PUBLICATION

D.C. Federal Appeals Court Upholds Disallowances Based on "Must-Bill" Bad Debt Policy

August 26, 2021

In a recent blow for providers, the United States Court of Appeals for the District of Columbia Circuit upheld in *New LifeCare Hospitals of N.C., LLC v. Becerra* the Medicare program's denial of Medicare bad debt to a group of hospitals that challenged the application of the agency's must-bill policy.

Medicare Bad Debt and the Must-Bill Policy

Medicare makes payment to providers for Medicare bad debt, which is unpaid Medicare copay and deductible amounts for Medicare beneficiaries. Sometimes these beneficiaries are also eligible for Medicaid and are referred to as dual eligible beneficiaries. Patients who are eligible for both Medicaid and Medicare often are unable to afford their Medicare copay and deductible amounts, which the state Medicaid program may pay. If the Medicaid program does not cover these amounts, they can be claimed as Medicare bad debt.

Before a provider may seek reimbursement for its Medicare bad debt, it must demonstrate that "reasonable collection efforts" were made, which includes billing the party responsible for the patients' payments. The Medicare Provider Reimbursement Manual further provides that Medicare bad debt does not include any amounts that a state Medicaid program is obligated to pay.

In 2004, the Centers for Medicare & Medicaid Services (CMS) issued a joint memorandum expanding on the reasonable collection efforts expected of providers with dual eligible patients, requiring providers to both: (1) bill the state Medicaid program for the unpaid copay and deductible amounts and (2) receive a remittance advice from the state Medicaid program, before claiming any related Medicare bad debt. This became known as the "must-bill" policy.

Additionally, Congress adopted the "Bad Debt Moratorium" law in 1987, which prevents CMS from making "any change in the policy in effect on August 1, 1987, with respect to payment" for "unpaid deductible and coinsurance amounts."

Case Background

The providers in *New LifeCare Hospitals* were four long-term care hospitals located in four different states: North Carolina, Pennsylvania, Texas and Louisiana. The hospitals treated patients who were dually eligible for both Medicare and Medicaid. In 2008, the hospitals claimed Medicare bad debt related to their dual eligible patients, which the Medicare program denied on the basis that the hospitals failed to comply with the must-bill policy. The hospitals were not enrolled in Medicaid during the year at issue, and thus did not bill Medicaid for the unpaid Medicare copayments and deductibles at issue.

The Medicare program denied payment of the amounts at issue and the providers appealed to the Provider Reimbursement Review Board (Board). The Board upheld the program's decision with regard to two of the hospitals but reversed with regard to the other two hospitals. With respect to the hospitals located in Louisiana and Texas, the Board found that they had made a business decision not to enroll in Medicaid and that nothing prevented them from complying with the must-bill policy except for their decision not to enroll, and thus the Board denied payment for these hospitals. However, for the hospitals located in North Carolina and Pennsylvania, the Board found they were unable through no fault of their own to bill Medicaid, and thus

ordered the Medicare program to accept an alternative form of documentation to the remittance advice and reconsider these claims.

The CMS Administrator reviewed the Board's determination and partially reversed it, resulting in a denial of all of the hospitals' reimbursement claims. The Administrator reasoned that the state Medicaid programs are required to allow limited enrollment for the purpose of complying with the must-bill policy, and that if a state refuses, the provider's recourse is to sue the state.

The hospitals appealed this decision to the United States District Court for the District of Columbia, challenging the Medicare program's sudden enforcement of the must-bill policy in April 2008 but not challenging the 2004 policy per se. The court ruled in favor of the agency, finding that the hospitals failed to prove that the agency actually changed its application of the must-bill policy. The court declined to reach the hospitals' arguments that the agency violated the Bad Debt Moratorium, because the hospitals did not raise that issue before the Administrator, even though it was addressed before the Board.

Appeals Court Decision

Before the appeals court, the hospitals argued the agency's abrupt enforcement of the must-bill policy in April 2008 amounted to an interpretive rule that violated the Medicare Act and the Administrative Procedure Act, because it required but lacked the requisite notice-and-comment rulemaking. The court rejected this argument, finding no change in policy by the agency. The court upheld the findings of the Administrator below that while Medicare contractors may have failed to properly audit the hospitals' must-bill compliance before April 2008, those errors do not amount to a change in agency policy. The court distinguished an earlier decision by the same court in *Select Specialty Hospital – Denver, et al. v. Azar,* which struck down the must-bill policy for failure of the agency to go through notice-and-comment rulemaking when it adopted the must-bill rule and, in particular, the remittance advice requirement. The court appears to have relied on the fact that the hospitals in *New LifeCare* challenged the agency's sudden enforcement of the must-bill policy and not the actual adoption of that policy, as was challenged in *Select Specialty*. For a discussion of the district court's rulings in *New LifeCare* and *Select Specialty* see our earlier article.

The court next addressed the hospitals' Bad Debt Moratorium challenge. The court noted the must-bill policy has two requirements, that a hospital (1) bill the state and (2) obtain a remittance advice. The hospitals argued that only the remittance advice requirement violated the Moratorium. The court found it did not need to address this argument, because the hospitals failed to challenge the finding below that they violated the billing requirement, which predated the remittance advice requirement. The hospitals advanced additional arguments, including several arbitrary and capricious arguments, that the court also rejected. The court affirmed the judgment of the district court.

Implications for Providers

In the last ten years there have been numerous decisions from the United States District Court for the District of Columbia, and one case in the United States District Court for the District of Maine, addressing the must-bill policy, which are discussed in earlier *Payment Matters* articles here, here, here and here. Only in the *Select Specialty* case did the hospital prevail in convincing the court to strike down the agency's application of the must-bill policy to disallow a hospital's dual eligible Medicare bad debt. So, while there may still be opportunities for successful challenges either with facts and arguments similar to those put forth by the *Select Specialties* hospitals or in federal courts outside D.C. or Maine, hospitals going forward would be better positioned on this issue to take steps to enroll in a state's Medicaid plan so they could submit bills to that plan. It may require making calls to the state plan to explain the need to be able to bill for Medicare bad debt purposes.

Additionally, the Medicare program recently changed its bad debt regulations regarding collection activities for dual eligible beneficiaries, building in an alternative to submission of remittance advices in certain circumstances. The regulation at42 C.F.R. § 413.89(e)(2)(iii)(B) provides:

When, through no fault of the provider, a provider does not receive a Medicaid remittance advice because the State does not permit a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, or because the State does not generate a Medicaid remittance advice, the provider—
(1) Must submit to its contractor, all of the following auditable and verifiable documentation:
(i) The State's Medicaid notification stating that the State has no legal obligation to pay the provider for the beneficiary's Medicare cost sharing.
(ii) A calculation of the amount the State owes the provider for Medicare cost sharing.
(iii) Verification of the beneficiary's eligibility for Medicaid for the date of service.

These provisions are applicable both retrospectively and prospectively. 85 Fed. Reg. 58432, 59004 (Sept. 18, 2020).

For more information or any question regarding these issues, please contact any member of Baker Donelson's Reimbursement team.