PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2016-D25

PROVIDERS –
LifeCare Hospitals

Provider Nos.: Various
(see Appendix A)

vs.

MEDICARE CONTRACTORS –
Novitas Solutions, Inc. and
Wisconsin Physicians Service

DATE OF HEARING -
February 21, 2014

Cost Reporting Periods Ended -
Various (see Appendix A)

CASE NOs.:
10-0988; 10-0989; 09-0320; 09-0330GC; 09-2117GC, 12-0057; 11-0569GC; 14-2864; 13-2360GC; 15-2603

INDEX

ISSUE STATEMENT

Whether the Centers for Medicare and Medicaid Services' ("CMS") must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in Medicaid?[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Provider Reimbursement Review Board ("Board") affirms the Medicare Contractors' dual eligible bad debt adjustments for those Providers located in Louisiana and Texas. The Board reverses the Medicare Contractors' dual eligible bad debt adjustments for those Providers located in North Carolina and Pennsylvania where the state Medicaid program would not enroll LTCHs. Therefore the Board remands the Providers located in North Carolina and Pennsylvania back to the relevant Medicare Contractor to determine the appropriate amount of bad debt reimbursement relating to the state Medicaid programs for North Carolina and Pennsylvania.

INTRODUCTION

LifeCare Management Services ("LifeCare") owns the four providers in this consolidated group appeal (the "LifeCare LTCHs" or "Providers"). The LifeCare LTCHs are Medicare-certified LTCHs located in Louisiana, Texas, North Carolina and Pennsylvania. None of the LifeCare LTCHs were enrolled as Medicaid providers in their respective states during the fiscal years ("FYs") at issue in this case – FYs 2005 to 2012.[2]

For FYs 2005 to 2012, the Medicare contractors[3] assigned to the LifeCare LTCHs (collectively, the "Medicare Contractors") issued notices of program reimbursement ("NPRs") denying payment for certain bad debts because the LifeCare LTCHs failed to obtain remittance advices ("RAs") from the relevant states Medicaid programs to document their bad debt claims. The LifeCare LTCHs filed timely appeals for each of the NPRs at issue and met the jurisdictional requirements for a hearing before the Board.[4]

The Board conducted a live hearing on February 21, 2014. The LifeCare LTCHs were represented by Jason M. Healy, Esq., of The Law Offices of Jason M. Healy, PLLC. The Medicare Contractors were represented by Robin Sanders, Esq., of the Blue Cross and Blue Shield Association.

STATEMENT OF THE FACTS AND RELEVANT LAW

For FYs 2005 to 2012, the LifeCare LTCHs claimed Medicare reimbursement for bad debt for unpaid Medicare co-insurance and deductibles for individuals who were eligible for both

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[1] Transcript ("Tr.") at 6.
[2] Stipulations at ¶ 4.
[3] The term "Medicare contractors" refers to fiscal intermediaries and Medicare administrative contractors.
[4] *See* 42 C.F.R. §§ 405.1835-405.1840.

Medicare and state Medicaid benefits (these individuals are commonly referred to as "dual eligible beneficiaries"). In addition, there are certain "qualified Medicare beneficiaries" or "QMBs" who are either a dual eligible or are entitled to Medicare Part A, whose family incomes do not exceed 100 percent of the federal poverty line ("FPL"), and whose resources do not exceed certain resource-eligibility standards.[5] Based on the testimony at the hearing, it is the Board's understanding that the bad debts at issue involve both dual eligibles and QMBs.[6] The Medicare Contractor denied bad debts reimbursement for these dual eligible beneficiaries because the LifeCare LTCHs did not comply with CMS' "must-bill" policy.

The Board has considered CMS' "must bill" policy as it relates to "dual eligible beneficiaries" and QMBs on numerous occasions. This policy requires that, prior to claiming a bad debt for a dual eligible or QMB, a provider must: (1) bill the relevant state Medicaid program for unpaid co-insurance and deductibles; and (2) obtain a Medicaid remittance advice ("RA") from the state Medicaid agency identifying the amount of payment or the reason for non-payment.

The regulations governing bad debt are located at 42 C.F.R. § 413.89 (2012).[7] Subsection (a) establishes the general rule that bad debts are deductions from revenue and are not to be included in allowable costs. However, in order to ensure that Medicare-covered costs are not shifted to individuals who are not covered by the Medicare program, subsection (d) specifies that debts attributable to Medicare deductibles and coinsurance are reimbursable as allowable costs. Subsection (e) specifies that such bad debts must meet the following criteria in order to be considered allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
(2) The provider must be able to establish that reasonable collection efforts were made.
(3) The debt was actually uncollectible when claimed as worthless.
(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

CMS has provided extensive guidance on its bad debt policy in the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), §§ 308, 310, 312 and 322. PRM 15-1 § 308 requires that the provider make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible. PRM 15-1 § 310 states that a "reasonable collection effort" involves sending a bill on or shortly after discharge or death.[8] However, this section by its own terms is inapplicable to indigent patients and specifically refers to § 312 which allows providers to "deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined to be eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively."

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[5] 42 U.S.C. § 1396d(p).
[6] *See* Tr. at 230.
[7] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).
[8] PRM 15-1 § 310 (copy included at Medicare Contractor Exhibit I-4 at 1-2).

While this language absolves the providers from taking further steps to prove the dual eligible patient indigent, subsection C of § 312 nonetheless requires providers to "determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian."

Further, federal law[9] requires state Medicaid programs to pay some or all of the deductibles and coinsurance for dual eligibles and QMBs, but the State may limit such payment to the state Medicaid program's "payment ceiling" which is generally the maximum amount that the state program would pay for the service. As a state often limits its obligations to pay deductibles and coinsurance to this ceiling, and this ceiling is close to (just above or below) the Medicare payment, state Medicaid programs often pay little to no portion of the Medicare deductibles and coinsurance due for dual eligibles and QMBs.

PRM 15-1 § 322 is entitled "Medicare Bad Debts Under State Welfare Programs" and, consistent with §§ 310 and 312, this section discusses bad debts involving dual eligibles and QMBs in terms of a State's "obligation" or responsibility to pay. These PRM provisions predate and, accordingly, comply with the Bad Debt Moratorium. The key sentences relevant to this appeal are:

> *Where the State is obligated* either by statute or *under the terms of its plan to pay* all, or *any part, of the Medicare deductible or coinsurance amounts*, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible and coinsurance amounts that the state is not obligated to pay can be included as a bad debt under Medicare, *provided that the requirements of § 312* or, if applicable, ***§ 310*** *are met.*[10]

First, this excerpt confirms that, if the Medicaid State plan provides for payment of Medicare coinsurance and deductibles (in whole or in part), then the amount of the payment cannot be allowable as a Medicare bad debt. Second, this excerpt cross-references the requirements of §§ 310 and 312 confirming that, *at a minimum*, the § 310 requirement to "bill . . . the party responsible" is applicable to claims involving dual eligibles and QMBs.[11] Finally, in order to be eligible for Medicaid payment (whether for a dual eligible or QMB), most state Medicaid programs require that a provider be enrolled or certified as a provider in the state Medicaid program.[12]

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[9] *See* 42 U.S.C. §§ 1396a(a)(10)(E), 1396a(n)(2), 1396d(p).

[10] (Emphasis added.)

[11] The Board recognizes that CMS issued a transmittal in November 1995 revising cost reporting instruction on bad debt documentation to allow providers "in lieu of billing" to submit alternative documentation to establish that nonpayment would have occurred if the crossover claim had been billed. *See* PRM 15-2, Ch. 11, Transmittal No. 4 (Nov. 1995) (revising PRM 15-2 § 1102.3). However, the Board notes that this decision does *not* opine on whether this 1995 transmittal does or does not violate the Bad Debt Moratorium (*i.e.*, whether that portion of CMS' "must bill" policy that requires billing of crossover claims even when nonpayment would have occurred if the crossover claim had been billed violates the Bad Debt Moratorium) because neither this sub-issue nor this transmittal are relevant to deciding the issues in this case.

[12] 42 C.F.R. § 431.107(2006).

In § 4008(c) of the Omnibus Budget Reconciliation Act of 1987,[13] Congress enacted a noncodified statutory provision that became known as the "Bad Debt Moratorium." In 1988, in § 8402 of the Technical and Miscellaneous Revenue Act of 1988,[14] Congress retroactively amended the Bad Debt Moratorium. In 1989, in § 6023 of the Omnibus Budget Reconciliation Act of 1989,[15] Congress again retroactively amended the Bad Debt Moratorium. As a result of these subsequent changes, the Bad Debt Moratorium essentially has two prongs: (1) the first prong prohibits CMS from changing its bad debt policy in effect on August 1, 1987; and (2) the second prong is a hold harmless provision that prohibits CMS from requiring a provider to change its bad debt collection policy when the Intermediary had accepted that policy prior to August 1, 1987.[16] The LifeCare LTCHs have only made arguments relative to the first prong.[17]

All of the LifeCare LTCHs were not enrolled as Medicaid providers in the respective state's Medicaid program during the fiscal years at issue.[18] Central to this case is the fact that the reasons for non-enrollment fall into two distinct categories that differ substantially in terms of why enrollment did not occur. In some states, the Medicaid program did not permit LTCHs, as a provider class, to enroll in the state Medicaid program and, therefore, enrollment was simply not an option for the LifeCare LTCHs.[19] In other states, enrollment of LTCHs was indisputably permitted; however, the LifeCare LTCHs voluntarily chose *not* to enroll.[20] In either case, the state Medicaid program refused to process claims submitted by the LifeCare LTCHs and issue Medicaid RAs because the LifeCare LTCHs were not enrolled as Medicaid providers.[21]

DISCUSSION, FINDINGS OF FACT, CONCLUSIONS OF LAW:

The LifeCare LTCHs contend that, prior to April 2008, the Medicare Contractors did not require non-Medicaid-participating providers to bill the various state Medicaid programs for Medicaid cost sharing amounts and obtain Medicaid RAs in order to be reimbursed for bad debts. The LifeCare LTCHs suggest that the Medicare Contractors either exempted these providers from the "must bill" policy or otherwise did not enforce the "must bill" policy.[22] However, the LifeCare LTCHs assert that, beginning in April 2008, the Medicare Contractors altered its well-established practice and began to deny these dual eligible bad debts unless the provider had an RA with a valid denial code. The LifeCare LTCHs state that they were first made aware of this change when they received adjustments to their NPRs beginning in April 2008.[23] The LifeCare LTCHs

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[13] Pub. L. No. 100-203, 101 Stat. 1330, 1330-55 (1987).
[14] Pub. L. No. 100-647, 102 Stat. 3342, 3798 (1988).
[15] Pub. L. No. 101-239, 103 Stat. 2106, 2167 (1989).
[16] Reprinted at 42 U.S.C. S 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services."
[17] *See* Tr. at 251-252.
[18] Stipulations, at ¶ 4; Providers' Post Hearing Brief at 5.
[19] Stipulations ¶ 5.
[20] Stipulations at ¶ 6.
[21] Providers' Post Hearing Brief at 5 (pointing out that, when the LifeCare LTCHs did attempt to bill the state Medicaid programs. the bills were not processed for payment and/or an RA was received with a denial code that indicated the relevant LifeCare LTCH was not eligible on the date of service). *See also* Provider Exhibits P-10, P-11.
[22] Providers' Post-Hearing Brief at 6; Tr.at 88.
[23] Providers' Post-Hearing Brief at 7 (citing to Provider Exhibits P-10 – P-19.

assert the relevant state Medicaid programs had no liability to pay a non-participating provider and, accordingly, they were excused from following Medicare policy related to dual eligible beneficiaries.[24]

LifeCare maintains that the Medicare Contractors' denial of the bad debts is unsupported by statute or regulation[25] and that the Medicare Contractors' application of the "must bill" policy is arbitrary and capricious.[26] The LifeCare LTCHs believe that they should be allowed to claim the Medicare bad debts because they have relied on longstanding agency practice which allowed non-Medicaid-participating providers to claim bad debts without obtaining Medicaid RAs.[27]

Further, the LifeCare LTCHs argue that CMS has recognized some exceptions to its "must bill" policy. Specifically, in briefs filed in connection with *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–0142 (N.D. Cal. Oct. 11, 2001), the Secretary recognized the following "two unique instances where the Secretary permits providers to claim Medicare crossover bad debt without billing the State Medicaid agency"[28]

1. Community mental health centers ("CMHCs").—CMHCs "are allowed to claim Medicare crossover bad debts without billing the State agency because CMHCs cannot bill the State agency given that they are not licensed by the State and, therefore, have no Medi-Cal provider numbers."[29]

2. Institutions for mental diseases ("IMDs").—IMDs "are permitted to claim Medicare crossover bad debts without billing the State agency where the services are provided to patients aged 22-64. This is because the Medicaid statute and regulations categorically preclude payment for services provided to patient aged 22-64 in IMDs, and the state accordingly has absolutely no responsibility for the coinsurance/deductibles associated with those particular services."[30]

The LifeCare LTCHs argue that the rationale for CMHCs and IMDs is equally applicable in this case because, similar to CMHCs and IMDs, many state Medicaid programs do not recognize and certify LTCHs as providers and, therefore, will neither enroll, process their Medicaid claims, nor issue RAs to them.[31]

Finally, the LifeCare LTCHs contend that they satisfied the requirement of *submitting* claims for the fiscal years at issue and that they could not obtain RAs because the state Medicaid program simply refused to process the claims of a non-Medicaid participating provider. As a result, the

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[24] Providers' Post Hearing Brief at 29.
[25] Providers' Final Position Paper at 46.
[26] *Id.* at 36-38.
[27] Providers' Post Hearing Brief at 57.
[28] Defendant's Memorandum in Reply to Plaintiffs' Opposition to Defendant's Motion for Summary Judgment at 9n.5, *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–0142, 2001 WL 1256890 (N.D. Cal. Oct. 11, 2001) (copy included at Provider Exhibit P-27).
[29] *Id.* (citations omitted).
[30] *Id.* (citations omitted).
[31] *See* Providers' Post-Hearing Brief at 87-91.

LifeCare LTCHs contend that they were forced to bear the costs of allowable Medicare bad debts, in violation of Medicare's statutory prohibition on cost shifting.[32] Further, they assert that, in connection with state Medicaid programs for which they did not enroll, the Medicare Contractors violated the Bad Debt Moratorium by requiring the LifeCare LTCHs to obtain Medicaid RAs from such state Medicaid programs prior to a claiming Medicare bad debt for a dual eligible or QMB.[33]

For its part, the Medicare Contractors maintain that federal regulations require providers to "maintain sufficient financial records and statistical data for proper determination of costs payable under the program"[34] and that requiring a provider to obtain RAs from the state Medicaid program is the only way to meet this requirement.[35] In addition, the Medicare Contractors state that the core requirement for CMS' "must bill" policy is found in the statute at 42 U.S.C. § 1396d(p)(3) which imposes cost sharing for dual eligible Medicare patients.[36] The Medicare Contractors assert that the need for CMS' "must bill" as it relates to dual eligibles is plainly evident because a patient's Medicaid status may change over the course of a very short period and states are entitled to change, enhance, or modify provisions of their Medicaid state plans, including their cost sharing obligation sunder § 1396d(p). It is the state Medicaid program that maintains the most accurate and up-to-date information to make a determination of a patient's Medicaid eligibility status at the time of service and the state must determine its cost sharing responsibility, if any, for any unpaid Medicare deductibles and coinsurance based on the state plan in effect.[37]

Having considered the positions of the parties, the evidence presented and the statutory and regulatory authority, the Board finds that pre-1987 bad debt policy in the PRM clearly established that providers have an obligation to bill "the responsible party." The Board recognizes that this decision differs from the Board's findings and conclusions in its 2010 decision in *Select Specialty '05 Medicare Dual Eligible Bad Debt Grp. v Blue Cross Blue Shield Ass'n* ("*Select*").[38] However, the Board now has the benefit of considering several federal court decisions on this matter as well as the Administrator's decision upon remand of the *Select* case from the U.S. District Court for the District of Columbia ("D.C.").[39]

Three federal courts have reviewed CMS' "must bill" policy. While none of the decisions applied the Bad Debt Moratorium, they are still instructive as to CMS' policy. The First Circuit concluded that "some version" of a "must bill" policy has generally been enforced and that a general requirement (as opposed to a *per se* requirement) to obtain a Medicaid RA for crossover claims is entitled to deference where "the Secretary has made exceptions and accepted

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[32] *See id.* at 74-79; 42 U.S.C.§ 1395x(v)(1)(A)(i).
[33] *See* Providers' Post-Hearing Brief at 73-74.
[34] 42 C.F.R. § 413.20(a).
[35] Medicare Contractor's Post-Hearing Brief at 16.
[36] *Id.* at 9.
[37] Medicare Contractor's Final Position Paper at 8.
[38] PRRB Dec. No. 2010-D25 (Apr. 13, 2010), *rev'd*, CMS Adm'r Dec. (Mar. 15, 2016).
[39] *Select Specialty '05 Medicare Dual Eligible Bad Debt Grp. v Blue Cross Blue Shield Ass'n*, CMS Adm'r Dec. (Mar. 15, 2016), *on remand from*, *Cove Associates Joint Venture v Sebelius*, 848 F. Supp. 2d 13 (D.D.C. 2012).

alternative documentation *from the State* where circumstances warranted the exception."[40] Similarly, the D.C. Circuit found that it is "sensible for the Secretary to require that the state determine in the first instance the Medicaid eligibility of the claims and the appropriate amount of state payment owed."[41] Finally, the Ninth Circuit deferred to the Secretary's reasonable determination that "the must bill policy is a 'fundamental requirement to demonstrate'… that reasonable collection efforts [have been] made and that 'the debt was actually uncollectible when claimed [as worthless]."[42]

A. LIFECARE LTCHS LOCATED IN LOUISIANA AND TEXAS.

Our review of the record shows that, for the state Medicaid program in Louisiana and Texas, the two LifeCare LTCHs located in these states could have enrolled in those programs even though there are bad debts at issue involving those programs. Specifically, these LifeCare LTCHs faced no bar on enrolling as a Medicaid provider in Louisiana and Texas and obtaining a Medicaid billing number for those programs. In this regard, the LifeCare LTCHs' witness testified that the LifeCare LTCH located in Louisiana voluntarily terminated its Medicaid participation in 1997[43] and that the LifeCare LTCH located in Texas chose not to enroll as a Medicaid provider because of the low rate of reimbursement.[44]

Notwithstanding their decision not to enroll in the Group A States, the LifeCare LTCHs located in those states did submit certain claims involving the bad debts at issue in this case. However, none of these claims were paid and the LifeCare LTCHs receive little communication back from the state Medicaid programs except to deny the claims because the LifeCare LTCHs were not enrolled as Medicaid providers. None of the claims were denied because the LifeCare LTCH *could not* enroll or that the claim was not payable.[45]

As previously discussed, PRM 15-1 § 322 confirms that, if the Medicaid State plan provides for payment of Medicare coinsurance and deductibles (in whole or in part), then the amount of the payment cannot be allowable as Medicare bad debt. Significantly, this is a blanket requirement that it not predicated on whether the provider does or does not participates in the relevant Medicaid program.[46] Second, this excerpt cross-references the requirements of § 310 confirming that, *at a minimum*, the § 310 requirement to "bill . . . the party responsible" is applicable to crossover claims (*i.e.*, claims involving dual eligibles and QMBs).[47]

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[40] *Maine Med. Ctr. v. Burwell*, 775 F. 3d 470, 475, 480 (1st Cir. 2015) (emphasis in original).
[41] *Grossmont Hosp. Corp v. Burwell*, 797 F. 3d 1079, 1085 (D.C. Cir. 2015), *reh'g en banc denied*, (D.C. Cir. 2015).
[42] *Community Hosp. of Monterey Peninsula v. Thompson*, 323 F.3d 782, 792, 796 (9th Cir. 2003).
[43] Tr. at 186-187.
[44] Tr. at 190-191.
[45] *See* Providers' Reply Brief at 4, 7-8 (citing to Provider Exhibits P-44, P-45, P-51 to P-53).
[46] *See also Cove Assocs. Jt. Venture v. Sebelius*, 848 F. Supp. 2.d 13, 25 (D.D.C. 2012).
[47] The Board recognizes that CMS issued a transmittal in November 1995 revising cost reporting instruction on bad debt documentation to allow providers "in lieu of billing" to submit alternative documentation to establish that nonpayment would have occurred if the crossover claim had been billed. *See* PRM 15-2, Ch. 11, Transmittal No. 4 (Nov. 1995) (revising PRM 15-2 § 1102.3). However, the Board notes that this decision does *not* opine on whether this 1995 transmittal does or does not violate the Bad Debt Moratorium (*i.e.*, whether that portion of CMS' "must bill" policy that requires billing of crossover claims even when nonpayment would have occurred if the crossover

Notwithstanding the § 322 need to determine whether the relevant state Medicaid program was "responsible," the Lifecare LTCHs made business decisions not to enroll in the state's Medicaid programs for Louisiana and Texas and have not submitted any documentation (whether in the form of RAs or other evidence[48]) that confirms these state Medicaid programs are not responsible for Medicare coinsurance and deductibles of either dual eligibles or QMBs. Further, as previously noted, PRM § 322 pre-dates and complies with the Bad Debt Moratorium.[49]

Further, the Board notes that, in October 2004,[50] the Medicare Contractors advised the LifeCare LTCHs that they would be required to bill the state Medicaid program for dual eligibles and QMBs.[51] Up until approximately April 2008, however, the evidence in record indicates that some of the Medicare Contractors continued to reimburse some of the LifeCare LTCHs' bad debts related to dual eligibles and QMBs without a Medicaid RA.[52] Since the LifeCare LTCHs located in Louisiana and Texas clearly had the ability to become Medicaid providers but choose not do so until *after* the end of the fiscal years at issue, theses LTCHs cannot demonstrate during the time period covered in this appeal that they were compliance with full set of Medicare bad debt requirements.[53]

The Board finds that, notwithstanding the fact that the LTCHs were on notice that Medicaid billing was required to ensure Medicare reimbursement for bad debts, the Louisiana and Texas

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claim had been billed violates the Bad Debt Moratorium) because neither this sub-issue nor this transmittal are relevant to deciding the issues in this case.

[48] The LifeCare LTCHs point to the 1995 bad debt instructions for the CMS Form 339 to support their position that an RA is not required (*see* Providers' Final Position Paper at 4) yet they did not comply with those instructions. These instructions specify that, "to establish that Medicaid is not responsible for payment," the provide may, in lieu of billing, furnish documentation of Medicaid eligibility and proof that "non-payment would have occurred if the . . . claim had been filed with Medicaid." However, the LifeCare LTCHs have not furnished any evidence that the Louisiana and Texas are not responsible for payment *under the state Medicaid plan* had a claim been filed. As the LifeCare LTCHs have not submitted evidence outside of RAs to demonstrate that Louisiana and Texas had no responsibility for coinsurance and deductibles, the Board need not address: (1) whether this other documentation would be acceptable; or (2) whether the CMS' position that the "must bill" policy necessarily includes obtaining an RA from a state even when that state has no responsibility violates the Bad Debt Moratorium.

[49] In support of its position, the Board notes the following examples of pre-1987 agency statements and Board cases applying CMS' bad debt policy: HCFA Action No. HCFA-AT-77-73 (MMB) (July 5, 1977) (responding to questions about a change in federal law in January, 1968 which made payment of Medicare deductible and copayments by the state Medicaid program optional) (copy included as Board Exhibit B-1); *Geriatric and Med'l Ctrs., Inc. v. Blue Cross Ass'n,* PRRB Dec. No. 82-D62 (Mar. 3, 1982) (finding that "the cost of these services were not included in payments for services covered by the State of Pennsylvania"), *decl'd* review, HCFA Adm'r (Apr. 23, 1982); *Concourse Nursing Home Grp. Appeal v. Travelers Ins. Co.*, PRRB Dec. No. 1983-D152 (Sept. 27, 1983) (finding that "the Provider has furnished no documentation which would support its contentions that it had established collection policies and procedures or that actual collection efforts were made to obtain payments from the patients or the Medicaid authorities before an account balance was considered . . . bad debt"), *decl'd review*, HCFA Adm'r (Nov. 4, 1983); *St. Joseph Hospital v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 84-D109 (Apr. 16, 1984) (finding that "the Provider did not attempt to bill the State of Georgia for its Medicaid patients"), *decl'd review*, HCFA Adm'r (May 14, 1984).

[50] Well in advance of the 2005 – 20012 cost reports at issue in this appeal.

[51] Medicare Contractor's Post-Hearing Brief at 18; Exhibit I-7; Tr. at 184.

[52] Providers' Post Hearing Brief at 63.

[53] PRM 15-1 § 312.

LTCHs made a business decision *not* to participate as providers in the state Medicaid program and it was this unilateral exercise of discretion that precluded billing Medicaid and obtaining the Medicaid RAs required for bad debt reimbursement. The Board concludes that the Medicare Contractor's disallowance of the LTCHs' bad debt was proper since the respective LTCHs could have enrolled in the state's Medicaid program but choose not to, and in so choosing precluded compliance with the full set of applicable bad debt reimbursement requirements.

B. STATES IN WHICH LTCHS DID NOT HAVE THE OPTION TO BE CERTIFIED AS MEDICAID PROVIDERS

The record shows that the LTCHs located in North Carolina and Pennsylvania, through no act or choice of their own did not have the option enroll in their respective state Medicaid program as Medicaid providers for the fiscal years at issue.[54] The Board finds that both the state Medicaid program for North Carolina and Pennsylvania neither recognized nor reimbursed LTCHs, including but not limited to the LifeCare LTCHs. This is similar to the exception to the must bill policy that CMS recognized for CMHCs in the *Monterey* case.

Moreover, the LifeCare LTCHs located in North Carolina and Pennsylvania clearly appeared to be caught in a "Catch-22" as identified by the D.C. District Court in *Cove Assocs. Jt. Venture v. Sebelius* ("*Cove*").[55] Like the LTCHS in Cove, the LifeCare LTCHs located in North Carolina and Pennsylvania were told to comply with the Medicare "must bill" policy but were unable to do so because billing privileges for these state Medicaid programs were contingent on enrollment in those programs and, as LTCHs, they could not enroll in the relevant state Medicaid programs. As the *Cove* Court stated, LTCHs in these situations "are left in the untenable position of either refusing to treat dual-eligible patients or absorbing the bad debts associated with those patients."[56]

In *Cove*, the Secretary's position was that "states are required to issue RAs (regardless of a provider's participation status)" although the agency's counsel conceded "it was in a better position that the providers to ensure that the states comply." However, the *Cove* Court was "not willing to place a stamp of judicial approval on a policy that would put non-participating providers in the position of not being paid due to the delinquency of federally-funded state programs."[57]

In the present case, it is North Carolina and Pennsylvania's prohibition on enrolling LTCHs as Medicaid providers (rather than the LifeCare LTCHs' discretionary avoidance of enrollment in Medicaid) that prevented the LifeCare LTCHs located in North Carolina and Pennsylvania from obtaining Medicaid RAs. Based on *Cove,* the Board concludes that the Medicare Contractor's disallowance of the bad debt reimbursement should be reversed for the LifeCare LTCHs located in North Carolina and Pennsylvania where the record before the Board shows the respective state

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[54] Providers' Final Position Paper at 42; Providers' Post Hearing Brief at 41 – 45; Provider Exhibits P- 54, P-55; Tr. at 129, 132-133.
[55] *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012) (copy included at Provider Exhibit P-25).
[56] *Id*. at 28.
[57] *Id*. at 28.

Medicaid programs (for those years) were unwilling to enroll LTCHs as Medicaid providers. These years should be remanded to Medicare Contractor to determine the appropriate bad debt reimbursement involving the state Medicaid programs for North Carolina and Pennsylvania based on documentation that does not include a State-issued RA.

DECISION AND ORDER:

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Provider Reimbursement Review Board ("Board") the Board affirms the Medicare Contractors' dual eligible bad debt adjustments for those LifeCare LTCHs located in Louisiana and Texas. The Board reverses the Medicare Contractors' dual eligible bad debt adjustments for those LifeCare LTCHs located in North Carolina and Pennsylvania where the state Medicaid program would not enroll LTCHs. Therefore the Board remands the LifeCare LTCHs located in North Carolina and Pennsylvania back to the relevant Medicare Contractor to determine the appropriate amount of bad debt reimbursement relating to the state Medicaid programs for North Carolina and Pennsylvania.

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FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: September 28, 2016

APPENDIX A

State	Provider No.	Provider Name	FYE	Case No.	Date of Enrollment in Medicaid**
Louisiana	19-2015	LifeCare Hospitals of New Orleans, Louisiana	07/31/2005	10-0988	Provider was enrolled in Medicaid but terminated enrollment in 1997.
Louisiana	19-2015	LifeCare Hospitals of New Orleans, Louisiana	07/31/2006	10-0989	Provider was enrolled in Medicaid but terminated enrollment in 1997.
North Carolina	34-2013	LifeCare Hospital of North Carolina	02/28/2007	09-0330GC	Enroll in Medicaid in May 2011
North Carolina	34-2013	LifeCare Hospital of North Carolina	02/29/2008	09-2117GC	Enroll in Medicaid in May 2011
North Carolina	34-2013	LifeCare Hospital of North Carolina	02/28/2009	11-0569GC	Enroll in Medicaid in May 2011
North Carolina	34-2013	LifeCare Hospital of North Carolina	02/28/2010	12-0057	Enroll in Medicaid in May 2011
North Carolina	34-2013	LifeCare Hospital of North Carolina	02/28/2011	13-2360GC	Enroll in Medicaid in May 2011
Pennsylvania	39-2048	Life Care Hospital of Chester County, PA	03/31/2008	09-2117GC	Enrolled in Medicaid in May 2012
Pennsylvania	39-2048	Life Care Hospital of Chester County, PA	03/31/2011	13-2360GC	Enrolled in Medicaid in May 2012
Pennsylvania	39-2048	Life Care Hospital of Chester County, PA	03/31/2012	14-2864	Enrolled in Medicaid in May 2012
Pennsylvania	39-2048*	Life Care Hospital of Chester County, PA	03/31/2007	09-0330GC	Enrolled in Medicaid in May 2012
Texas	45-2063	LifeCare Hospital of South Texas	12/31/2006	09-0320	Enroll in Medicaid in February 2011
Texas	45-2063*	LifeCare Hospital of South Texas	12/31/2007	09-0330GC	Enroll in Medicaid in February 2011
Texas	45-2063	LifeCare Hospital of South Texas	12/31/2009	11-0569GC	Enroll in Medicaid in February 2011
Texas	45-2063	LifeCare Hospital of South Texas	12/31/2012	15-2603	Enroll in Medicaid in February 2011

* Provider number is incorrect on Schedule of Providers for CN 09-0330GC

** *See* Provider Exhibit P-55.