PUBLICATION

Court Again Rules Medicare's "Must Bill" Policy for Medicare Dual Eligible Bad Debts Is Reasonable [Ober|Kaler]

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The United States District Court for the District of Columbia once again upheld the decision of the Secretary of Health and Human Services (Secretary) to deny reimbursement for Medicare bad debts associated with copayments and deductibles for Medicare beneficiaries who were also eligible for Medicaid, i.e., dual eligible beneficiaries. *Grossmont Hospital Corp., et al., v. Sebelius*, Civil Action No. 10-cv-1201 (D.D.C. Nov. 9. 2012). The same court ruled similarly in *Cove Associates Joint Venture v. Sebelius*, No. 1:10-cv-0316 (D.D.C. Mar. 26, 2012).

In order for a Medicare bad debt to be allowable, a provider must demonstrate, among other things, that no other source, including the State, is responsible for the payment. Pursuant to a Joint Signature Memorandum issued by CMS as a "clarification" of its policy on August 10, 2004, JSM-370, a provider must bill and receive a remittance advice from the State in cases where the State owes nothing or only a portion of a dual eligible patient's Medicare deductible or copayment.

The bad debt at issue in this case arose from services provided from May 1, 1994 through June 30, 1998, at several hospitals located in California. Prior to May 1, 1994, the state Medicaid program, Medi-Cal, paid 100 percent of the dual eligibles' Medicare deductibles and copayments, such that there were generally no bad debts associated with the claims for these patients. On May 1, 1994, California stopped payment of these amounts, in contravention of its Medicaid State plan, and the Medicare program refused to pay the related bad debts amounts. Several hospitals sued the Medi-Cal program, and, as a result, the State amended its State Medicaid plan retroactively to May 1, 1994, to establish a payment ceiling on its responsibility for Medicare deductibles and copayments. The Secretary reached an agreement with the State, whereby the State agreed to reprocess the claims for the period at issue and furnish reports to the Medicare program that showed the comparison of amounts paid by Medicare and the Medicaid payment rate for the Medicare coinsurance and deductible amounts. The Medicare program then made payment to the providers for the related Medicare bad debt amounts.

The hospitals in this appeal believed that the payment they received from the State was inaccurate and asked Medi-Cal to correct the data, but Medi-Cal never did. The hospitals then opted to calculate, on their own, the amounts of bad debt they believed they were further entitled to from the Medicare program. The Medicare intermediary denied payment for these claims. Although the Provider Reimbursement Review Board (PRRB) ruled in favor of the providers, the CMS Administrator reversed. The Administrator ruled that, although the providers asserted that they had billed the State Medi-Cal program through the automated "crossover" system, there was no evidence of the claims in the state system, and thus they were not billed to the State. The Administrator's decision, however, ultimately turned on the determination that the bad debt cost was not allowable until such time as the State issued a determination on the claims.

The providers argued that the Secretary violated the "Bad Debt Moratorium Laws" by interpreting the "must bill" policy to require a State determination on the bad debt claims. The court, however, refused to consider this argument, as the providers did not raise it in the administrative proceedings below, either before the PRRB or through comments to the CMS Administrator. The court deferred to the Secretary and found the "must bill" policy, including the requirement that providers supply documents prepared by the State to support that the

State has no liability for the outstanding amounts, to be reasonable. The court further determined that the “hold harmless” provisions of JSM-370 did not apply in this case, as the providers' intermediary never accepted alternative documents in lieu of State remittance advices.

Comments

Providers with similar denials from their Medicare contractors should consider filing suit against their State Medicaid programs, if those programs are refusing to pay Medicare copayments and deductibles in violation of their State Medicaid Plans. This case also highlights the need, from a legal perspective, to raise all potential arguments early on in the administrative process, in order to allow those arguments to be considered. Specifically, the providers in this case did not raise arguments related to the Moratorium Laws before the PRRB or in comments to the CMS Administrator, which barred the argument from consideration by the court.