PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2017-D9

PROVIDER –
North Sunflower County Hospital
Ruleville, Mississippi

Provider No.: 25-1318

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

DATE OF HEARING -
March 22, 2016

Cost Reporting Period Ended –
September 30, 2007

CASE NO.: 10-0015

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ISSUE STATEMENT

Whether the Intermediary's reduction to the Provider's fiscal year ending September 30, 2007 ("FY 2007") cost report to disallow Medicare bad debts related to the Provider's geropsychiatric program was proper?[1]

DECISION

After consideration of Medicare laws and guidelines, the parties' contentions, and the evidence presented, the Provider Reimbursement Review Board ("Board") reverses the Medicare Contractor's adjustment for the bad debts at issue related to individuals who are eligible for both Medicare and Mississippi's Medicaid benefits ("dual eligible individuals").

INTRODUCTION

North Sunflower County Hospital ("North Sunflower" or "Provider") is a county-owned hospital located in Ruleville, Mississippi. The cost reporting period at issue is FY 2007 and North Sunflower's designated Medicare contractor[2] is Novitas Solutions, Inc. ("Medicare Contractor").[3] The Medicare Contractor disallowed $50,387 in bad debts for dual eligible individuals for FY 2007 because North Sunflower failed to submit valid remittance advices ("RAs") from the Mississippi Medicaid program to document the bad debts claimed on its cost report.

North Sunflower filed a timely appeal of its Notice of Program Reimbursement ("NPR") with the Board and met the jurisdictional requirements for a hearing. Accordingly, the Board held a hearing on the record. North Sunflower was represented by Julie B. Mitchell, Esq. and Phillip J. Chapman, Esq., of Mitchell Day Law Firm, P.L.L.C. The Medicare Contractor was represented by Wilson C. Leong, Esq., CPA, of Federal Specialized Services.

STATEMENT OF THE FACTS AND RELEVANT LAW

North Sunflower claimed Medicare bad debt reimbursement on its FY 2007 cost report for unpaid deductible and co-insurance for dual eligible individuals. Some number of these dual eligible individuals are "qualified Medicare beneficiaries" or "QMBs" whose income and resources are higher than other dual eligible individuals.[4]

The Medicare Contractor disallowed the bad debt reimbursement for dual eligible beneficiaries because the Provider did not comply with CMS' "must bill" policy. This policy requires that prior to claiming a bad debt for a dual eligible beneficiary or QMB, a provider must: 1) bill the relevant state Medicaid program for unpaid coinsurance and deductibles; and 2) obtain a

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[1] *See* Provider's Final Position Paper at 3.
[2] The term "Medicare contractor" includes both fiscal intermediaries and Medicare administrative contractors.
[3] The Provider's Medicare Contractor at the time of the determination was Trispan Health Services, Inc. ("Trispan"). Subsequently, Novitas Solutions, Inc. replaced Trispan.
[4] 42 U.S.C. § 1396d(p). QMB income limit is 100 percent of the federal poverty level ("FPL"), and resource limit is generally higher than state Medicaid resource limits.

Medicaid RA from the state Medicaid agency identifying the amount of payment or the reason for non-payment.

The regulations governing bad debt are located at 42 C.F.R. § 413.89 (2007).[5] Subsection (e) specifies that such bad debts must meet the following criteria in order to be considered allowable:

(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.

CMS has provided extensive guidance on its bad debt policy in the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), §§ 308, 310, 312 and 322.[6] 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 15-1 § 310 states that a "reasonable collection effort" involves sending a bill on or shortly after discharge or death. However, this section by its own terms is not applicable to indigent patients and specifically refers to § 312 which allows providers to "deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined to be eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively." While this language absolves the providers from45 taking further steps to prove the dual eligible patient indigent, subsection C of § 312 nonetheless 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."

Further, federal law[7] requires state Medicaid programs to pay some or all of the deductibles and coinsurance for dual eligibles and QMBs but the State may limit such payment to the state Medicaid program's "payment ceiling," (*i.e.*, the maximum amount that the state program would pay for the service). As a state often limits its obligations to pay deductibles and coinsurance to this ceiling, and this ceiling is close to (just above or below) the Medicare payment, state Medicaid programs often pay little to no portion of the Medicare deductibles and coinsurance due for dual eligibles and QMBs.

PRM 15-1 § 322 is entitled "Medicare Bad Debts Under State Welfare Programs" and, consistent with §§ 310 and 312, this section discusses bad debts involving dual eligibles and QMBs in terms of a State's "obligation" or responsibility to pay. The key sentences relevant to this appeal are:

[5] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).
[6] For copies of the PRM sections, *see* Medicare Contractor Exhibit I-4.
[7] *See* 42 U.S.C. §§ 1396a(a)(10)(E), 1396a(n)(2), 1396d(p).

> *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 and coinsurance amounts that the state is not obligated to pay can be included as a bad debt under Medicare, *provided that the requirements of § 312* or, if applicable, ***§ 310*** *are met.*[8]

First, this excerpt confirms that, if the Medicaid State plan provides for payment of Medicare coinsurance and deductibles (in whole or in part), then the amount of the payment cannot be allowable as a Medicare bad debt. Second, this excerpt cross-references the requirements of §§ 310 and 312 confirming that, *at a minimum*, the § 310 requirement to "bill . . . the party responsible" is applicable to claims involving dual eligibles and QMBs.[9] Finally, in order to be eligible for Medicaid payment (whether for a dual eligible or QMB), most state Medicaid programs require that a provider be enrolled or certified as a provider in the state Medicaid program.[10]

DISCUSSION, FINDINGS OF FACT, CONCLUSIONS OF LAW:

The Medicare Contractor believes its bad debt adjustments were proper because North Sunflower did not properly comply with CMS' "must bill" policy. The Medicare Contractor contends that the core requirement for "must bill" is found in federal statute and implemented by federal regulations and points to 42 U.S.C. § 1396(p)(3) that imposes cost sharing for dual eligible Medicare patients.[11] The Medicare Contractor asserts that the need for CMS' "must bill" as it relates to dual eligible individuals is plainly evident because a patient's Medicaid status may change over the course of a very short period and states are entitled to change, enhance, or modify provisions of their Medicaid state plans, including their cost sharing obligation sunder § 1396d(p). It is the state Medicaid program that maintains the most accurate and up-to-date information to make a determination of a patient's Medicaid eligibility status at the time of service and the state must determine its cost sharing responsibility, if any, for any unpaid Medicare deductibles and coinsurance based on the state plan in effect.[12] Further, the Medicare Contractor points to regulations at 42 CFR § 413.89 and PRM §§ 310, 312, and 322 for the requirement to bill the state and have the state verify the patient's Medicaid status at the time of services and its cost sharing responsibility, by issuing a RA.[13]

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[8] (emphasis added.)

[9] 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). The Ninth Circuit in *Community Hosp. of Monterey Peninsula v. Thompson*, 323 F. 3d 782 (9th Cir. 2003) ruled that this transmittal was contrary to the Secretary's must bill policy and could not be enforced relative to the time at issue for the *Monterey* provider. This transmittal is not relevant to deciding the issue in this case and, accordingly, the Board does not address it.

[10] 42 U.S.C. §§ 1396, 1396a(d); 42 CFR § 482.1(a).

[11] Medicare Contractor's Final Position Paper at 6-7.

[12] *Id.*

[13] *Id.* at 5-6.

North Sunflower asserts that it could not obtain Medicaid RAs because the Mississippi Division of Medicaid ("DOM") does not cover services provided in a geropsychiatric unit of a hospital and will not issue Medicaid provider numbers for billing of services provided by such geropsychiatric units.[14] In addition, North Sunflower argues that it submitted sufficient alternative documentation to the Medicare Contractor and, accordingly, the Board should reverse the Medicare Contractor's adjustment.[15]

The Board's review of the record shows that the Mississippi Medicaid Program did not allow geropsychiatric units such as the one at North Sunflower to enroll in the Mississippi Medicaid program for the fiscal year at issue.[16] Based its review of similar cases, the Board is aware that North Sunflower's inability to obtain an RA is similar to the two exceptions to the "must bill" policy that the Secretary recognized in a brief that she filed in connection with *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–0142 (N.D. Cal. Oct. 11, 2001) ("*Monterey")*. Specifically, the following excerpts from that brief describe "two unique instances where ***the Secretary*** permits providers to claim Medicare crossover bad debt without billing the State Medicaid agency"[17]

1. Community mental health centers ("CMHCs").—CMHCs "are allowed to claim Medicare crossover bad debts without billing the State agency because CMHCs cannot bill the State agency given that they are not licensed by the State and, therefore, have no Medi-Cal provider numbers."[18]

2. Institutions for mental diseases ("IMDs").—IMDs "are permitted to claim Medicare crossover bad debts without billing the State agency where the services are provided to patients aged 22-64. This is because the Medicaid statute and regulations categorically preclude payment for services provided to patient aged 22-64 in IMDs, and the state accordingly has absolutely no responsibility for the coinsurance/deductibles associated with those particular services."[19]

Accordingly, consistent with the Secretary-recognized exceptions to the "must bill" policy, the Board concludes that North Sunflower's inability to obtain RAs from the Mississippi Medicaid Program qualifies as an exception to the "must bill" policy.

In further support of this conclusion, the Board notes that North Sunflower clearly was caught in the same "Catch-22" described by the D.C. District Court in *Cove Assocs. Jt. Venture v. Sebelius* ("*Cove*").[20] Like the long term care hospitals in *Cove,* North Sunflower

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[14] Provider's Final Position Paper at 9. *See also* Provider Exhibits P-7, P-9.
[15] Provider's Final Position Paper at 4.
[16] *Id.* at 4; Provider Exhibit P-9.
[17] 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) (emphasis added). An example of prior Board decisions referencing these exceptions is *LifeCare Hosps v. Novitas Solutions, Inc.*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016), *modified by*, CMS Adm'r Dec. (Nov. 28, 2016).
[18] *Id.* (citations omitted).
[19] *Id.* (citations omitted).
[20] *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).

was unable to enroll in the Mississippi Medicaid program for FY 2007 and, accordingly, could not bill the program and obtain Medicaid RAs in compliance with Medicare's "must bill" policy. As the *Cove* Court stated, in these situations providers "are left in the untenable position of either refusing to treat dual-eligible patients or absorbing the bad debts associated with those patients."[21]

The Board recognizes that the Administrator has addressed this issue in a recent decision stating:

> In instances where the State does not process a dual eligible claim, a Provider's remedy must be sought with the state. If a state does not have the ability to process a dual eligible beneficiary claims, for all types of Medicare providers, then the State is out of compliance with 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 Providers to take legal action with their states."[22]

However, the Board is not convinced that requiring an individual provider to take legal action against its State is a viable means for the provider to obtain Medicare bad debt reimbursement. Rather, the Board points to *Cove*, where the agency's counsel conceded "it is in a better position than the providers to ensure that the states comply with the applicable regulations of the Medicaid program."[23] The *Cove* Court was "not willing to place a stamp of judicial approval on a policy that would put non-participating providers in the position of not being paid due to the delinquency of federally-funded state programs."[24]

In the present case, North Sunflower has submitted documentation to confirm that Mississippi Medicaid neither covered nor paid for services provided in a geropsychiatric unit of a hospital during the time at issue.[25] In addition, North Sunflower did in fact submit bills for FY 2007 to the DOM but the Mississippi Medicaid Program refused to process those claims and issue RAs based on: (1) Mississippi's prohibition on enrolling geropsychiatric units as Medicaid providers (rather than the North Sunflower's discretionary avoidance of enrolling its geropsychiatric unit in Medicaid) and (2) Mississippi Medicaid's noncoverage of geropsychiatric services.[26] Consistent with the exceptions recognized by the Secretary and the rationale in *Cove*, the Board concludes that the Medicare Contractor's disallowance of the bad debt reimbursement at issue should be reversed.

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[21] *Id.*
[22] *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups. v. Novitas Solutions, Inc*., CMS Adm'r Dec. at 17 (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D22 (Sept. 27, 2016). *See also Life Care Hospitals v. Novitas Solutions, Inc.*, CMS Adm'r Dec. (Nov. 29, 2016), *modifying*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016).
[23] *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).
[24] *Id.*
[25] Provider Exhibits P-7, P-9.
[26] Provider's Final Position Paper at 10-11; Provider Exhibits P-7, P-9, P-11.

DECISION

After consideration of Medicare laws and guidelines, the parties' contentions, and the evidence presented, the Provider Reimbursement Review Board ("Board") reverses the Medicare Contractor's adjustment for the bad debts at issue related to individuals who are eligible for both Medicare and Mississippi's Medicaid benefits ("dual eligible individuals").

BOARD MEMBERS PARTICIPATING:

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L. Sue Andersen, Esq.
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FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: March 2, 2017