PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2017-D6

PROVIDER –
Memorial Hermann Continuing Care Hospital

Provider No.: 45-2072

vs.

MEDICARE CONTRACTOR –
Cahaba Safeguard Administrators, LLC

HEARING DATE –
February 19, 2014

Cost Reporting Periods Ended –
February 28, 2005; February 28, 2007

CASE NOs.: 06-2131; 10-0547

INDEX

ISSUE

Whether the Medicare Contractor's adjustment to apply the "must-bill" policy to bad debts related to dual eligible Medicare and Medicaid beneficiaries was proper. [1]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that Cahaba Safeguard Administrators ("Medicare Contractor") [2] properly adjusted the Medicare bad debts related to Medicare and Medicaid dual eligible beneficiaries on the cost reports covering the fiscal years ("FYs") 2005 and 2007[3] for Memorial Herman Continuing Care Hospital ("MHCCH" or "Provider").

INTRODUCTION

MHCCH is a Medicare-certified long term care hospital ("LTCH") located in Houston, Texas. In its cost reports for FYs 2005 and 2007, MHCCH claimed bad debt reimbursement attributable to unpaid deductible and coinsurance amounts for Medicare patients, who were also eligible for benefits under the state's Medicaid program (these beneficiaries are commonly referred to as "dual eligible" beneficiaries). MHCCH did not participate in the Texas Medicaid program during the years under appeal and, therefore, did not bill the Texas Medicaid program for any deductible and coinsurance attributable to these dual eligible beneficiaries. The Medicare Contractor disallowed the bad debts related to the dual eligible beneficiaries because MHCCH had not billed the State Medicaid agency.[4]

MHCCH filed timely appeals of their Notices of Program Reimbursement ("NPR"s) with the Board and met the jurisdictional requirements for a hearing. The Board held a hearing on the record for these appeals. MHCCH was represented by R. Jeffrey Layne, Esq., of Norton Rose Fulbright. The Medicare Contractor was represented by Robin Sanders, Esq., of the Blue Cross Blue Shield Association.

STATEMENT OF THE FACTS

The Medicare Contractor disallowed MHCCH's Medicare bad debts related to dual eligible beneficiaries, because MHCCH did not bill the Texas Medicaid program and could not produce remittance advices ('RAs") showing that the State Medicaid program was not liable for the

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[1] This is the only remaining issue in this appeal, *i.e.*, Case Nos. 06-2131 and 10-0547. Initially, MHCCH was part of a group case made up of related parties with multiple issues. However, the parties entered into administrative resolutions for many of the other issues. The group case was then reorganized resulting in the spin off of these two cases which were consolidated for purposes of the hearing. *See* Joint Stipulation dated October 23, 2013 (attached to the letter sent to Chris Zielonis from Norton, Rose Fulbright dated October 23, 2013).

[2] The Medicare contractor who audited the cost reports was Trailblazer Health Enterprises, LLC, but the appeals responsibility has been since reassigned to Cahaba Safeguard Administrators.

[3] MHCCH's fiscal year ends on February 28th (*e.g.*, FY 2005 ended on Feb. 28, 2005).

[4] Medicare Contractor's Consolidated Final Position Paper at 10.

unpaid coinsurance or deductible amounts.[5] Relying on CMS' Joint Signature Memorandum 370 ("JSM 370") issued August 10, 2004, the Medicare Contractor supported its disallowance saying that CMS' "must bill" policy requires a provider to: 1) bill the state Medicaid program for unpaid deductibles and copayments and 2) obtain a statement, *i.e.*, an RA from the state Medicaid agency identifying the amount of payment or the reason for non-payment. [6]

Medicare regulations at 42 C.F.R. § 413.89(a) (2004)[7] establish a general rule that bad debts are deductions from revenue and are not considered to be allowable costs. Subsection (d) provides an exception to this general rule, namely that bad debts attributable to Medicare deductibles and coinsurance may be reimbursable as allowable costs. Subsection (e) provides the following criteria that bad debts must meet in order to be reimbursed:

> (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 that there was no likelihood of recovery at any time in the future.[8]

CMS has provided extensive guidance on its bad debt policy at CMS Pub. 15-1, Provider Reimbursement Manual Part 1 ("PRM 15-1") §§ 308, 310, 312 and 322. PRM 15-1 § 308 requires that the provider make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible. PRM 15-I § 310 iterates that a "reasonable collection effort" involves the issuance of a bill on or shortly after discharge or death….[9] A provider may "deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively"[10] and avoid further collections efforts against its Medicaid-eligible patients.

While the providers need not take further steps to prove that its dual eligible patients are indigent, subsection C of § 312 also requires providers to "determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian . . .".[11] This guidance further directs providers to § 322 for direction regarding the liability of State Medicaid programs for payment of deductibles and coinsurance of dual eligibles and claiming amounts not covered by the State Medicaid program as Medicare bad debts if they meet the requirements of § 312.[12] Finally, in order to be eligible for Medicaid payments, most state Medicaid programs require that a provider be enrolled or certified as a provider in the state

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[5] *See* Provider Exhibit P-15 at 4.
[6] *Id*. at 13.
[7] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).
[8] 42 C.F.R. § 413.89(e).
[9] PRM 15-1 Chapter 3 § 310.
[10] PRM 15-1 Chapter 3 § 312.
[11] *Id.*
[12] PRM 15-1 Chapter 3 § 322.

Medicaid program.[13]

However, in 1987, Congress enacted a noncodified statutory provision that became known as the "Bad Debt Moratorium."[14] The Moratorium, as amended, prevents the Secretary of Health and Human Services from making any change in her bad debt policy relating to unrecovered costs associated with unpaid deductible and coinsurance amounts (including the criteria for what constitutes a reasonable collection effort, criteria for the determination of indigency, record keeping and whether to refer a claim to an external collection agency) that was in effect on August 1, 1987. Further, the Moratorium prevents the Secretary from requiring a hospital to change its bad debt collection policy if a fiscal intermediary had accepted the policy that was in effect as of August 1, 1987.[15]

In this case the parties have stipulated that participation in Texas Medicaid was voluntary, that MHCCH could but did not enroll as a participating provider during the period under appeal, and that there is no mechanism for non-participating Medicaid providers to bill Texas Medicaid and obtain RAs.[16]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

MHCCH contends that the Secretary's must-bill policy has no basis in Medicare statute or regulations, and is inconsistent with the existing regulatory framework. MHCCH asserts that there is no Medicare regulation or guidance that requires providers to bill Medicaid or any other possible sources of payment before claiming unpaid amounts as a Medicare bad debt.[17] Rather MHCCH asserts that Medicare simply requires "the provider make a reasonable collection effort and apply sound business judgment."[18] MHCCH also claims the "must bill" policy is arbitrary and capricious because the Medicare Contractor's previous audits did not require RAs but rather accepted documentation that the patient was Medicaid eligible during the patient's stay.[19]

MHCCH further argues that the Secretary improperly changed her bad debt policy with respect to dual eligible beneficiaries through JSM 370, dated August 10, 2004 which required Medicare-certified hospitals to bill Medicaid to obtain a remittance advice before claiming the unpaid amount as a Medicare bad debt. MHCCH argues that a JSM is not an appropriate vehicle to set policy.[20] MHCCH contends that the "must bill" policy itself violated both prongs of the Bad Debt Moratorium. Specifically, MHCCH contends that: (1) CMS violated the first prong because CMS issued JSM 370 to change federal bad debt policy that was in effect in August

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[13] 42 C.F.R. § 431.107(2006).
[14] § 4008(c) of the Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330, 1330-55 (1987). The Moratorium was amended by § 8402 of the Technical and Miscellaneous Revenue Act of 1988, and § 6023 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2167.
[15] Reprinted at 42 U.S.C. § 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services."
[16] *See* Joint Stipulations at IV. Stipulations for Bad Debts Denied Based on the Must-Bill Policy, B – General Stipulations 1-3.
[17] Providers' Consolidated Position Paper at 20.
[18] *Id.* at 21.
[19] *Id* at 24-25.
[20] *Id.* at 20-21.

1987;[21] and (2) that CMS violated the second prong because the Medicare Contractor had previously accepted MHCCH's bad debts without requiring Medicaid billing and a remittance advice.

In support of its position, MHCCH cites multiple decisions by the Board and other federal courts,[22] including several decisions by the District Court for the District of Columbia ("D.C. Court"), upholding the Bad Debt Moratorium.[23] In particular, the MHCCH asserts that its continuing care facilities are in the same "Catch-22" situation discussed in *Cove Associates Joint Venture v. Sebelius* ("*Cove*").[24] In *Cove*, the D.C. Court found that providers were in the untenable situation of being unable to bill the state Medicaid program and, thus, forced to either not treat Medicaid patients or absorb the bad debt resulting from unpaid deductibles and copayments.

MHCCH further notes that, in previous audits, the Medicare Contractor had accepted the MHCCH's documentation of a patient's indigency and allowed the bad debt. MHCCH contends that the Medicare Contractor's rejection of this indigency documentation in this case deviates from its prior practice and, thereby, is an abuse of discretion and arbitrary and capricious.[25] In this regard, MHCCH relies on the Fifth Circuit's decision in *Harris County Hosp. District v. Shalala* ("*Harris*").[26] In *Harris*, the Fifth Circuit held that the Medicare contractor violated the Bad Debt Moratorium when it rejected the hospital's policy on indigency that it had, in previous years, accepted.

Having considered the position of the parties, the evidence presented and the statutory and regulatory authority, the Board finds that pre-1987 bad debt policy in the PRM clearly established that providers have an obligation to bill "the responsible party." The Board recognizes that this decision differs from the Board's findings and conclusions in its 2010 decision in *Select Specialty '05 Medicare Dual Eligible Bad Debt Grp. v. Blue Cross Blue Shield Ass'n* ("*Select*").[27] However, the Board now has the benefit of considering several federal court decisions on this matter as well as the Administrator's decision upon remand of the *Select* case from the U.S. District Court for the District of Columbia ("D.C.").[28]

Three federal circuit courts of appeal have reviewed CMS' "must bill" policy. While none of the decisions applied the Bad Debt Moratorium, they are still instructive as to CMS' policy. The First Circuit concluded that "some version" of a "must bill" policy has generally been enforced and that a general requirement (as opposed to a *per se* requirement) to obtain a Medicaid RA for crossover claims is entitled to deference where "the Secretary has made exceptions and accepted

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[21] *Id.*
[22] *Id.*
[23] *See* Provider's Consolidated Position Paper at 8-9 (citing to *Foothill,* 558 F. Supp. 2d 1 (D.D.C. 2008); *District Hosp. Partner, L.P. v. Sebelius,* 971 F.Supp.2d 15 at 26-27 (D.D.C. 2013)).
[24] 848 F.Supp 2d 13 (D.D.C., 2012) ("Cove").
[25] *See* Provider's Consolidated Position Paper at 24-25 (referencing *Cove Assocs. Joint Venture v. Sebelius*).
[26] *See* 64 F.3d 220 (5th Cir. 1995).
[27] PRRB Dec. No. 2010-D25 (Apr. 13, 2010), *rev'd,* CMS Adm'r Dec. (Mar. 2016).
[28] *Select Specialty '05 Medicare Dual Eligible Bad Debt Grp. v. Blue Cross Blue Shield Ass'n*, CMS Adm'r Dec. (Mar. 14, 2016), *on remand from, Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp 2d. 13 (D.D.C. 2012).

the alternative documentation *from the State* where circumstances warranted the exception."[29] Similarly, the D.C. Circuit found that it is "sensible for the Secretary to require that the state determine in the first instance the Medicaid eligibility of the claims and the appropriate amount of state payment owed."[30] Finally, the Ninth Circuit deferred to the Secretary's reasonable determination that "the must bill policy is a 'fundamental requirement to demonstrate' . . . that reasonable collection efforts [have been] made and that 'the debt was actually uncollectible when claimed [as worthless].'"[31]

As previously discussed, PRM 15-1 § 322 confirms that, if the Medicaid state plan provides payment of Medicare coinsurance and deductibles (in whole or in part), then the amount of payment cannot be allowable as Medicare bad debt. Significantly, this is a blanket requirement that is not predicated on whether the provider does or does not participate in the relevant state Medicaid program.[32] Second, this excerpt cross-references the requirement of § 310 confirming that, *at a minimum*, the § 310 requirement to "bill . . . the party responsible" is applicable to crossover claims (*i.e.*, claims involving dual eligibles).[33] Further, as previously noted, PRM § 322 pre-dates and complies with the first prong of the Bad Debt Moratorium.[34]

Based on § 322, the Board disagrees with the Provider's assertions that, as *non*-participating providers, they would not have to bill the State Medicaid program. In this regard, MHCCH does not claim that the Texas Medicaid program would not allow MHCCH to become a Medicaid

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[29] *Maine Med. Ctr. v. Burwell,* 775 F.3d 470, 475, 480 (1st Cir.2015) (emphasis in original).
[30] *Grossmont Hosp. Corp. V. Burwell,* 797 F.3d 1079, 1085 (D.C. Cir. 2015), *reh'g en banc denied,* (D.C. Cir. Oct. 19, 2015).
[31] *Community Hosp. of Monterey Peninsula v. Thompson,* 323 F.3d 782, 792, 796 (9th Cir. 2003).
[32] *See also Cove Assoc. Jt. Venture v Sebelius,* 848 F. Supp. 2d 13, 25 (D.D.C. 2012).
[33] The Board recognizes that CMS issued a transmittal in November 1995 revising cost reporting instruction on bad debt documentation to allow providers "in lieu of billing" to submit alternative documentation to establish that nonpayment would have occurred if the crossover claim had been billed. *See* PRM 15-2, Ch. 11, Transmittal No. 4 (Nov. 1995) (revising PRM 15-2 § 1102.3). However, the Board notes that this decision does *not* opine on whether this 1995 transmittal does or does not violate the Bad Debt Moratorium (*i.e.,* whether that portion of CMS' "must bill" policy that requires billing of crossover claims even when nonpayment would have occurred if the crossover claim had been billed violates the Bad Debt Moratorium) because neither this sub-issue nor this transmittal are relevant to deciding the issues in this case. In this regard, the Board notes that, while MHCCH has asserted that California would not have paid any of the claims at issue based on certain information obtained from the Texas State Medicaid Program (*see* Provider's Consolidated Position Paper at 27), MHCCH has not furnished any evidence such as affidavits or documentation from the Texas Medicaid Program to support its assertion and calculations.
[34] In support of its position, the Board notes the following examples of pre-1987 agency statements and Board cases applying CMS' bad debt policy: HCFA Action No. HCFA-AT-77-73 (MMB) (July 5, 1977) (responding to questions about a change in federal law in January 1968 which made payment of Medicare deductible and copayments by the state Medicaid program optional); *Geriatric and Med'l Ctrs., Inc. v. Blue Cross Ass'n*, PRRB Dec. No. 1982-D62 (Mar. 3, 1982) (finding that "the cost of these services were not included in payments for services covered by the State of Pennsylvania"), *decl'd review,* HCFA Adm'r (Apr. 23, 1982); *Concourse Nursing Home Grp. Appeal v. Travelers Ins. CO.,* PRRB Dec. No. 1983-D152 (Sept. 27, 1983) (finding that "the Provider has furnished no documentation which would support its contentions that it had established collection policies and procedures or that actual collection efforts were made to obtain payments from the patient or the Medicaid authorities before an account balance was considered . . . bad debt"), *decl'd review*, HCFA Adm'r (Nov. 4, 1983); *St. Joseph Hosp. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 1984-D109 (Apr. 16, 1984) (finding that "the Provider did not attempt to bill the State of Georgia for its Medicaid patients"), *decl'd review*, HCFA Adm'r (May 14, 1984).

participating provider if it chose to apply. Rather, it appears that MHCCH made a discretionary business decision not to enroll in the Texas Medicaid program even though such a choice precludes it from being able to bill the program and obtaining the required RAs to document the state's cost sharing liability.[35] For this reason, the Board concludes the Medicare Contractor correctly denied bad debt reimbursement.

Finally, MHCCH urges the Board to find, consistent with the Fifth Circuit in *Harris*, that the Medicare Contractor had accepted its bad debts in prior years without requiring that the Texas Medicaid program be billed, and that the Medicare Contractor violated the second prong of the Bad Debt Moratorium by requiring MHCCH to change its Medicaid billing policy.[36] However, in *Harris*, the Fifth Circuit states in dicta: "The OBRA's prohibition against forcing a change in hospital policy is triggered by the intermediary's acceptance of the hospital's existing policies before August 1, 1987."[37] Significantly, the Board finds no evidence in the record to document or confirm: (1) what MHCCH's Medicaid billing policy was prior to August 1, 1987; (2) the Medicare Contractor had accepted that policy and reimbursed similar claims under that policy; or (3) the Medicare Contractor did not consistently apply CMS' "must bill" policy in previous audits.[38] Therefore, the Board concludes the second prong of the Bad Debt Moratorium was not violated because the record does not show that the provider was forced to change its policy regarding Medicaid billing.

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that the Medicare Contractor properly adjusted the Medicare bad debts related to Medicare and Medicaid dual eligible beneficiaries on the cost reports covering FYs 2005 and 2007 for MHCCH.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
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[35] In this regard, the Board notes that its review of the Texas Medicaid program in another case suggests that LTCHs could participate and enroll in the Texas Medicaid Program. *See LifeCare Hosps. V. Novitas Solutions, Inc.*, PRRB Dec. No. 2016D-25 (covering FYs 2005 to 2012).
[36] *See* Provider's Consolidated Final Position Paper at 16, 24.
[37] 64 F.3d at 222.
[38] The Board recognizes that the record does contain affidavits executed in 2013 by then current MHCCH employees. However, the Board does not give any weight to them as the affiants provide no basis for their "personal knowledge" of the pre-1987 factual and policy assertions which occurred roughly 25 years prior.

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: February 9, 2017