The Law Offices of
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Health Care Provider
Legal Alert

July 2013 Vol. 3, No. 4

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Bad Debt Update: Recent Decision Affirms Providers' Bad Debt Claims While Collection Efforts Continue & CMS Bulletin on QMB Cost Sharing

For providers participating in the Medicare program, bad debt reimbursement is an important way to offset otherwise uncollectible co-insurance and deductible amounts. However, the Centers for Medicare & Medicaid Services (CMS) has been unwilling to reimburse bad debts where collection efforts continue at an outside collection agency. The United States District Court for the District of Columbia's recent decision in *District Hospital Partners, L.P v. Sebelius* took issue with this policy. In a decision that may substantially benefit providers, the court affirmed providers' claims for Medicare bad debt reimbursement while collection efforts continued at an outside collection agency.[1] More recently, CMS issued an Informational Bulletin on Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs). For the first time, CMS acknowledges the difficulties that Medicare providers have encountered with state Medicaid programs concerning crossover claims for Medicare cost-sharing amounts, including claims for QMB cost sharing.[2] It remains to be seen whether states will fix the many enrollment and billing impediments that still prevent providers from obtaining the processed Medicaid bills needed to satisfy Medicare's "must bill" bad debt policy.

Please feel free to reach us at the phone numbers or email address to the left if you have questions about how this decision or CMS Bulletin affect your bad debt claims, or for assistance in challenging denied bad debt amounts.

Bad Debt Reimbursement. The Medicare program defines "bad debts" as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services."[3] In other words, bad debts represent unpaid amounts owed by Medicare patients for rendered Medicare services. Because the Medicare program prohibits these unpaid costs to be borne by non-Medicare patients (*i.e.* "cost-shifting"), Medicare will reimburse providers for these costs where: (1) the debt is related to covered services and derived from deductible and coinsurance amounts; (2) the provider can establish that reasonable collection efforts were made; (3) the debt is actually uncollectible; and (4) sound business judgment established no likelihood of recovery.[4]

Bad Debt Moratorium. In 1987, Congress enacted the so-called "Bad Debt Moratorium" in response to proposed Medicare program changes.[5] Effective on August 1, 1987, the moratorium stated in relevant part that "the Secretary…shall not make any change in the policy…with respect to payment…to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts."[6] Congress subsequently amended the

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moratorium twice. First, in 1988, the moratorium was amended to further define "reasonable collection effort" by including "criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency."[7] Second, in 1989, Congress amended the moratorium by adding a sentence stating: "The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy."[8]

Therefore, as amended, the moratorium places two limitations on CMS' treatment of the bad debt policy. First, CMS cannot change its bad debt policy following the effective date of August 1, 1987. Second, CMS cannot require a provider to change the bad debt policy that provider had in place on August 1, 1987.

Presumption of Collectability Policy. The CMS presumption of collectability policy limits providers' ability to claim bad debt reimbursement for bad debts pending collection at an outside collection agency. First articulated in a Medicare Intermediary (MIM) transmittal letter from September 1989, the policy is described as follows:

> If the bad debt is written-off on the provider's books 121 days after the date of the bill and then turned over to a collection agency, the amount cannot be claimed as Medicare bad debt on the day of the write-off. It can be claimed as Medicare bad debt only after the collection agency completes its collection effort.[9]

Applied since the 1989 audit guidance, CMS has at times offered various defenses for the presumption of collectability policy. In particular, the agency has noted that support for the policy is inherent in the regulations pertaining to reasonable collection efforts and bad debt reimbursement.[10] Additionally, CMS has asserted justification for the policy by citing various Provider Reimbursement Manual (PRM) provisions.

***District Hospital Partners, L.P. v. Sebelius*.** The D.C. District Court's recent decision centers on cost reports submitted by provider plaintiffs for fiscal years 2003, 2004, and 2005. The cost reports included claims for reimbursable bad debts, some of which had been sent to an outside collection agency following 120 days of internal collection efforts. These steps were taken in accordance with the providers' established bad debt policies. In disallowing the claimed bad debt, the fiscal intermediary reasoned that "an ongoing collection effort at [an] outside collection agency indicated that the bad debts were not yet deemed worthless."[11] The fiscal intermediary pointed to CMS' presumption of collectability as support for its conclusion.

On appeal of the fiscal intermediary's determinations, the PRRB reversed, unanimously holding that the bad debts were properly claimed despite the fact that the accounts remained at an outside collection agency.[12] The PRRB not only relied on its interpretation of Medicare's definition of "reasonable collection efforts"[13] and the "Presumption of Noncollectibility,"[14] but more significantly focused on the effect of the Bad Debt Moratorium in defeating CMS's contention

that its published audit guidance in 1989 was controlling.[15] That guidance instructed intermediaries to disallow bad debts for cost sharing amounts that outside collection agencies were still working to collect.

On July 26, 2011, the Administrator reversed the PRRB and reinstated the fiscal intermediary's bad debt disallowance.[16] The Administrator determined that the Bad Debt Moratorium was not applicable, instead concluding that the issue was whether the providers had undergone reasonable collection efforts. Because CMS had "always required that a provider demonstrate that its collection efforts were reasonable," the Administrator concluded that there had been no change in CMS policy violative of the moratorium.[17] Like the fiscal intermediary, the Administrator relied on CMS' presumption of collectability policy with regard to accounts sent to outside collection agencies.

The providers timely appealed to the United States District Court for the District of Columbia. Before the District Court, the providers' primary argument was again that because CMS' presumption of collectability was instituted after 1987, it violated the first prong of the Bad Debt Moratorium prohibiting the Secretary from changing bad debt policies. Reversing the Administrator and finding for the providers, the Court systematically dismissed each argument the agency presented justifying its presumption of collectability policy.

Despite the agency's argument, the Court found no support for the presumption of collectability in either the regulations or PRM provisions. According to the Court, not only does "the very wording of [42 C.F.R. § 413.89] fail[] to support such an interpretation," but the cited PRM "tacitly contradicts" the agency's proposed interpretation.[18] The Court similarly disagreed with the agency's contention that the agency MIM transmittal letter from September 1989 demonstrated that the presumption of collectability existed before 1987. Emphasizing as dispositive that the letter was issued in 1989 *and* specifically titled a "New Policy," the Court next considered the agency's claims regarding a pair of 1990 HCFA memoranda.[19] The agency asserted that both memoranda established the longstanding nature of the presumption of collectability policy, thus establishing its existence prior to the 1987 moratorium. However, the Court concluded that "a close look at the language of the [critical] Memorandum in its entirety squarely contradicts" the agency's assertion.[20] Finally, the District Court dismissed the agency's final pair of arguments, concluding that a 2008 CMS memorandum "actually contradicts the [agency's] position" and that cited CMS administration decisions were simply not applicable.[21]

CMS Bulletin on QMB Cost Sharing. On June 7, 2013, CMS published an Informational Bulletin on the payment of Medicare cost sharing for QMBs. QMBs are persons who (i) are entitled to Medicare Part A and eligible for Medicare Part B; (ii) have an income below 100 percent of the Federal Poverty Level; and (iii) have been determined to be eligible for QMB status by their State Medicaid Agency.[22] State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost sharing due for QMBs according to the State's CMS-approved Medicare cost-sharing payment methodology.[23] This Bulletin is the first time that CMS has recognized "repeated reports of QMB crossover claims not being processed in state [Medicaid Management Information Systems] MMIS systems" prompting CMS to "remind states of their claim processing obligations under federal law."[24] According to CMS, this typically occurs when: (i) a Medicare-certified provider is not enrolled in Medicaid; (ii) the MMIS does not recognize the provider identifier; (iii) the provider type is recognized by Medicare

but not by the state Medicaid program; or (iv) the service is provided by an out-of-state provider.[25] CMS states that "in circumstances where a provider has submitted a claim to Medicaid for processing in accordance with the timely filing provisions of 42 CFR §424.44; and the provider has executed the necessary provider agreement according to a state's procedures for provider enrollment, the state *must* process the claim in accordance with the timely claims processing provisions of 42 CFR §447.45 and must issue the provider an RA for those claims as required by the [State Medicaid Manual] SMM."[26] CMS is offering states technical assistance to meet this obligation.

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[1] *Dist. Hosp. Partners, L.P. v. Sebelius*, CIV.A. 11-1717 GK, 2013 WL 1209956 (D.C. Mar. 26, 2013).
[2] CMS Informational Bulletin: Payment of Medicare Cost Sharing for Qualified Medicare Beneficiaries (QMBs), 1-3 (June 7, 2013).
[3] 42 C.F.R. § 413.89(b)(1).
[4] *Id*. at § 413.89(e).
[5] Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 § 4008, 101 Stat. 1330.
[6] *Id*.
[7] Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647 § 802, 102 Stat. 3798.
[8] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6023, 103 Stat. 2106.
[9] Medicare Intermediary Manual, Transmittal No. 28, September 1989.
[10] *See* 42 C.F.R. § 413.89.
[11] *Dist. Hosp.,* at *4 (quoting AR 60).
[12] *Univ. Health Servs., Inc. v. BlueCross BlueShield Ass'n*, Case No. 07-0084GC, 2011 WL 2574339 (P.R.R.B. May 27, 2011).
[13] Provider Reimbursement Manual, Part 1, CMS Pub. 15-1, § 310.
[14] *Id*. at § 310.2.
[15] Medicare Intermediary Manual, CMS Pub. 13, § 4198 (stating "If the bad debt is written-off on the provider's books 121 days after the date of the bill and then turned over to a collection agency, the amount cannot be claimed as a Medicare bad debt on the date of the write-off. It can be claimed as a Medicare bad debt only after the collection agency completes its collection effort.").
[16] *Univ. Health Servs., Inc. v. Blue Cross Blue Shield Ass'n*, 2011 WL 4499597 (H.C.F.A. Admin. Dec. July 26, 2011).
[17] *Id*. at *9.
[18] *Dist. Hosp.*, at *6.
[19] *Id*. at *6-7.
[20] *Id*. at *7.
[21] *Id*. at *9-10.
[22] CMS Informational Bulletin: Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs), 1 (Jan. 6, 2012) available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf.
[23] Social Security Act § 1902(a)(10)(E) (directing state Medicaid agencies to reimburse providers for QMB cost-sharing amounts "'without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan.'"); *see* CMS Informational Bulletin: Payment of Medicare Cost Sharing for Qualified Medicare Beneficiaries (QMBs), 1-2 (June 7, 2013).
[24] CMS Informational Bulletin: Payment of Medicare Cost Sharing for Qualified Medicare Beneficiaries (QMBs), 2 (June 7, 2013).
[25] *Id.*
[26] *Id.*

About Us

The Law Offices of Jason M. Healy PLLC is a Washington, D.C. based law firm serving national and local clients. We focus primarily on legal issues affecting health care providers and welfare benefit plans. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations, and address compliance matters. We also represent health care providers in reimbursement audits, appeals, litigation, and transactions. We help sponsors of welfare benefit plans understand and comply with federal and state laws and prepare plan documents. Located one block from The White House and just minutes from the Department of Health and Human Services and Congressional offices, we are well positioned to provide legal support for advocacy efforts. Our Principal, Jason M. Healy, is a health care lawyer with over 15 years of experience with the array of legal issues facing health care providers.

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