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Court Upholds "Must-Bill" Policy for Dual-Eligible Bad Debts, Remands on Prior Lack of Enforcement

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On March 26, 2012, the U.S. District Court for the District of Columbia upheld the application of the Department of Health and Human Services' (HHS) "must-bill" policy to two long term care providers attempting to collect Medicare reimbursement for bad debts incurred as a result of treating certain dual-eligible patients. *Cove Associates Joint Venture v. Sebelius*, No. 1:10-cv-01316 (D.D.C. Mar. 26, 2012) [PDF]. Under the must-bill policy, a provider is required to bill its state Medicaid program for uncollectable coinsurance and deductible obligations associated with dual-eligibles before claiming payment for such costs as bad debt from Medicare. The policy also requires the provider to submit a state remittance advice as evidence that the state has refused payment. However, the court remanded the case to the CMS to determine whether the providers were justified in relying on CMS' prior failure to enforce the must-bill policy with respect to dual-eligible reimbursement claims from non-participating Medicaid providers.

The case involves two separate providers of skilled nursing and long term care hospital services (collectively, plaintiffs). The plaintiffs voluntarily elected not to participate in their respective state's Medicaid programs, but they do admit dual-eligible beneficiaries. The plaintiffs' respective fiscal intermediaries denied a total of $574,348 of dual-eligible bad debt reimbursement for the 2004 and 2005 fiscal years, citing the must-bill policy and the plaintiffs' failure to obtain a state remittance advice as the reason for denying reimbursement. The plaintiffs were unable to obtain a state-issued remittance advice, however, because the states refused to issue such advice to non-participating providers.

The Provider Reimbursement Review Board (PRRB) reversed the fiscal intermediaries' judgments, concluding that the application of the must-bill policy to

dual-eligible bad debts is improper when the provider does not participate in the Medicaid program. The CMS Administrator reversed the PRRB's ruling, however, holding that the bad debts were properly disallowed by the fiscal intermediaries because the state had not issued remittance advice for these services. Consequently, the bad debts did not satisfy the Medicare bad debt criteria.

The question presented to the court was whether the Administrator's decision that the must-bill policy applies to a provider's dual-eligible bad debts when the provider does not participate in the Medicaid program is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." Applying substantial deference, the court concluded that the must-bill policy is consistent with the Medicare statute and regulations, and is not an unreasonable implementation of either. However, the court left open the possibility that it may be arbitrary and capricious for the Secretary to not accept an alternative form of documentation in lieu of remittance advice or require the states to issue remittance advice to non-participating providers, observing that these providers are caught in a classic Catch-22: the fiscal intermediaries refuse to reimburse the facilities without a state-issued remittance advice, and the states refuse to issue such advice. The plaintiffs were denied summary judgment, however, because they had not yet made the correct applications to receive reimbursement – they had merely submitted "sample" bills with fabricated claim numbers.

The court also concluded that enforcement of the must-bill policy to plaintiffs' claims may be arbitrary, capricious, or an abuse of discretion because it constituted an unexplained departure from CMS's prior treatment of their dual-eligible bad debts. For all of plaintiffs' cost reporting prior to fiscal year 2004-2005, the fiscal intermediaries reimbursed plaintiffs for dual-eligible bad debts without the state remittance advice. Consequently, the court remanded the case to the agency for consideration of the limited issue of whether the plaintiffs were justified in relying on CMS' prior failure to enforce the must-bill policy with respect to dual-eligible reimbursement claims from non-participating Medicaid providers.

Ober|Kaler's Comments

The appeal period in this case is still running. Hospitals attempting to collect Medicare reimbursement for bad debts incurred as a result of treating dual-eligible patients should investigate whether they can work with their state Medicaid department to submit bills and obtain remittance advices or obtain other documentation which demonstrates that the state has refused payment.