PUBLICATION

D.C. District Court Issues Two Decisions Addressing CMS's Medicare Bad Debt "Must Bill" Policy – One Rejecting the Policy and the Other Upholding the Policy

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In a significant break from preceding court decisions, the United States District Court for the District of Columbia recently struck down CMS's "must bill" policy, which requires that Medicare providers bill Medicaid and obtain remittance advices (RAs) from Medicaid before Medicare bad debt associated with dual eligible patients is allowed. In *Select Specialty Hospital – Denver, et al v. Azar,* the court applied the Supreme Court's recent ruling in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019), in finding that the CMS's "must bill" policy, reflected in a 2004 Joint Signature Memorandum (JSM-370) to Medicare contractors, was a substantive legal standard that the agency failed to appropriately adopt through notice-and-comment rulemaking. *Select*, No. 10-1356, Aug. 22, 2019.

However, even more recently, the same court upheld that same "must bill" policy in *New Lifecare Hospitals of N. Car. LLC, et al v. Azar*, No. 17-00237, September 27, 2019. The court in *Lifecare* did not address the Supreme Court's *Allina* decision, but ruled that the providers failed to prove a change in agency policy and that the providers had waived any arguments related to the Bad Debt Moratorium laws.

Background

Medicare reimburses providers for a portion of their bad debt through the cost reporting process. Bad debt includes unpaid copayments and deductibles for Medicare beneficiaries who are also eligible for Medicaid, i.e., dual eligible beneficiaries. *See* 42 C.F.R. § 413.89. For bad debt to be allowable, a provider must demonstrate, among other things, that no other source, including the state, is responsible for the payment. Medicare Provider Reimbursement Manual (PRM) § 312.C. 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 an RA from the state Medicaid agency reflecting that Medicaid will not pay the claim (or the beneficiary contribution) before the unpaid costs are eligible to be considered Medicare bad debt.

Select Specialty Decision

The providers in the *Select* case included 75 long term care hospitals (LTCHs) located in 26 states that sought Medicare bad debt reimbursement from 2005 through 2010, for dual eligible patients. The Medicare contractors for these providers rejected the claims because the providers did not produce Medicaid RAs to demonstrate that the Medicaid program was not responsible for the payments. The court found that the "must bill" policy was first applied to the appealing hospitals in 2007 for fiscal year 2005. None of the providers were participating in their states' Medicaid program until after the contractors' first disallowances, and during the relevant years some of the states would not permit the providers to enroll in Medicaid, e.g., a number of the states did not permit LTCHs to enroll. After Medicare began denying the providers' bad debts, the providers began submitting patient claims to their state Medicaid agencies which claims were rejected, because the providers were not, or could not, be enrolled in Medicaid. The providers also began submitting Medicaid enrollment applications, some of which were denied and some of which were granted. However, even once enrolled, the providers could not obtain Medicaid RAs for past periods.

The *Select* court looked first to the Supreme Court's recent *Allina* decision in analyzing the case, reiterating the standard set forth in *Allina* before the Circuit Court: "[T]he Medicare Act requires notice-and-comment rulemaking for any (1) 'rule, requirement, or other statement of policy' that (2) 'establishes or changes' (3) a

'substantive legal standard' that (4) governs 'payment for services.'" *Allina Health Services v. Price*, 863 F.3d 937, 943 (quoting 42 U.S.C. § 1395hh(a)(2)). The only element in dispute was whether the agency's application of the "must bill" policy constituted a change in a "substantive legal standard" within the meaning of the statute. The court concluded that requiring an RA, although perhaps appearing to be a merely procedural requirement, actually had significant substantive consequences for the contractual obligations that LTCHs had to undertake. The court concluded that when CMS imposed the RA requirement, it changed the "substantive legal standard" – state Medicaid participation – that LTCHs had to satisfy for bad debt reimbursement. Accordingly, the agency was required to adopt the requirement using proper notice-and-comment rulemaking, which it did not do.

Clearly, the court found the agency's position to be unreasonable when it stated that "CMS created a bureaucratic nightmare by requiring a certain type of paperwork that the plaintiffs simply could not provide without sufficient advanced notice, and by obstinately continuing to reject reimbursement claims rather than working to find reasonable solution." The court remanded the case to the agency "promptly" to reconsider whether the providers were entitled to the bad debt reimbursement absent the application of the "must bill" policy.

Lifecare Decision

A different judge from the same court, the United District Court for the District of Columbia, one month later upheld CMS's "must bill" policy against four LTCHs, located in four different states, all of which were not enrolled in Medicaid. The court found that the providers did not object to the must bill policy per se. Most significantly, the court did not address the effect of the Supreme Court's *Allina* decision on that policy. The court appeared to rely heavily on what it assessed as an absence of proof to substantiate a change in CMS policy that it began denying dual eligible bad debts for the LTCHs in 2008.

Contrary to the ruling in *Select*, the court in *Lifecare* found that the "must bill" policy does not unlawfully require providers to participate in Medicaid. The court also found that the providers had waived their argument that the agency's action violated the Moratorium Laws, which generally bar the agency from making changes in its bad debt policy in effect on August 1, 1987, because although the providers raised this issue before the Provider Reimbursement Review Board (PRRB), they did not do so before the Administrator. *See* Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100–203, tit. IV, § 4008(c), 101 Stat. 1330–55, as amended by Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100–647, tit. VIII, § 8402, 102 Stat. 3342, 3798, reprinted as amended at 42 U.S.C. § 1395f note (2012).

The court was not convinced that the providers were barred from billing the state Medicaid agencies and, ultimately, deferred to the agency determination, finding a "rational connection between the facts found the choices made."

Conclusion

It is highly likely that one or both of these decisions will be appealed to the United State Court of Appeals for the District of Columbia. There have been numerous decisions from the United States District Court for the District of Columbia in the last ten years addressing the "must bill" policy, which are discussed in earlier *Payment Matters* articles here, here and here. All of the more recent decisions, with the exception of *Select*, have upheld the policy. The Supreme Court's recent ruling in *Allina*, however, imposes more restrictive requirements on CMS's adoption of policies, requiring notice-and-comment rulemaking in far more situations than heretofore have been required. Providers have been protesting the "must bill" rule since it came out in 2004, and it appears there is at least one more round before the issue is resolved. The application of the *Allina* decision could turn the issue around for providers.