CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the cases of:	**Claim for:**
Hillcrest Specialty Hospital **Provider**	**Cost Reporting Period(s) Ending:** **08/31/2007 and 08/31/2008**
vs.	
Wisconsin Physicians Service **Intermediary**	**Review of:** **PRRB Dec. No. 2018-D3** **Dated: November 6, 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 partial reversal of the Board's decision. The Medicare Administrative Contractor (MAC) commented requesting a partial reversal of the Board's decision. The Provider also commented requesting that the Board's decision be reversed in part. 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 claimed dual eligible beneficiaries unpaid coinsurance and deductibles when the Provider does not participate in the respective State's Medicaid program.

The Board addressed this case as two separate issues. First, the Board addressed the Provider's Medicare dual eligible bad debt claims in which the Provider claimed it was unable to enroll in the State Medicaid program of Oklahoma due to its designation as a Long Term Care Hospital (LTCH). The Provider alleged that, since it was unable to be enrolled and certified as a Medicaid provider, it was also unable to receive a billing number in order to submit and received remittance advices (RAs). On this issue, the Board found that the facts in this case created an exception to the "must-bill" policy and reversed the MAC's adjustment of the bad debts. The Board cited the settlement agreement referred to the brief filed in the case of *Community Hospital of Monterey Peninsula v. Thompson*

(Monterey)[1] to create an exception to the must-bill policy in this case. The Board stated that the Provider was in a similar situation to the Providers referenced in the *Monterey* brief who were excluded from the must-bill requirement because of their designations as either community mental health centers (CMHCs) or institutions for medical diseases (IMDs) and, thus, the same exception should apply in this case. In addition, the Board supported its decision to reverse the adjustments by referring to the "Catch-22" language provided in *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2nd 13, 28 (D.D.C. 2012), asserting that requiring an individual provider to take legal action against its own state is not a viable means for the provider to receive bad debt reimbursement. Lastly, the Board claimed that bad debt payments made in years prior by the contractor on similar dual eligible bad debt claims "constitutes an explicit or affirmative agency action on policy" in which the MAC exempted the Provider from the must-bill policy by accepting alternative documentation.[2]

The second issue in this case was for a singular claim filed on behalf of an out-of-State beneficiary that resided in Kansas. The Board held that the Provider admittedly chose not to enroll in the State's Medicaid program and the Board affirmed the MAC's dual-eligibility adjustments holding that the Provider Review Reimbursement Manual (PRM) 15-1 §310 clearly establishes that providers have an obligation to bill "the responsible party" and if a state Medicaid program can be billed on behalf of its enrollees, then it should be. Additionally the Board noted that PRM 15-1 §322 confirms that, if the Medicaid State plan provides payment of Medicare coinsurance and deductibles, then the amount of payment cannot be included in Medicare bad debt. The Board stated that the responsibility to bill the State is not predicated on whether the Provider does, or does not, participate in the relevant State Medicaid program citing both the recent Administrator's decision in *Select Specialty'05 Medicare Dual Eligible Bad Debt Grp. v. Blue Cross Blue Shield Ass'n* (Select)[3] and the U.S. District Court of the District of Columbia decision in *Cove Assoc. Jt. Venture v. Sebelius* (Cove).[4]

SUMMARY OF COMMENTS

The Provider commented requesting that the Administrator affirm the portion of the Board's decision that reversed the MAC's bad debt adjustment for the in-State Oklahoma beneficiaries and reverse the portion of the Board's decision that affirmed the MAC's dual eligible bad debt adjustment for the out-of-State Kansas beneficiary.

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[1] Case No. C-01-0142 (N.D. Cal. Oct. 11, 2001).
[2] Provider Exhibits 35-37.
[3] CMS Adm'r Dec. (Mar. 14, 2016), *on remand from, Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2nd 13 (D.D.C. 2012).
[4] 848 F. Supp. 2d 13, 25 (D.D.C. 2012).

The Provider claimed that the Intermediary's must-bill policy has no foundation in law and that the application of the must-bill policy when the Provider does not participate in Medicaid programs is improper. The Provider alleged that there has never been a court decision that addresses whether the must-bill policy applies to providers that did not participate in Medicaid.

First, the Provider addressed the Oklahoma bad debt claims where the State would not enroll the Provider because it was a LTCH. The Provider pointed to the settlement referenced in the *Monterey* filings in which the Secretary allowed exceptions to the must-bill policy for providers based on their designation as community mental health centers (CMHCs) and institutions for medical diseases (IMDs). The Provider argued that, although the Administrator has previously pointed out that the exceptions applied in *Monterey* were for the limited purposes of that settlement, that the discussion used should still apply to this scenario because the Secretary did not specifically state that the rationale provided in its' brief was only applicable to that case. Additionally, the Provider insisted that the "Catch-22" rationale from *Cove* supports that it would be unreasonable of CMS to expect the Provider to file suit against the State to enforce the State's obligation to provide State issued RAs for non-Medicaid participants. Lastly, the Provider also contended there was legitimate reliance for the Provider that the MAC would reimburse these bad debt claims as it had in previous years. Thus, the Provider claimed that previous reimbursement on these claims without a state-issued RA should create an exception to the must-bill policy for this Provider. Based on these reasons, the Provider asserted that the disallowances by the MAC on these claims for Oklahoma should be reversed.

Second, in regard to the bad debt claim in which the Provider did not enroll in the Kansas State Medicaid, the Provider alleged that there is no must-bill requirement in this instance as Kansas has no responsibility for the bad debt at issue. Furthermore, the Provider declared that requiring this Provider to enroll in a State Medicaid program in which the LTCH does not reside would be an unreasonable expectation which would require all Providers to enroll in every State's Medicaid program in the event that they treat an out-of-State patient.

The MAC commented, requesting that the Administrator uphold the Board's decision affirming the MAC's disallowance of dual eligible bad debts where the Provider chose not to enroll in the State Medicaid program, and reverse the Board's decision to reverse and remand the MAC's disallowance of dual eligible bad debt adjustments where the corresponding State's Medicaid program would not enroll a LTCH.

The MAC asserted that, even though the Provider was not enrolled, or could not be enrolled in the Oklahoma Medicaid program, the program still has a responsibility to issue RAs. The MAC pointed out that the Administrator has previously addressed all the issues the Board used in its decision and, instead, the Board is relying on equitable principles to grant the Provider relief. The MAC stated that the Board is not a court of equity and there is no statutory or regulatory basis in which relief may be granted in this case. The MAC

maintained that the Provider must bill the State Medicaid program and receive a RA in order to received bad debt reimbursement.

The Centers for Medicare (CM) commented requesting that the Administrator uphold the Board's decision to affirm the MAC's disallowance of the bad debt claim for the out-of-State claim where the Provider chose not to enroll in the Medicaid program and reverse the Board's allowance of the bad debts claimed for the second group on which the Oklahoma Medicaid allegedly refused to enroll LTCHs for the cost reporting periods in question. CM stated that the Board was correct to affirm the disallowance in the first instance because the Provider made a choice not to enroll in the Kansas' Medicaid program and, therefore, did not bill and receive the necessary State-issued RAs. Regarding the second issue, CM claimed that the Board erred in reversing the MAC's disallowance of the dual eligible bad debts. CM pointed out that there is a longstanding "must bill" policy and that the Administrator has consistently held that the requirement for the Provider to bill and receive a State issued RA has been previously upheld, even in situations where the respective State fails to meet its statutory responsibility to reimburse bad debt.

Regarding the first issue, CM stated that the Board properly affirmed the MAC's disallowance of the bad debt reimbursement for failure to adhere to the "must bill" policy for the bad debt adjustment in Kansas because the Provider could have enrolled in the Kansas Medicaid program, but chose not to do so. Provider Review Reimbursement Manual (PRM) §§310, 312 and 322, complying with 42 CFR §413.89(e)(2), sets forth the criteria for the reasonable collection effort of bad debts when a patient is a dual eligible QMB. The PRM establishes the requirement that the Provider must bill and receive a State issued remittance advice in order to fulfill reasonable collection efforts.

On the second issue where the Provider alleged it was ineligible to enroll in the Oklahoma Medicaid program based on its LTCH designation and, thus, was unable to obtain a billing number needed for the purpose of billing and receiving a state RA; CM disagrees with the Board's finding that the MAC incorrectly denied the dual eligible bad debt claims. CM stressed that there is no exception to the "must-bill" policy. Specifically, CM argued that there is no exception in the case of IMDs or CMHCs as alleged by the Board. Rather, CM distinguished that IMDs are excluded from Medicaid payments by §1905(a) of the Act and, therefore, meet all the criteria under §42 CFR §410.89 and Chapter 3 of the PRM and are eligible for the payment of unpaid deductible and coinsurance bad debts without producing a State RA. In regard to CMHCs, CM stressed that this was permitted as a one-time bad debt reimbursement as the result of a limited settlement agreement dealing only with CMHCs in California and does not exclude the statutory requirement that a State must determine its cost sharing by processing dual eligible beneficiary claims for all types of Medicare certified providers-whether or not the State covers services under its plan. Where a State has refused its statutory responsibility to provide State issued RAs in these

instances, CM has suggested that the providers should seek judicial remedy similar to the Florida Providers in *Alpha Comm. Mental Health Ctr. v. Benson*[5].

CM also disagreed with the Board's findings that "the exhibits demonstrate the Medicare contractor in these cases exempted the Provider from the must-bill policy until December 2008." CM instead pointed out that the letter and "bad debt documentation" does not support the assertion that the contractor exempted the Provider from the must-bill policy. The Board incorrectly found that the Provider "justifiably relied on prior audit treatment that allowed these bad debts without billing the state." CM stated that a provider's submission of bad debt reimbursement on its cost report is often not reviewed or audited and, thus, "prior audit treatment" where there is no evidence a MAC reviewed the documentation does not rise to the level of an affirmative agency exception to a policy.

Lastly, CM argued that the "Catch 22" argument in *Cove* incorrectly attempted to place the burden on CMS to resolve a provider's failure to obtain the necessary RA from the state. CM instead contended that the Oklahoma Medicaid, in failing to issue state issued RAs, ignored both a statutory duty to determine its cost sharing liability for dual eligible beneficiaries and the meaning and effect of 3490.14(B) of the State Medicaid Manual (SMM) which provides a mechanism by which a provider can bill the State for the determination of the State's cost sharing amounts without actually being or becoming a Medicaid provider.

Discussion

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

Medicaid State Plans

Relevant to the issue involved in this case, two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.[6] 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

[5] Case. No. 2008 CA 004161 (2nd Cir. 2010).
[6] Section 1901 of the Social Security Act (Pub. Law 89-97).

categorically needy.[7] 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.[8]

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.[9] If the State plan is approved by CMS, under section 1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[10] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for "medical assistance" under the State plan.

In particular, section 1901 of the Act sets forth that appropriations under that title are "[for the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services…." Section 1902 sets forth the criteria for State plan approval.[11] Section 1902(a)(10)(E)(i) of the Act requires Medicaid State plans to make "medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries…."

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

[7] Section 1902(a) (10) of the Act.
[8] Section 1902(a) (1) (C) (i) of the Act.
[9] *Id*. §1902 *et seq.*, of the Act.
[10] *Id.*
[11] 42 C.F.R. §200.203 defining a State plan as "a comprehensive written commitment by a Medicaid agency submitted under section 1902(a) of the Act to administer or supervise the administration of a Medicaid plan in accordance with Federal requirement."

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

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

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

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

> Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

Section 1902(n) provides that:

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

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 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]

Medicare

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

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

[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.

B program by entering into an agreement with the Secretary and by paying the Medicare premiums and deductibles and coinsurance for its recipients as part of its Medicaid program.

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

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

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

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

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

Unpaid Coinsurance and Deductibles

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

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 deductible or coinsurance amounts that the State is not obligated to pay can

[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.

> 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.)

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 payment even where the State Medicaid program does not cover the service.

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 the Medicaid payment rates and, thus, to determine the State's cost sharing liability for unpaid Medicare deductibles and coinsurance. In addition, it is clear from section 322 of the PRM that the amount that can be claimed as bad debts is the amount the State "does not pay" which presumes that the State has been billed and the State had rendered a determination on such a claim.

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 a State where Medicaid does not fully pay for the QMBs cost sharing, CMS determined that Medicare may reimburse providers' bad debts.

The amount of the cost-sharing to be paid is best determined by the State. Section 1902(n) provides the State Medicaid programs with some flexibility in setting their Medicare cost-sharing payment methods specifically for QMBs, but has historically also been applied to QMB Plus and Full Benefit Dual Eligibles. The cost sharing amounts that 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, the State has greater flexibility in setting the negotiated rate, but the rate must be sufficient for the State to assure CMS that it will not adversely affect access to care for the beneficiary.[15]

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[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.

[15] 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

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

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

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).

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

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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.

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[16] 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.

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.
>
> ****
>
> 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.*[17]

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. [18]

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 determination made by the State in order to establish the amount of bad debts owed under Medicare. The above policy has been consistently articulated in the final decisions of the Secretary addressing this issue, since well before the cost year in this case.[19]

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[17] *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

[18] *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.

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

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

Other controlling precedence and guidance for dual-eligible patients' unpaid coinsurance and deductibles are reflected in Administrator decisions and CMS policy pronouncements. The Administrator, through adjudication, addressed this policy in many cases including *Community Hospital of the Monterey Peninsula*, PRRB Dec. No. 2000-D80 (Oct. 31, 2000). As a result of that litigation, CMS issued a joint memorandum on August 10, 2004 regarding bad debts of dual-eligible beneficiaries. The Joint Signature Memorandum (JSM-370) restated Medicare's longstanding bad debt policy that:

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

The memorandum noted that in *Community Hospital of Monterey Peninsula v. Thompson*, 323 F.3d 1079 (9th Cir. 2008), the Ninth Circuit upheld this policy of the Secretary. Section 1905(p)(3) of the Act imposes liability for cost sharing amounts for QMBs on the States through section 1902(n)(2) that allows the States to limit that amount to the Medicaid rate and essentially pay nothing towards dual-eligible cost sharing if the Medicaid rate is lower than what Medicare would pay for the service. Where the State owes none, or a portion of the dual-eligible deductible and coinsurance amounts, the unpaid liability for the bad debt is not reimbursable until the provider bills the State and the State refuses payment, all of which is demonstrated through a Remittance Advice. Importantly, the memorandum also indicated that, in November 1995, language was added to the PRM at section 1102.3L, which was inconsistent with this policy. The Ninth Circuit panel found that section 1102.3L was inconsistent with the Secretary's policy and also noted that, effective in August of 1987, Congress had imposed a moratorium on changes in bad debt reimbursement policies and, therefore, the Secretary lacked authority in November of 1995 to promulgate a change in policy. As a result of the Ninth Circuit decision, CMS changed the language in PRM—II Section 1102.3L to revert back to pre-1995 language, which requires providers to bill the individual States for dual-eligible co-pays and deductibles before claiming Medicare bad debts. The CMS JSM also provided a limited "hold harmless provision."[20]

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

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[20] This memorandum also served as a directive to hold harmless providers that can demonstrate that they followed the instructions previously laid out at 1102.3L, for open cost reporting periods beginning prior to January 1, 2004. Intermediaries who followed the now-obsolete section 11102.3L instructions for cost reporting periods prior to January 1, 2004, may reimburse providers they service for dual eligible bad debts with respect to unsettled cost reports that were deemed allowed using other documentation in lieu of billing the State. Intermediaries that required the provider to file a State Remittance Advice for cost reporting periods prior to January 1, 2004 may not reopen the provider's cost reports to accept alternative documentation for such cost reporting periods. This hold harmless policy affects only those providers with cost reports that were open as of the date of the issuance of the memorandum relating to cost reporting periods before January 1, 2004 and who relied on the previous language of section 1102.3L in providing documentation. The cost years in this case are all post-the hold harmless cost years. The relevance to the hold harmless provision in this case maybe whether it was applied for some of the Providers' prior cost years raised during the discussion of whether the MAC had made payments prior to 2008. For example, Exhibit 35 is for cost year ending 08/31/2004.

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.[21]

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

Consistent with the statute, regulation and PRM, a provider must bill the State and the State must process the bills or claims to produce a remittance advice for each beneficiary to determine their Medicaid status, at the time of service and the State's liability for unpaid Medicare deductible and coinsurance amounts. Thus, it is unacceptable for a provider to write-off a Medicare bad debt as worthless without first billing the State and receiving a determination from the State. Even in cases where the provider has calculated that the State has no liability for outstanding deductible and coinsurance amounts, the provider must bill the State and receive a remittance advice before claiming a bad debt as worthless because, as stated above, the State has the most current and accurate information to make a determination on the beneficiaries' status at the time of the services and to determine the State's cost sharing liability for all covered stays of dual eligible beneficiaries.[22]

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

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

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

The Provider in this case is a Medicare-certified LTCH located in Oklahoma but within driving distance for out-of-state patients from several other States, including Kansas, Missouri and Arkansas. For the fiscal years at issue (FYEs 08/31/2007 and 08/31/2008), there were two separate States involved- one QMB patient from Kansas[23] and the remaining beneficiaries were located in-State. The Provider was not enrolled in any State Medicaid programs. The Provider admittedly chose not enroll in Kansas Medicaid[24] and it alleged that it was not able to enroll in the Oklahoma Medicaid program because it was designated as a LTCH.[25]

The Provider claimed bad debts for dual eligible crossover claims and the MAC disallowed such claims for failure to submit a State issued RA. In the past, the Provider alleged that the MAC had paid the Provider for dual eligible bad debts.[26] The Provider claimed these payments were sufficient enough to create a must-bill exception.

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 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) and Chapter Three of the PRM. In the specific instance of the Kansas Medicaid patient, the Providers failure to obtain a remittance advice was not due to reliance on any affirmative action on the part of CMS, but due rather to the Provider's business decision not to enroll in the respective State's Medicaid program.

The non-Medicaid enrollment status of a provider does not change the legal responsibilities that result from the dual eligible status of a Medicare beneficiary for which a State may be liable for cost sharing amounts depending upon its Medicaid rate. The Board erroneously relied upon the "Catch-22" dicta introduced by the D.C. District Court in 2012 in Cove Associates. Jt. Venture. V. Sebelius,[27] in which the Court indicated that the 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 remittance advices. The Court further noted a reluctance to "place a stamp of approval on a policy that would put non-participating

[23] See Exhibit P-48. This patient was identified internally by patient number on the next to last line of the listing at Exhibit P-47. The internal insurance code in the second column refers to Kansas Medicaid. See Hillcrest Medical Center insurance plan codes at Exhibit P-48, at 5.
[24] Provider's Post Hearing Brief at 26.
[25] Provider Exhibits P-7 and P-8.
[26] See Exhibit P-35-P-37.
[27] 848 F. Supp. 2d 13 (D.D.C. 2012).

providers in the position of not being paid due to the delinquency of federally funded state programs."[28]

However, the State has a statutory obligation to determine its cost sharing liability concerning dual eligible beneficiaries, regardless of the Medicare-only participating status of the entity providing the services.[29] This legal responsibility is reflected in CMS' State Medicare Manual (SMM), wherein it is set forth the state's statutory duty to determine its cost sharing liability. Section 3490.14(B) specifically provides that:

> [S]ubject 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. 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 the Medicaid 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 noninsurance for QMBs.

Consequently, a State must be able to process dual eligible beneficiary claims to determine the State's cost sharing liability. In instances where the State does not process a dual eligible claim, a Provider's remedy must be sought with the State.[30] If a State does not have the ability to process dual eligible beneficiary claims for all types of Medicare providers, then the State is out of compliance with the Federal statute and the state must be forced to comply. Where States are made aware of their duty and still refuse to enroll Providers for the purpose of billing and receiving remittance advices, or otherwise refuse to process non-enrolled providers' claims, then the appropriate course would be for the Provider to take legal action with their State. CM pointed to a similar situation in Florida[31] where a provider successfully brought forth a case against the State Medicaid agency for failure to comply with the Federal statute to process claims for dual eligible beneficiaries so that the State could produce a remittance advices and determine its cost sharing liability. Thus, the Administrator finds that for non-Medicaid participating Providers, it is in many situations a business decision not to enroll in Medicaid and, regardless, that the State has a legal responsibility to process the claim for dually eligible patient claims for Medicare only providers. Finally, there is legal recourse available for Providers to require States to issue

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[28] *Id*, at 28.
[29] *See, e.g*., section 1902(a)(10)(E) of the Act.
[30] *See Alpha Comm. Mental Health Ctr. v. Benson*, Case No. 2008 CA 004161 (2nd Cir. 2010).
[31] *Id.*

remittance advices. Accordingly, the "Catch-22" description is not an accurate description, nor an appropriate legal basis for the Board to allow an equitable payment to the Providers.[32]

The Provider also claimed that the MAC had paid previous cost year claims that were allegedly submitted without State remittance advices and, accordingly, the Provider argued that this was evidence they were thus exempt from this requirement. Notably, there is no statement in the JSM, related PRM sections, or prior Administrator decisions (including multiple situations where providers have also claimed "impossibility")[33] distinguishing non-Medicaid participating hospitals from participating providers in the application of the policy. This is not surprising as a State has a legal responsibility for cost sharing for dually eligible even where a provider is Medicare participating only. Additionally, the Providers have not provided evidence to demonstrate that the CMS affirmatively misled the Providers that the must bill policy did not apply to them because they were non-Medicaid participants.

In addition, any allowance of bad debts contrary to the must-bill policy, as the Provider has alleged happened in the past, does not constitute an explicit or affirmative agency action on policy. Generally, MAC's do not review every item of the cost report every year. The focus, scope and criteria for annual audits change from year to year. Further, may incorrectly receive payment for an undocumented claim, either because the matter was not audited or the MAC misapplied policy, but that does not relieve the provider of its responsibility to follow the rules and regulations of CMS. Such an error to allow for payment, if made by the MAC, also does not demonstrate that CMS has abandoned or changed a policy or otherwise authorized such payment. In addition, CMS did allow a limited hold harmless provision for years beginning prior to January 1, 2004, and some of the documentation relates to a FYE 08/2005. The PRM criteria 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. Under section 1815, 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, consistent with the statute, the regulations require that providers maintain verifiable and supporting documents

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[32] 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. Therefore, while the CMS may be in a better position to enforce Federal law, an agency compliance action is not a specific timely 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. As noted, *supra,* CMS has been working with States to assist them in this particular legal obligation.

[33] *See e.g. Village Green Nursing Home, PRRB Dec. No*. 2000-D59, where Administrator upheld disallowance for bad debts.

to justify their requests for payment under Medicare. The regulation at 42 CFR 413.20 provides that: "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for provider determination of costs payable under the program….Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained…." As used in the context of the regulation at §413.20, "maintain" means that the provider is required to keep "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 Providers also relied upon a footnote in the Secretary's "Defendant's Memorandum in Reply to the Plaintiffs Opposition to Defendant's Motion for Summary Judgment"[34] in the District Court case of *Community Hosp. of Monterey Peninsula v. Thompson* as a basis for claiming that there should also exist an exception for these LTCHs to the must-bill policy. The Administrator notes that 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.[35] The District Court ruled against the Secretary on the must-bill policy at the District Court. However, on appeal, this case was overturned by the United States Court of Appeals, Ninth Circuit, and remanded to the District court in the Secretary's favor. 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."[36] 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.[37] Even assuming arguendo such a policy existed, in this instance the Provider holds a LTCH designation only for purposes of exclusion from the Medicare Inpatient Prospective Payment System. 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 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

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[34] Defendant's Memorandum in Reply to Plaintiffs' Opposition to Defendant's Motion for Summary Judgment at 9n.5, *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C-01-0142, 2001 WL 1256890 (N.D. Cal. Oct. 11, 2001)

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

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

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

except for inpatient psychiatric hospitals services for individuals under age 21." Thus, the Administrator finds that the footnote in the brief in Community Hosp. does not create an exception to the must-bill policy for Medicare only participating LTCHs.

In light of the foregoing, the Provider has not demonstrated that the bad debts that were identified by the Provider was actually uncollectible and worthless. The fact remains that States are in the best situation to make a determination on the State's share of cost sharing and that States will always have some amount of cost sharing liability for beneficiaries' deductibles. Because the State has not issued remittance advices for these services contemporaneous with the cost reporting periods, 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 they have 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 cost-sharing amount of the coinsurance and deductible and the State has not made a determination on these claims, the elements of the bad debts regulation are not met in this case.

Decision

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

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

Date: 1/8/18

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