The Law Offices of
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Health Care Provider
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FEDERAL COURT STRIKES DOWN "MUST-BILL" REQUIREMENTS FOR DUAL ELIGIBLE BAD DEBTS OF NON-MEDICAID-PARTICIPATING PROVIDERS

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In a long-running challenge to denied Medicare bad debts by 75 long-term care hospitals ("LTCHs") in 26 states and spanning six fiscal years, the United States District Court for the District of Columbia ruled that the Centers for Medicare & Medicaid Services ("CMS") should not have required them to bill the state Medicaid programs and obtain a remittance advice ("RA") with a payment determination (*i.e.*, the "must-bill" policy) because this was a change to a substantive legal requirement that required notice and comment rulemaking.[1] This is also one of the first cases to apply the recent Supreme Court decision in *Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019). We represented the providers in these appeals.

Chief Judge Beryl Howell issued the memorandum opinion in these three consolidated cases. She found that, before 2007, CMS reimbursed these LTCHs for their dual-eligible patients' unpaid co-insurance and deductible amounts ("bad debts") without requiring them to bill the state Medicaid programs for an RA showing how much of that bad debt would be covered. CMS considered it unnecessary for them to bill state Medicaid programs because the states were not liable for dual-eligible bad debts incurred at LTCHs that do not participate in Medicaid. But, in 2007, CMS abruptly began applying the must-bill policy to these LTCHs while reviewing their filed cost reports, denying Medicare reimbursement unless the LTCH had both billed the state Medicaid program and received an RA to prove that Medicaid was not liable for the bad debt. However, the LTCHs were not enrolled in Medicaid, so they could not bill the state or obtain valid RAs. This put the LTCHs in a classic catch-22 with no way to comply with the new must-bill policy. To make matters worse, many states refused to enroll the hospitals in their Medicaid programs because LTCH was not a recognized provider-type. Even in states that eventually allowed the LTCHs to enroll in Medicaid, it was impossible to obtain RAs for the prior fiscal years in most cases.

The plaintiffs argued, among other things, that CMS was not allowed to change the requirements for Medicare bad debt reimbursement for non-Medicaid-participating providers without conducting notice-and-comment rulemaking, as required by the Medicare Act, 42 U.S.C. § 1395hh(a)(2). Chief Judge Howell determined that the D.C. Circuit's holding in *Allina Health Servs. v. Price* (*Allina II*), 863 F.3d 937 (D.C. Cir. 2017), which was recently

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affirmed by the Supreme Court, confirms that the plaintiffs are correct. First, the must-bill policy has two components. Even though the state billing requirement may have existed in some form since 1983, it was not applied to these non-Medicaid-participating LTCHs until some of the FY 2005 cost reports were audited in 2007. CMS did not impose an absolute RA requirement until it issued Joint Signature Memorandum 370 ("JSM-370") in 2004. But, a JSM is not issued to the public and it is not an appropriate vehicle to set policy. It is a way for CMS to communicate internally with its contractors. Citing another recent decision by this court, Chief Judge Howell concluded that nothing in the record supports an absolute RA requirement before JSM-370.[2] Second, contemporaneous correspondence in the record confirmed that "CMS's application of the must-bill and RA requirements to the plaintiffs in 2007 was a change in policy."[3] Third, there is no legal requirement that a Medicare-certified hospital enroll in Medicaid as a condition of participation in Medicare or to obtain Medicare reimbursement.

The opinion holds that, under the Supreme Court's recent decision in *Allina*, the "plaintiffs are entitled to summary judgment on their claim that CMS was required, under the Medicare Act, 42 U.S.C. § 1395hh(a)(2), to conduct notice-and-comment rulemaking before subjecting the plaintiffs, as non-Medicaid-participating providers, to the must-bill policy and the RA requirement."[4] This section of the 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."[5] After sorting through the differences between a "substantive legal standard" under the Medicare Act versus the Administrative Procedure Act ("APA"), the opinion states that when CMS imposed the RA requirement it changed a substantive legal standard under the D.C. Circuit's definition of that term because it "changed the eligibility criteria for reimbursement under the Medicare Act for dual-eligible patients, by requiring provider participation in the state Medicaid program."[6] CMS argued that the plaintiffs do not have to participate in Medicaid to comply with the must-bill policy. They can just submit bills and the states are required to process them. But nothing in the record supported this position and the LTCHs' own experience was that the states would not allow them to submit bills if they were not enrolled as full-fledged Medicaid providers.

Chief Judge Howell's conclusion is deeply critical of CMS, echoing the plaintiffs' frustration with CMS on this issue:

> 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 deny reimbursement claims rather than working to find a reasonable solution in conjunction with the state Medicaid programs. For many of the plaintiffs, this has already been a twelve-year journey to obtain reimbursement for dual-eligible patients' bad debts. Indeed, this whole affair is likely just the sort of scenario Congress sought to avoid by enacting the notice-and-comment requirement of § 1395hh(a)(2), ensuring that all parties would receive sufficient advanced notice of meaningful changes to reimbursement requirements. At any rate, without satisfying the notice-and-comment obligation of § 1395hh(a)(2), CMS could not, and indeed

cannot, impose the must-bill policy and RA requirement on the plaintiffs for the period when they were non-Medicaid-participating providers.[7]

The Court's order set aside and struck in their entirety all of the CMS Administrator decisions in this consolidated case, and the opinion directed the agency to promptly determine the plaintiffs' bad debt reimbursement *without* considering the must-bill and RA requirements.

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[1] *Select Specialty Hospital – Denver, Inc., et al. v. Azar*, No. 10-1356, Memorandum Opinion, Dkt. 75 (Aug. 22, 2019) (C.J. Howell).
[2] *Mercy Gen. Hosp. v. Azar*, 344 F. Supp. 3d 321, 351 (D.D.C. 2018) ("[T]he Court concludes that the Administrator's finding that a remittance advice requirement existed prior to [August 1, 1987] is not supported by substantial evidence.").
[3] *Select Specialty Hospital – Denver,* Memorandum Opinion at 12.
[4] *Id*. at 21.
[5] *Id*. (citing *Allina II*, 863 F.3d at 943 (quoting 42 U.S.C. § 1395hh(a)(2)).
[6] *Id*.
[7] *Id*. at 27.

About Us

The Law Offices of Jason M. Healy PLLC is a Washington, D.C. based law firm serving national and local clients. We focus primarily on legal issues affecting health care providers and welfare benefit plans. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations, and address compliance matters. We also represent health care providers in reimbursement audits, appeals, litigation, and transactions. We help sponsors of welfare benefit plans understand and comply with federal and state laws and prepare plan documents. Located in Washington, DC, just minutes from the Department of Health and Human Services, Congressional offices, and the White House, we are well positioned to provide legal support for advocacy efforts. Our Principal, Jason M. Healy, is a health care lawyer with over 20 years of experience with the array of legal issues facing health care providers.

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