**A. Facts**

In accordance with CMS’ policy and pursuant to the audit adjustments at issue, the MAC disallowed bad debt amounts that had not been properly billed to the Medicaid agency, and therefore had not been established as uncollectible. With two exceptions, the Providers included the estimated reimbursement effect of this issue in its filed Protested Amounts on the filed cost reports.[[1]](#footnote-1) The MAC adjusted to remove these Protested Amounts in audit adjustment numbers noted on the Schedule of Providers (Exhibit C-1).

The Providers assert that these bad debts were not billed to Medicaid but are reimbursable. As stated on page 5 of its Position Paper:

The Providers contend that the MAC did not determine Medicare reimbursement for allowable bad debts in accordance with the Statutory instruction at 42 U.S.C. §1395x(v). Specifically, the Providers disagree with the MAC’s position that they cannot claim bad debts for all indigent/crossover Outpatients unless those crossover patients were billed to the Medicaid program.[[2]](#footnote-2)

The group’s issue statement includes the above paragraph and continues: [[3]](#footnote-3)

The Providers contend that the MAC advised that the Providers could only claim these crossover bad debts if they show proof in the form of a denial on a remittance advice. The Providers contend that this is inconsistent with the Regulations and Instruction per 42 S.F.R. §413.80 and the Provider Reimbursement Manual (“PRM”) Part 1, §308.

However, the Providers transferred into the group include a different dispute about a technical malfunction which prevented the claims from being properly billed: [[4]](#footnote-4)

The MAC eliminate the Provider's protested amounts reported on the as-filed cost

report, which included an amount related to the issue of inpatient and outpatient

Medicare unbilled crossover bad debts. The Provider contends that their bad debts

reimbursement is understated by co-payments related to Medicare crossover claims not completely billed because some of the payment information was cut-off due to the restriction in the number of crossover bad debt claim lines that can be processed by the State of California or for other reasons.

The applicable Medicare Regulation is 42 C.F.R. §413.89. The estimated amount of Medicare reimbursement at issue is $ (amount varies by provider).

In its Preliminary Paper, the Group has briefed Outpatient Crossover Bad Debt claims that are associated with dual eligible accounts that the Providers failed to bill to the Medicaid program. The Providers have not discussed in its paper the dispute that was defined by the transferred providers, describing outpatient claims not completely billed due to technical difficulties, such as “…. payment information was cut-off due to the restriction in the number of crossover bad debt claim lines that can be processed…).

In addition, the MAC points out that the current group includes FY 2016, but the dispute that is briefed in the Group’s Preliminary Position Paper appears to center around the requirements stated in the FFY 2021 Final Rule (85 Federal Register 58989 – 59006, 59023 – 59025, 9/18/2020).[[5]](#footnote-5) As stated on pages 5-6 of its Position Paper:

The FY 2021 IPPS Final Rule, 85 *Fed. Reg*. 58432 (Sept. 18, 2020), amends the Medicare bad debt regulation at 42 C.F.R. § 413.89, and codifies policy regarding the claiming of so-called crossover bad debts involving dual eligible beneficiaries and makes that policy retroactively applicable, including to this Appeal.

A separate group appeal has been established for these providers to address the topic of FFY 2021 Unbilled Outpatient Crossover Bad Debt claims *(PRRB Case 21-1130GC Dignity Health FFY 2021 Medicare Unbilled Outpatient Crossover Bad Debts CIRP Group*). The Providers are disputing the same issue in two open group appeals.

The MAC asserts that Medicare policy does not allow a bad debt to be claimed until it has been established as uncollectible, including properly billing the Medicaid agency for Medicaid eligible patients. Of significance, the MAC disagrees with the Providers attempt at disputing the same issue in multiple group appeals. A separate group appeal has been established for addressing any disagreements regarding the FFY 2021 Final Rule instructions about the must bill requirements for bad debt claims.

**B. Argument**

Regulation 42 C.F.R. § 413.89 provides four (4) criteria that a provider must meet with respect to a receivable from a beneficiary in order to claim that receivable as a bad debt. In general, a provider must establish that the debt relates to covered services and is derived from deductible and coinsurance amounts, that reasonable collection efforts were made, that the debt was actually uncollectible when claimed, and that sound business judgment indicates there is no likelihood of future recovery.

The controlling regulation regarding Medicare bad debts is found at 42 C.F.R. § 413.89 (Exhibit C-2). In subsection (e), this regulation provides that for bad debts to be 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.

Similarly, program instructions contained in the Provider Reimbursement Manual (PRM), Part 1 (“CMS Pub. 15-1”) Section 310 (Exhibit C-3) require that for Medicare bad debts to be allowable a “reasonable collection effort” must be made, and comparable efforts must be made to collect Medicare bad debts as are made to collect non-Medicare accounts. The manual instructions also require that “(t)he provider’s collection efforts should be documented in the patient’s file by copies of the bill(s), follow up letters, reports of telephone and personal contact, etc.”

A debt may be deemed uncollectible if the patient is indigent and the provider concludes that there has been no improvement in the patient’s financial condition. As part of the manual requirements, CMS has a must bill policy for Medicare/Medicaid dual eligible beneficiaries. The must bill policy states that if a patient is determined by the provider to be indigent or medically indigent, the provider does not need to attempt to collect from the patient. However, the provider must make certain that no source other than the patient would be legally responsible for the patient’s medical bill; e.g., title XIX, local welfare agency…, prior to claiming the bad debt from Medicare. In determining the indigence of a Medicare beneficiary, CMS Pub. 15-1 Section 312 (Exhibit C-3) provides that a provider should apply its customary methods for determining the indigence of patients under the following guidelines:

A. The patient’s indigence must be determined by the provider, not by the patient, i.e., a patient’s signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;

B. The provider should take into account a patient’s total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient’s daily living), liabilities, and income and expenses. In making this analysis, the provider should take into account any extenuating circumstances that would affect the determination of the patient’s indigence;

C. The provider must 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; and

D. The patient’s file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.”

Once 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 procedures. (See §322 for bad debts under State Welfare Programs.)

Item C in this section clearly requires that providers must determine that no other source is responsible for the patient’s deductible and coinsurance, including Medicaid. Providers must be able to document this determination. Medicare policies require that providers must bill the Medicaid program and be able to document the response received from the Medicaid program through the Medicaid remittance advice. The Providers in this group do not dispute the fact that they failed to bill the Medicaid program.

The Providers are required to document the State’s liability for any cost sharing amounts related to unpaid Medicare deductible and coinsurance amounts for dual eligible beneficiaries. The Medicare must-bill policy is an effectuation of this requirement. The must-bill policy is set forth in CMS Pub. 15-1 Sections 310, 312 and 322 (Exhibit C-3).

**The Bad Debt Moratorium**

The 1987 Omnibus Budget Reconciliation Act and related regulations imposed a “bad debt moratorium” that provided, in relevant part “in making payments to hospitals under [the Medicare program], the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under [the Medicare program] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under [the Medicare program].” Pub. L No. 100-203 § 4008. In 1989, Congress amended the bad debt moratorium by adding a prohibition on requiring a hospital to change its bad debt collection policy if a fiscal intermediary has accepted a provider’s policy with respect to indigency determination procedures, record keeping and determining whether to refer a claim to an external collection agency prior to August 1, 1987. Pub. L. No. 101-239 § 6203. The bad debt moratorium, as it currently stands, prohibits CMS from changing its bad debt policy from the policy that was in effect on August 1, 1987, and it prohibits CMS from requiring providers to change their bad debt procedures from those in effect on August 1, 1987. The operative question, in bad debt moratorium analyses, therefore, is: “what was CMS’s bad debt policy and procedure prior to August 1, 1987?”

In August 1968, the Provider Reimbursement Manual (PRM) Revision 3, Section 322, provided that “the unpaid deductible and coinsurance amounts of beneficiaries who are medically needy are allowable as bad debts to the extent the State plan imposes cost sharing on the welfare recipients. The portion of care not covered by Medicare must be paid under the public assistance program if the individual would otherwise be eligible for the service.” (PRM Rev. 3, Section 322 attached as Exhibit C-4). The PRM also required that providers undertake “reasonable collection efforts” that included “efforts customarily put forth to collect bills of comparable amounts of non-Medicare patients.” (PRM Rev. 3 Section 310). These two Sections were the precursor to the must-bill policy at issue in the present matter.

Additionally, in December 1985, the Medicare Intermediary Manual was amended to provide:

Prior to 1968, title XIX State plans under the Federal medical assistance programs were required to pay the Part A deductible and coinsurance amounts for outpatient hospital services. Effective January 1, 1968, State title XIX plans are no longer required to pay these amounts, but instead have the option to do so. Therefore, to the extent that State plans do not provide for payment of the Medicare deductible and coinsurance amounts for patients eligible for title XIX benefits, such unpaid amounts are allowable as bad debts provided that the requirements relative to indigent or medically indigent patients are met. To determine if title XIX deductible and coinsurance amounts for individuals entitled to benefits under title XIX are allowable bad debts, perform the following steps:

1. Where the Medicare deductible and coinsurance amounts for patients eligible for title XIX benefits were paid by the State or Welfare agency, insure [sic] that those amounts are not included in the claimed bad debts.

2. Review the provider’s policies and procedures for billing the State for the deductible and coinsurance amounts. If the provider does not have an ongoing billing system or if there is a system but it has not operated properly, disallow related bad debts for deductible and coinsurance amounts claimed under Medicare.

3. If the State is being billed correctly and has accepted liability, ascertain that title XIX deductible and coinsurance amounts are not included in the claimed bad debts.

4. If the State has been billed, but did not pay the amount due, determine if there is a written notice of rejection in the patient’s file. Review the rejection notice and if it is found to be acceptable, allow the bad debt for Medicare purposes.

**December 1985 Medicare Intermediary Manual § 15.08 attached as Exhibit C-5.**

As of December 1985, therefore, providers were required to bill the state Medicaid program and to maintain a written notice of rejection from that program in the patient’s file. This is the precursor to the Medicaid remittance advice (RA) at issue in this matter, and that was at issue in *Select Specialty Hospital Denver, Inc. v. Azar*, No. 10 CV 1356 (D.D.C. August 22, 2019), *amended by Select Specialty Hospital Denver, Inc. v. Azar*, No. 10 CV 1356, 2019 WL 5697076 (D.D.C. November 4, 2019). As early as 1985, CMS was allowing the written notice of rejection to be in the form of an RA. *See, California Hospitals Crossover Bad Debts Group Appeals*, PRRB Dec. 2000-D80 (discussing the history regarding the RA requirement) attached as Exhibit C-6; *see also, Hospital de Area de Carolina*, Admin. Dec. No 93-D23 (involving a 1987 cost report and was decided in 1993) attached as Exhibit C-7; *St. Joseph Hospital*, PRRB Dec. 1984-D109 (holding that collection efforts were not adequate when a Provider failed to take a claim to collections to collect amounts owed by the Medicaid systems) attached as Exhibit C-8; *Concourse Nursing Home*, PRRB Dec. No. 83-D152 (involving 1977 and 1978 cost reports that were denied as there was no documentation that actual collection efforts were made to obtain payment from the Medicaid authorities before account balances were considered uncollectable) attached as Exhibit C-9.

Furthermore, for any provider to argue that it was foreclosed from enrolling in the state Medicaid program and was without legal recourse, that argument is unpersuasive. For example, a group of providers in Florida filed suit against the state for refusing to permit the providers to enroll in the state Medicaid program. The result of the lawsuit was a settlement agreement in which the state of Florida enrolled the providers for the limited purpose of issuing RAs. *See, Hope Horizon Ctr. v. Sebelius, No. 10 CV 1570 (D.D.C. dismissed Jan. 7, 2014)* Settlement Agreement referenced by the court is attached as Exhibit C-10.

CMS’s policy whereby an RA was required, predated the bad debt moratorium by at least two years. It also predated the purported 2007 change alleged by the providers in the *Select Specialty Hospital Denver* case. Accordingly, because the policy was not new, it cannot have violated the moratorium, nor could it have caught any provider by surprise.

The requirement of a state RA was not a substantive change that required notice and comment prior to taking effect. The *Select Specialty Hospital* Denver Court disagreed with this statement, but when it did so, it did not have the benefit of the above-discussed documents. In *Clarian Health West, LLC v. Hargan*, 878 F. 3d 346 (D.C. Cir. 2017), the Appellate Court held that a statement of the circumstances under which intermediaries were required to report hospitals for outlier reconciliation was not a substantive legal standard because the statement “merely reflected the agency’s policy about how best to deploy its contractors’ limited resources.” *Id.* at 355. In *Clarian*, the instructions “did not alter whether an outlier payment [was] warranted or the amount of an outlier payment.” *Id.* at 354. Like *Clarian*, the requirement that providers obtain an RA prior to the allowance of a bad debt did not change CMS’s policy (that policy had been in effect since at least 1985) nor did it change which, and under what circumstances, providers would receive bad debt reimbursement. Accordingly, like in *Clarian*, the purported 2007 change did not require notice or comment.

**C. Conclusion**

Because the requirement that providers bill the state Medicaid program is nearly as old as the Medicare Act itself, and because the requirement that providers obtain an RA predates the bad debt moratorium by nearly two years, the MAC’s disallowance is proper. The requirement of a state RA is not a substantive or even a policy change. Instead, it is a clarification of existing CMS policy and, as such, neither notice nor comment was required. A Medicare bad debt for a dual eligible beneficiary can only be written off after the State has been properly billed and the State remits a payment, or denial of payment, to the Provider. The Provider has failed to establish that the accounts were “actually uncollectible” at the time they were written off.

For the FY 2016 cost reporting periods, the MAC respectfully requests that the Board deny the Provider’s request to allow unbilled dual eligible beneficiary Medicare bad debts. The MAC adjustments are in accordance with Medicare regulations for Bad Debt reimbursement at 42 C.F.R. § 413.89. The MACs’ adjustments should be affirmed.[[6]](#footnote-6)

The Providers’ dispute about FFY 2021 that is briefed in the Preliminary Paper is not appropriate. A separate group appeal has been established for addressing any disagreements regarding the FFY 2021 Final Rule instructions for billing crossover bad debt. If this briefing has been intentional, the MAC requests the Board to dismiss the current case due to duplication with *PRRB Case 21-1130GC Dignity Health FFY 2021 Medicare Unbilled Outpatient Crossover Bad Debts CIRP Group*.

**IV. LAW, REGULATIONS AND PROGRAM INSTRUCTIONS**

**United States Statutes**

Omnibus Budget Reconciliation Act of 1987, Pub. L No. 100-203 § 4008;Omnibus Budget Reconciliation Act of 1989, Pub. L No. 101-239 § 6203

**Code of Federal Regulations**

42 C.F.R. § 413.89

**Federal Register Notices**

85 Federal Register 58989 – 59006, 59023 – 59025 (Sept 18, 2020)

**Judicial Decisions**

*Clarian Health West, LLC v. Hargan*, 878 F. 3d 346 (D.C. Cir. 2017);*Hope Horizon Ctr. v. Sebelius, No. 10 CV 1570 (D.D.C. dismissed Jan. 7, 2014)* Settlement Agreement;*Select Specialty Hospital Denver, Inc. v. Azar*, No. 10 CV 1356 (D.D.C. August 22, 2019), *amended by Select Specialty Hospital Denver, Inc. v. Azar*, No. 10 CV 1356, 2019 WL 5697076 (D.D.C. November 4, 2019)

**Agency Decisions**

*California Hospitals Crossover Bad Debts Group Appeals, PRRB Dec. 2000-D80 (September 6, 2000);Hospital de Area de Carolina, Admin. Dec. No 93-D23 (April 26, 1993)*

*St. Joseph Hospital, PRRB Dec. 84-D109 (April 16, 1984);Concourse Nursing Home, PRRB Dec. No. 83-D152 (September 27, 1983)*

**Program Instructions**

Provider Reimbursement Manual (PRM) Revision No. 3, August 1968, Chapter 3

CMS Pub. 15-1 (PRM), Chapter 3;Medicare Intermediary Manual (MIM), Part 4 – Audit Procedures, Transmittal No. 16, December 1985, Chapter 5

**V. EXHIBITS**

C-1. Schedule of Providers (OH CDMS)

C-2. 42 C.F.R. § 413.89

C-3. CMS Pub. 15-1, Chapter 3

C-4. Provider Reimbursement Manual (PRM) Revision No. 3, August 1968, Chapter 3

C-5. Medicare Intermediary Manual (MIM), Part 4 – Audit Procedures, Transmittal No. 16, December 1985, Chapter 5

C-6. *California Hospitals Crossover Bad Debts Group Appeals*, PRRB Dec. 2000-D80 (September 6, 2000)

C-7. *Hospital de Area de Carolina*, Admin. Dec. No 93-D23 (April 26, 1993)

C-8. *St. Joseph Hospital*, PRRB Dec. 84-D109 (April 16, 1984)

C-9. *Concourse Nursing Home*, PRRB Dec. No. 83-D152 (September 27, 1983)

C-10. *Hope Horizon Ctr. v. Sebelius*, No. 10 CV 1570 Settlement Agreement

C-11. Group Issue Statements: (1) Appeal Request and (2) Issue Transfers

C-12. 85 Federal Register 58989 – 59006, 59023 – 59025 (Sept 18, 2020)

1. Mercy Hospital, provider 05-0295 and St. Rose Dominican Hospital – San Martin campus, provider 29-0053 are unable to support a MAC determination relating to the Group dispute. This impediment was included in the MAC’s JC submitted January 23, 2023. [↑](#footnote-ref-1)
2. A separate group appeal has been established for unbilled inpatient crossover bad debt for these providers - *PRRB case 18-1330GC QRS Dignity Health 2016 Medicare Unbilled Inpatient Crossover Bad Debts CIRP Group.* [↑](#footnote-ref-2)
3. See Exhibit C-11, pp. 2 and 3, for the issue statement submitted with the Group Request. [↑](#footnote-ref-3)
4. See Exhibit C-11, page 4 for an issue statement for a transferred provider. [↑](#footnote-ref-4)
5. See Exhibit C-12 for 85 FR 58989-59006, 59023-29025 (Sept 18, 2020). [↑](#footnote-ref-5)
6. The MAC disagrees to the inclusion of various providers in this group appeal. The jurisdictional impediments, including lack of a protest item or MAC adjustment, are detailed in the Jurisdictional Challenge submitted on January 23, 2023. [↑](#footnote-ref-6)