PUBLICATION

CMS Prevails in Dual Eligible Bad Debt Challenge [Ober|Kaler]

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In a decision handed down on August 7, 2015, the United States Court of Appeals for the District of Columbia Circuit upheld the denial of the providers' bad debt claims associated with dual eligible beneficiaries. *Grossmont Hosp. Corp., d/b/a Sharp Grossmont Hosp., et al. v. Burwell*, No. 12-5411 (D.C. Cir., Aug. 7, 2015) [PDF].

At issue were claims for co-insurance and deductibles associated with dual eligible beneficiaries for the period between May 1994 through March 1999, which Medi-Cal failed to process. Although one of the hospitals initially sent a letter to the state concerning the missing claims and although a few telephone calls were made to the state, the hospitals did not take further steps to obtain a state determination of payment responsibility for the missing claims, at least until 2006. In 2006, Grossmont sent a letter to the state with a request to process certain missing claims. At that point, however, the state denied the request because the claims were not submitted in a timely fashion.

Having failed to obtain payment from the state for the dual eligibles' deductibles and co-insurance amounts, the providers claimed those amounts as Medicare bad debts. The intermediary denied these claims, and the Secretary affirmed that denial. The Secretary ruled that, under long-standing Medicare policy, Medicare will not reimburse a hospital for dual eligibles' unpaid deductible and co-insurance amounts unless the hospital first bills the state Medicaid agency (the "must bill" policy) and obtains a determination from the state as to its payment responsibility ("mandatory state determination"). The Secretary concluded that no state determination had been made regarding the missing claims and therefore the claims were not reimbursable. The D.C. Circuit agreed, rejecting Grossmont's challenges.

Before the court, Grossmont contended that the mandatory state determination policy was arbitrary and capricious and not based on substantial evidence. The Secretary responded to these arguments by asserting that the state is the best source of Medicaid eligibility and state payment information necessary to calculate properly the state's payment responsibility, observing that the state had not made this determination. The Secretary further asserted that the Provider Reimbursement Manual requires that reasonable collection efforts mandate 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. The court concluded that this requirement was a reasonable one and that the hospitals had not timely billed Medi-Cal for the claims at issue.

The court further ruled that the hold harmless provision of Joint Signature Memorandum 370 did not apply here. Under the memorandum, reimbursement for certain claims prior to 2004 was allowable if the claims were supported by other documentation in lieu of billing the state. This exception did not apply, however, unless the provider's intermediary at the time allowed the use of alternative documentation. The record evidence in this case showed that the intermediary never allowed Grossmont to rely on documentation that was not produced by Medi-Cal itself. Accordingly, the Joint Signature Memorandum did not apply.

Ober|Kaler's Comments

This is yet another case demonstrating how difficult it can be to obtain reimbursement for bad debt claims in instances where the provider has not complied fully with the Medicare bad debt regulation, the applicable

manual provisions, and, most particularly, the Secretary's interpretations of those provisions. The courts are inclined to follow those interpretations to the letter, thereby rejecting hospitals' challenges.