires that:

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

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 provides that:

> Where the State is obligated either by statute or under the terms of its plan to pay all, or any part of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such

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

> deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare provided that the requirements of §312 or, if applicable, §310 are met.

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

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

Section 322 of the PRM concludes by explaining that:

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

The 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 and the State had rendered a determination on such a claim.

Relevant to this case, sections 1905(p)(1) and 1905(p)(3) of the Act requires State participation in payment of coinsurance and deductibles for dual eligibles although it may be limited to include even where the State Medicaid program does not cover the service.

Section 4714 of the Balanced Budget Act of 1997, amended the statute to state that: "the amount of payment made under the title XVIII plus the payment (if any) under the state plan shall be considered to be payment in full for the service." When first enacted, CMS proposed to prohibit Providers from claiming any unpaid portion of the QMBs' Medicare deductibles and coinsurance as bad debts, if Medicaid had determined that payment in full had been made. CMS initially considered that, as the State's actual payment was payment in full for the Medicare deductible and coinsurance, there was no amount to be claimed as Medicare bad debt.[14] CMS subsequently reconsidered its policy in 1998 and determined Congress had not spoken directly on this issue and determined that section 4714(A) of the BBA did not preclude the Medicare program from recognizing the unpaid QMB cost sharing as Medicare bad debt. Therefore, effective on the date of the BBA 1997 enactment (August 5, 1997) in State's where Medicaid does not fully pay for the QMBs cost sharing, CMS determined that Medicare may reimburse providers' bad debts.

Section 1902(n) provides the State Medicaid programs with some flexibility in setting their Medicare cost-sharing payment methods specifically for QMBs, but has historically also been applied to QMB Plus and Full Benefit Dual Eligibles. The cost sharing amounts that States can pay are: 1) The Medicare cost-sharing amount (generally called the Medicare rate); 2) The Medicaid state plan rate for the same service when it's provided to a non-Medicare-eligible Medicaid beneficiary; or 3) A negotiated rate that is approved by CMS. The State has the option to establish a different payment method for each group of dual eligibles (QMB, QMB Plus, Other Dual Eligibles) and can establish different payment methods for Part A deductible, Part A coinsurance, Part B deductible, or Part B coinsurance within each group. The State may mix all of the optional payment methods as it chooses, as long as the State can assure CMS that the selected payment methods will not adversely affect access to care for the beneficiary. Regarding the negotiated rate, for Medicare services that are not covered in the Medicaid state plan for non-Medicare-eligible Medicaid beneficiaries, the State has greater flexibility in setting the negotiated rate, but the rate must

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

be sufficient for the State to assure CMS that it will not adversely affect access to care for the beneficiary.

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

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

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

1. Medicare Services Covered by Medicaid.--For Medicare services which are also covered under your State's Medicaid plan (whether they are within the amount, duration, and scope limitations of that plan), you have several options. Your payment rates for particular services may be the same as the payment rates applicable for Medicaid recipients who are not Medicare eligible, or you may choose to set separate, higher payment rates up to the Medicare allowable rate for service or the Medicare deductible and coinsurance.

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

B. Payment to Providers.—[….][15] *Medicaid payment of Medicare deductible and coinsurance amounts may be made only to Medicaid participating providers, even though a Medicare service may not be covered by Medicaid in the State plan. A provider agreement necessary for participation for this purpose (e.g., for furnishing the services to the individual as a QMB) may be executed through the submission of a claim to the Medicaid agency requesting Medicaid payment for Medicare deductibles and coinsurance for QMBs. The claim may not be disallowed on the basis that the Medicare service is not covered by Medicaid in the State plan or that the provider accepts the patient as a QMB only.* The actual payment made by Medicaid, plus the QMB's Medicaid copayment liability, if any, under the State plan, is payment in full for Medicare deductibles and coinsurance. In this case, the provider is restricted under §1902(a)(25)(C) of the Act, from seeking to collect any amount from a QMB for Medicare deductibles or

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

coinsurance, which is in excess of his/her liability under Medicaid, even if Medicaid's payment is less than the Medicare deductibles and coinsurance

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D. Examples.--Following are examples of situations to illustrate the payment responsibilities in subsection B. In each of the examples, the provider accepts Medicare assignment…

Column A shows Medicare deductible is met and State imposes no Medicaid copayment.
Column B shows Medicare deductible is met and State does impose Medicaid copayment.
Column C shows Medicare deductible is not met and State imposes no Medicaid copayment.

MEDICAID RATE FOR MEDICARE
DEDUCTIBLES AND COINSURANCE

Example 1

	A	B	C
Provider charges	$125	$125	$125
Medicare rate for service	100	100	100
Medicare deductible not met	0	0	50
Medicare pays 80% of rate for service less deductible not met	80	80	40
Medicare coinsurance	20	20	10
Medicaid rate for Medicare			
--deductible	50	50	50
--coinsurance	20	20	10
Medicaid copayment option	0	5	0
Medicaid pays for Medicare deductible and coinsurance	20	15	60
Patient copayment liability under Medicaid	0	5	0

Example 2

	A	B	C
Provider charges	$125	$125	$125
Medicare rate for service	100	100	100
Medicare deductible not met	0	0	50
Medicare pays 80% of rate for service less deductible not met	80	80	40
Medicare coinsurance	20	20	10
Medicaid rate for Medicare service	100	100	100
Medicaid copayment option	0	5	0

Medicaid pays for Medicare deductible and coinsurance	20	15	60
Patient copayment liability under Medicaid	0	5	0

Example 3

	A	B	C
Provider charges	$125	$125	$125
Medicare rate for service	100	100	100
Medicare deductible not met	0	0	50
Medicare pays 80% of rate for service less deductible not met	80	80	40
Medicare coinsurance	20	20	10
Medicaid rate for Medicare service	90	90	90
Medicaid copayment option	0	5	0
Medicaid pays for Medicare deductible and coinsurance	10	5	50
Patient copayment liability under Medicaid	0	5	0

Example 4

	A	B	C
Provider charges	$125	$125	$125
Medicare rate for service	100	100	100
Medicare deductible not met	0	0	50
Medicare pays 80% of rate for service less deductible not met	80	80	40
Medicare coinsurance	20	20	10
Medicaid rate for Medicare service	80	80	80
Medicaid copayment option	0	5	0
Medicaid pays for Medicare deductible and coinsurance	0	0	40
Patient copayment liability under Medicaid	0	0	0

(Rev. 57 3-5-89, Rev. 57 3-5-91)

CMS (formerly HCFA) issued a letter to State Directors in November 1997 explaining that:

> Section 4714 of the BBA clearly provides that States have flexibility in establishing the amount of payment for Medicare cost-sharing in their

> Medicaid State plans. Therefore, HCFA's policy, as described in section 3490.14 of the SMM, has been validated and all States, including those previously required by the courts to pay the full Medicare cost-sharing amount, may now take advantage of its flexibility.
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> Specifically, section 4714 of BBA amends 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. Thus, a State's payment for Medicare cost-sharing for a QMB may be reduced or even eliminated because the State is using the State plan payment rate. In situations where the rate payable under the State plan exceeds the amount Medicare pays, but is less than the full Medicare-approved amount, *the policy described in the SMM generally continues to be viable. Section 3490.14 of the SMM requires States to pay, at a minimum, the difference between the amount Medicare pays and the rate Medicaid pays for a Medicaid recipient not entitled to Medicare.*[16]

CMS has subsequently issued several informative bulletins addressing this issue and reminding the States of their responsibility and offering assistance to process and adjudicate and reimburse providers for QMB cost sharing even if the service or item is not covered by Medicaid irrespective of whether the provider type is recognized in the State plan and whether or not the QMB is eligible for coverage of Medicaid State plan services. For full benefit dual eligible who are not eligible as QMBs, a State may elect to limit coverage of Medicare cost sharing to only those services also covered in the Medicaid state plan. In addition, State's must have a mechanism to ensure that providers who enroll only for the purpose of submitting claims for reimbursement of QMB cost sharing while in compliance with provider screening and enrollment requirements. [17]

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[16] Letter, dated November 24, 1997, to State Medicaid Directors from Director, Center for Medicaid and State Operations, HCFA. https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pd

[17] *See*, June 7, 2013 Joint CMCS, MMCO and CM Memorandum "Payment of Medicare Cost Sharing for Qualified Medicaid Beneficiaries (QMBs)." https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-06-07-2013.pdf; *See* June 7, 2013 Joint CMCS and MMCO Memorandum "Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs)." https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pd.

The Administrator, through adjudication, further addressed the impact on the Medicare bad debts policy, again upholding the long standing requirement that providers bill the State for unpaid coinsurance and deductibles for Medicaid dual eligible individuals and have such claims adjudicated by the States as reflected in an RA before claiming as a Medicare bad debt. (*Community Hospital of the Monterey Peninsula*, PRRB Dec. No. 2000-D80 (Oct. 31, 2000). As a result of that litigation, CMS issued a joint memorandum on August 10, 2004 regarding unpaid coinsurance and deductibles of dual- eligible beneficiaries. 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. Thus, in order to meet the requirements for a reasonable collection effort with respect to deductible and coinsurance amounts owed by a dual-eligible beneficiary, the longstanding policy of Medicare is that a provider must bill the patient or entity legally responsible for such debt and receive a determination by the State on such a claim.

The memorandum noted that in, *Community Hospital of the Monterey Peninsula v. Thompson*, 323 F.3d 782 (9th Cir. 2003), the Ninth Circuit upheld this policy of the Secretary. 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 pay minimal amounts towards dual-eligible cost sharing if the Medicaid rate is lower than what Medicare would pay for the service. Where the State owes none, or a portion of the dual-eligible deductible and coinsurance amounts, the unpaid liability is not reimbursable until the provider bills the State and the State refuses payment, all of which is demonstrated through a Remittance Advice. Importantly, the memorandum also indicated that, in November 1995, language was added to the PRM at section 1102.3L, which was inconsistent with this policy. The Ninth Circuit panel found that section 1102.3L was inconsistent with the Secretary's policy and also noted that, effective in August of 1987, Congress had imposed a moratorium on changes in bad debt reimbursement policies and, therefore, the Secretary lacked authority in November of 1995 to promulgate a change in policy. As a result of the Ninth Circuit decision, CMS changed the language in PRM – II Section 1102.3L to revert back to pre-1995 language, which requires providers to bill the individual States for dual-eligible coinsurance and deductibles before claiming the

unpaid portion as Medicare bad debts. The CMS JSM also provided a limited "hold harmless provision." [18]

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

Reading the sections together, the Administrator concludes that, involving dual eligible the State is the responsible party and is to be billed, and a determination made by the State in order to establish the amount of bad debts owed under Medicare. The State must determine the liability for any portion of the deductible and coinsurance amounts. The above policy has been consistently articulated in the final decisions of the Secretary addressing this

[18] 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 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.

issue, since well before the cost year in this case.[19] Thus, in fulfilling, *inter alia*, 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 (to pre-1995 language) section 1102.3L of the PRM, Part II (Exhibit 5 to Form CMS-339) requires the submission of the following documentation:

> 1. Evidence that the patient is eligible for Medicaid, e.g., Medicaid card or I.D. number
> 2. Copies of bills for Medicare deductibles and coinsurance that were sent to the State Medicaid Agency.
> 3. Copies of the remittance advice from the State Medicaid Agency showing the amount of the provider's claim(s) for Medicare deductibles and coinsurance denied. [20]

The Provider in this case is an inpatient county-owned hospital in Ruleville, Mississippi that offers geropsychiatric services. The cost reporting year at issue is 2007. During the cost reporting period at issue, the Provider claimed unpaid Medicare deductibles and coinsurance as bad debts on its cost reports f for beneficiaries who were also eligible for Medicaid benefits under the State's Medicaid program (i.e., dual eligible beneficiaries) but did not include State RAs. The Intermediary disallowed all the bad debts based upon the "must bill" policy which requires the Provider to bill the State Medicaid program and obtain RAs, showing the State has adjudicated the amount due and made payment in accordance with that determination.

The Provider asserted that it submitted claims for the bad debts at issue in this case but the State would not issue RAs. The Provider explained that the Mississippi Division of Medicaid (DOM) does not cover services provided in a geropsychiatric unit of a hospital and, accordingly, will not issue Medicaid provider numbers for billing of services provided by such geropsychiatric units, nor provide RAs. The letter stated that:

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[19] *See, e.g., California Hospitals Crossover Bad Debts Group Appeal*, PRRB Dec. No. 2000-D80 (Oct. 31, 2000); *See also California Hospital*s at n.16 (listing cases). These decisions have denied payment when there is no documentation that actual collection efforts were made to obtain payments from the Medicaid authority before an account is considered uncollectible and when the provider did not bill the State for its Medicaid patients. One of the earliest cases was decided in 1993 and involved a 1987 cost year. *See, Hospital de Area de Carolina*, PRRB Dec. No. 93-D23. To the extent any CMS statements may be interpreted as being inconsistent with CMS policy, such an interpretation would be contrary to the OBRA moratorium.

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

> [ ] I am attaching a list of Medicare crossover claims for your senior care unit that were denied by Medicaid. Please note the denial reason for these claims is either "crossover provider not found" or "billing provider NPI invalid." This is because Mississippi Medicaid does not cover services provide[d) in a geropsychiatric unit of a hospital and therefore does not issue a provider number for these units. I am attaching a copy of section 25.24 of the Mississippi Medicaid policy manual.

The Provider asserted that this alternative documentation should be sufficient to meet the needs of the "must-bill" requirement that the State demonstrates that it does not have any deductible or coinsurance liability.[21]

After a review of the record and the applicable law and Medicare policy, the Administrator finds that the Provider failed to meet all the regulatory requirements and the Manual guidelines for reimbursement of the subject amounts as Medicare bad debts. The Administrator finds that the bad debts claimed by the Provider on its cost report should be disallowed because the Provider failed to determine if the State was liable for any cost sharing amounts and, thus, 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.

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 determination from the State on that claim. It is only through the State's records and claims system can the amount of any payment be determined and in most cases the State will always be liable to pay for some portion of a beneficiary's unpaid deductible amounts. The legal responsibility set forth at sections 1905(p)(1) and 1905(p)(3) of the Act require State participation in payment of coinsurance and deductibles for dual eligibles, although payment may be limited, but the liability extends to items and services the State Medicaid program does not cover the service. The statute at section 1903(r)(1) requires automated facilitation of cross-over claims between State Medicaid programs and the Medicare program for dual eligible patients.

The CMS "must bill" policy concerning dual-eligible beneficiaries continues to be critical to determining legal responsibility for the bad debt because individual States administer their Medicaid programs differently and maintain billing and documentation requirements

[21] Provider Exhibit 9. It is unclear whether the Provider submitted all of its claims to the State for adjudication and the timing of the submission (e.g., timeliness). The State letter included in the record is dated March 16, 2009. The State denied the claims based on reasoning that was contrary to the Federal statute and not because the claims were adjudicated as being a zero amount owed. The letter as submitted did not include the referenced attachment.

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

The PRM requirement and CMS "must bill" policy, that the State be required to make a determination on any debts owed before it may be claimed as a Medicare bad debt, has been in place for years prior to these cost years. The State has a statutory obligation to determine its cost sharing liability concerning dual eligible beneficiaries, regardless of the Medicare only status of the Provider providing the services or whether the State plan covers the item or service and has the most current and accurate patient and financial information to determine the beneficiary's dual eligible status, at the time of service, and to determine the State's cost sharing liability for dual eligible beneficiaries. Further, consistent with the foregoing, payments shall not 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. The regulations require that providers maintain verifiable and supporting documents to justify their requests for payment under Medicare.[22] Where a provider does not show that the State has made a determination and paid its share, a disallowance does not involve cost shifting as the provider has not provided the required documentation for payment and to show no other party is obligated for any portion.

[22] The regulation at 42 CFR 413.20 provides that: "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for provider determination of costs payable under the program.... Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained...." As used in the context of the regulation at §413.20, "maintain" means that the provider is required to keep "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.

The Board and Provider also incorrectly rely upon a footnote in the Secretary's "Defendant's Memorandum in Reply to the Plaintiff's Opposition to Defendant's Motion for Summary Judgment"[23] in the District Court case of *Community Hosp. of Monterey Peninsula v. Thompson* as a basis for claiming there should exist an exception for geropsychiatric units to the must-bill policy. This brief was filed in reply to the Plaintiff's brief while the case was pending at the United States District Court, N.D. of California.[24] The District Court ruled against the Secretary on the must-bill. However, on appeal, this case was overturned by the United States Court of Appeals for the Ninth Circuit, and remanded to the District court in the Secretary's favor.

The brief itself is not in the record and direct evidence of the underlying basis for the footnote statement is not presented. CM has pointed out that the specific situation referenced within the footnote regarding CMCHs was a very limited settlement agreement between the Secretary and CMCHs located in the State of California located in California, which "*are not licensed by the State* and, therefore, have no Medi-Cal provider number"[25] Settlements are not admissible as evidence and would not be properly considered in this case. There is no evidence extraneous to this footnote of such a policy and in fact with respect to Community Mental Health Centers (CMCHs), the Administrator has upheld the must bill rule for such providers in past cases.[26] Even assuming, *arguendo*, such a policy existed, in this instance the Providers are licensed by the State (unlike the CMCHs so described). The second cited instance involved Institutions for Mental Diseases (IMDs) located in California, where the services were provided to individuals ages 22 to 64. The Federal statute and regulations precluded Medicaid payment for services provided to patients of that age group in IMDs. The Federal law exclusion for payment is found at section 1905(a)(B) and prohibits "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental disease except for inpatient psychiatric hospitals services for individuals under age 21." Thus, the Administrator finds that the footnote in the brief in *Community Hospital* does reflect exceptions to the must-bill policy, nor can it be used as a basis for creating an exception for Medicare-only participating hospitals with geropsychiatric units in States which refuse to enroll this type of provider and/or do not cover this type of service under the State plan.

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[23] Defendant's Memorandum in Reply to Plaintiffs' Opposition to Defendant's Motion for Summary Judgment at n.5, *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C-01-0142, 2001 WL 1256890 (N.D. Cal. Oct. 11, 2001)

[24] *Community Hospital of Monterey Peninsula v. Thompson*, Case No. C-01-0142 (N.D. Cal. Oct. 11, 2001)

[25] CMCHs have only been operating under Medicare conditions of participations implemented by CMS since 2014.

[26] *See, e.g., Royal Coast Rehabilitation Center*, PRRB Dec. 2000-D13, involving a CMHC.

Additionally, the Board adopted the "Catch-22" notion introduced by the D.C. District Court in 2012 in *Cove Associates. Jt. Venture v. Sebelius*, [27] in which the Court indicated that certain providers appear to be caught in an untenable position when they are required to comply with the "must-bill" policy and the State refuses to issue RAs. The Court further noted a reluctance to "place a stamp of approval on a policy that would put non-participating providers in the position of not being paid due to the delinquency of federally funded state programs."[28] The Administrator respectfully notes that the language cited is dicta and is set forth in a non-final and non-binding district court decision. Further, the while the Medicaid program can be referred to as a federally funded State program it is perhaps more accurately characterized as a jointly funded, voluntary, Federal-State program financed through Federal and State sources separate and distinct from the Medicare Part A Trust Fund.

The Board incorrectly concluded that payment was justified based on: Mississippi's prohibition on enrolling geropsychiatric center as a Medicaid provider (rather than the provider's discretionary avoidance of enrolling its unit in Medicaid) and Mississippi's noncoverage of geropsychiatric services. As explained above, States are obligated to process dual eligible beneficiary claims to determine the State's cost sharing liability even where the provider is Medicare only and the service or item is not covered by the Medicaid program. Where States are made aware of their duty and still refuse to enroll providers for the purpose of billing and receiving RA then the appropriate course would be for the providers to take legal action within their States.[29] CM pointed to a similar situation[30] where providers brought forth a mandamus case against the State Medicaid agency which resulted in the State agreeing to process in accordance with the Federal statute the claims for dual eligible beneficiaries so that the State would produce a RA and determine its cost sharing liability. Thus, the Administrator finds that, although the Provider might be in an unfavorable situation, there is recourse available for demanding States to issue RAs.

Related to this option for a provider to bring an action against the State, the Board also relied upon that part of the *Cove* opinion in which the agency counsel is stated to have acknowledged that CMS is in a better position than providers "to ensure States comply with the applicable regulations of the Medicaid program." *(Cove Associations Joint Venture v Sebeluis, 845 F. Supp.2d 13,* at 28.) The Board found it was not convinced that requiring an individual practitioner to take legal action against its State is a viable means for the Provider to receive reimbursement.

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[27] 848 F. Supp. 2d 13 (D.D.C. 2012).
[28] *Id.* at 28.
[29] *See Alpha Comm. Mental Health Ctr. vs. Holly Benson, as Sect. of Health Care Admin.,* Case No. 2008 CA 004161 (Fla. 2010).
[30] *Id.*

Generally, CMS is in a better position than providers to ensure States comply with the applicable regulations of the Medicaid program. CMS has oversight of the administration of the Medicaid program and the authority to withhold funds in response to a State's failure to comply with Federal laws applicable to a State Plan. However, with respect to giving a provider a specific timely remedy, it is the providers that maybe in a better position than CMS to obtain that relief, given the practical and legal limits of any compliance action. While CMS has authority to withhold funds based on a State's failure to comply with Federal law, Medicaid is a voluntary joint program and a compliance action reflects that fact. Compliance actions may have many steps (corrective action plans, etc.) and formal review (administrative and judicial appeal) and does not guarantee a provider a specific timely remedy sought (unlike a court mandamus action). Finally, reflective of the fact a compliance action is not a provider specific remedy, a possible consideration for CMS throughout any compliance action is that the withholding of funds may potentially be detrimental to the broader Medicaid population.[31]

In light of the foregoing, the Provider has not demonstrated that the unpaid coinsurance and deductibles[32] that were identified by the Provider were actually uncollectible and worthless when claimed. Because the Provider has not billed the State and received State issued RAs for these services contemporaneous with the 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

[31] Any Federal Medicaid compliance action has its own formal administrative appeal process available for the State (*see e.g.* 42 CFR 430.35) including the right to judicial review. CMS may withhold payments to the State, in whole or part, only after giving reasonable notice and opportunity for a hearing. The regulation explains that "Hearings… are generally not called until a reasonable effort has been made to resolve the issues through conferences and discussions. These may continue even if the date and place have been set for the hearing" A factor in allowing for time to resolve the issue is that a compliance action, which results in the withholding of funds, has a potentially detrimental effect on Medicaid patients and providers. The State will have fewer funds for administering the program and providing medical assistance. Further, as part of the process, a State may be required to submit an appropriate "corrective action plan", which, in and of itself, would also not resolve the Provider's immediate issue. Therefore, while the CMS maybe in a better position to enforce Federal law, an agency compliance action is not a specific remedy such as the mandamus action brought by the Providers in *Alpha Community Health Center.* CMS can penalize a State by withholding funds, but does not have the same authority of a court to order compliance, and must also balance the potential of adversely affecting the broader population of Medicaid patients. .As noted, *supra,* CMS has been working with States to assist them in this particular legal obligation.

[32] The majority of the claims in this case involve the Medicare deductible.

third party, the State who is responsible for determining its coinsurance and deductibles liability, the Provider has not shown that it has used reasonable collection efforts.

Notably, 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 Medicare program is reasonably balancing the accuracy of the bad debt payment 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 payer of last resort. As the State has a legal obligation to pay the bad debts and the State has not made a determination on these claims, the elements of the bad debts regulation are not met.

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: 5/8/17

/s/

Seema Verma
Administrator
Centers for Medicare & Medicaid Services