PUBLICATION

Medicare Bad Debt: Courts Again Uphold HHS's Stringent 'Must Bill' Policy Requirements [Ober|Kaler]

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On March 25, 2014, the United States District Court for the District of Maine upheld the decision of the Department of Health and Human Services (HHS) to withhold from Maine Medical Center (MMC), Medicare reimbursement for dual eligible "bad debt," i.e., reimbursement for unpaid Medicare coinsurance and deductibles for patients who are also covered by Medicaid. *Maine Medical Center v. Sebelius*, Civil Action No. 2:13-cv-00118-JAW (D. Me. 2014) [PDF]. In determining HHS had appropriately denied MMC reimbursement for its dual eligible bad debt, the court concluded MMC had failed to meet the requirements of HHS's "must bill" policy. The decision reflects a growing body of case law in which courts have deferred to HHS's "must bill" policy.

1. Overview of HHS's "must bill" policy for the dual eligible population

Medicare bad debt is allowable by HHS only if a provider demonstrates, among other criteria, that it made "reasonable collection efforts" and that the bad debt was "actually uncollectible when claimed as worthless." 42 C.F.R. § 413.413.89(e). In furtherance of these regulatory requirements, HHS has implemented a "must bill" policy for all dual eligibles. That is, prior to submitting any dual eligible bad debt claims to HHS, all providers must first bill the applicable state Medicaid program and obtain a remittance advice documenting the state's payment (or lack thereof). *See* Joint Signature Memorandum 370 (August 10, 2004); PRM § 310, 312, and 322. Prior *Payment Matters* articles discuss HHS dual eligible, bad debt policy and related case law. *See* Court Again Rules Medicare's 'Must Bill' Policy for Medicare Dual Eligible Bad Debts Is Reasonable" (2012).

2. MMC's (unsuccessful) argument: HHS's dual eligible bad debt policy should not apply to its "unique" circumstances

MMC sought reimbursement for its dual eligible bad debt for its fiscal years 2002 and 2003. To support its claim, MMC requested remittances from the state Medicaid program (MaineCare). However, due to an "anomaly of unknown origin," MaineCare was unable to produce the remittances.

While recognizing that it lacked the required remittances, it nonetheless proceeded with its claim for reimbursement from HHS. MMC maintained that the remittance advices were not required "under the unique circumstances involved in [its] case" as (1) MMC had in fact made reasonable efforts to collect the required documentation from MaineCare; and (2) Mainecare's benefit manual expressly precluded all payments for dual eligible coinsurance and/or deductible amounts, making the remittance advice requirement superfluous.

3. The court's conclusion: HHS' "must bill" policy was reasonable, even under MMC's "unique" circumstances

The court rejected MMC's contention, asserting that CMS's requirement for remittance advices, even in the unique circumstances faced by MMC, was not arbitrary and capricious. It acknowledged that MMC would not be "getting paid for reimbursable services [MMC] rendered that either or both governments in some proportion

would admittedly owe had all procedural requirements been satisfied"; however, it ultimately concluded that HHS had a reasonable statutory and regulatory basis for its remittance advice requirement, with which MMC had failed to comply.

Ober|Kaler's Comments

Courts have consistently rejected providers' arguments to allow Medicare dual eligible bad debt in the absence of Medicaid remittance advices, even when the providers appear to have reasonable arguments for why the state could not or should not need to be billed and/or provide the remittance advices. In light of these decisions, providers should focus their efforts on getting the remittance advices from their state Medicaid programs, working with these programs when possible and taking other action involving CMS and/or the courts if necessary.