PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D23

PROVIDER –
Life Care Center of Scottsdale

Provider No.: 03-5143

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Riverbend Government Benefits
Administrator

DATE OF HEARING –
June 2, 2009

Cost Reporting Periods Ended –
December 31, 2004 and
December 31, 2005

CASE NOs.: 07-0459 and 07-2370

INDEX

ISSUE:

Whether the CMS must-bill policy applies to the Provider's dual-eligible bad debts when the Provider did not participate in the Medicaid program.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h; 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The Medicare program reimburses providers for bad debts resulting from deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries. 42 C.F.R. §413.89(e) requires that bad debts must meet the following criteria to be 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 Pub. 15-1, Provider Reimbursement Manual Part I ("PRM-I") §308 restates these requirements, while PRM-I §310 addresses the concept of "reasonable collection effort" as follows:

> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort

> the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See §312 for indigent or medically indigent patients.)

PRM-I §312 states that, "providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively." For such beneficiaries, the debt may be deemed uncollectible without applying the collection procedures outlined in §310.

This section goes on to reference PRM-I §322 to address Medicare bad debts under State Welfare Programs. Section 322, states in pertinent part:

> Effective with the 1967 Amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically or medically needy persons. For example, a State which covers hospital care for only 30 days for Medicaid recipients is not obligated (unless made part of the State title XIX plan) to pay all or part of the Medicare coinsurance from the 61st day on. For services that are within the scope of the title XIX plan, States continue to be obligated to pay the full deductible and coinsurance for categorically needy persons for most services, but can impose some cost sharing under the plan on medically needy persons as long as the amount paid is related to the individual's income or resources.
>
> 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 or 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.

PRM-II, §1102.3L, offers implementing guidance for debt collection activities and specifically addressed crossover bad debts (bad debts relating to beneficiaries dually eligible for Medicare and Medicaid). It states in relevant part:

> [e]vidence of a debt arising from Medicare/Medicaid crossovers may include a copy of the Medicaid remittance showing the crossover claim and resulting Medicaid payment or non-payment. However, it may not be

> necessary for a provider to actually bill the Medicaid program to establish a Medicare crossover bad debt where the provider can establish that Medicaid is not responsible for payment. In lieu of billing the Medicaid program, the provider must furnish documentation of:
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> - Medicaid eligibility at the time services were rendered (via valid Medicaid eligibility number), and
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> - Nonpayment would have occurred if the crossover claim had actually been filed with Medicaid.

The dispute in this case involves the Provider's debt collection and write-off policies for Medicare/Medicaid dual eligible patients.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Life Care Center of Scottsdale ("Provider") is a freestanding Medicare-certified skilled nursing facility ("SNF") located in Scottsdale, Arizona. The Provider does not participant in Arizona's Medicaid program, also referred to as Arizona Health Care Cost Containment System ("AHCCCS"). During the cost reporting periods at issue, the Provider claimed Medicare bad debts on their cost report for beneficiaries who were also eligible for Medicaid benefits under the state's Medicaid program (i.e. dual eligible beneficiaries). Riverbend Government Benefits Administrator ("Intermediary") disallowed all the bad debts based upon the CMS must-bill policy, which requires the Provider to bill the state Medicaid program and obtain a remittance advice (RA).

The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Jason M. Healy, Esq. ReedSmith LLP. The Intermediary was represented by Bernard M. Talbert, Esq. of the BlueCross BlueShield Association.

PARTIES' STIPULATIONS:

The parties submitted a joint stipulation of facts,[1] which includes the following:

1. The issue on appeal is whether the CMS "must-bill" policy applies to the Provider's dual eligible bad debts when the Provider did not participate in the Medicaid program.
2. The reimbursement amounts being appealed by the provider are: $46,694 for fiscal year end ("FYE") 12/31/2004 and $88,961 for FYE 12/31/2005.
3. The dual eligible residents at issue were eligible for Arizona Medicaid on their dates of service.
4. The bad debts in dispute are related to Medicare–covered services and derived from Medicare co-insurance amounts.
5. At all relevant times, the provider did not participate in or have a provider agreement with the Arizona Medicaid program.
6. A nursing facility's participation in the Arizona Medicaid program is voluntary.

[1] Joint Stipulations of Fact dated May 31, 2009.

7. At all relevant times, the provider did not admit new Medicaid residents other than dual eligibles.
8. There is no mechanism for non-Medicaid-participating providers in Arizona to bill the state for Medicare cost sharing amounts and obtain Medicaid remittance advices ("RAs").
9. Arizona Medicaid covers the SNF resident coinsurance for qualified Medicare beneficiaries ("QMB's"). Payment may be limited to the amount that the Arizona Medicaid contractor would have paid if it were the primary carrier, not to exceed the amount paid by Medicare for the days making up an individual bad debt claim. The amount of Medicaid liability, if any, can only be determined on a claim by claim basis.

PARTIES' CONTENTIONS:

The Provider contends that CMS' must-bill policy is invalid for the following overriding reasons[2]:

> (1) There is no statutory or regulatory authority for subjecting the Provider to CMS' must-bill policy;
> (2) there was no reason for the Providers to comply with the must-bill policy as they are non-Medicaid-participating providers;
> (3) the Intermediary's prior audit treatment and lack of prior notice to the Provider of a policy change; and
> (4) there was no ability for the Provider to comply with the must - bill policy because there is no mechanism within the Arizona Medicaid program that gives the Provider, as a non-Medicaid participating provider, the ability to obtain the RAs.[3]

The Provider asserts that there is no legal requirement that a Medicare-certified SNF enroll in Medicaid as a condition of participation in the Medicare program or to obtain Medicare reimbursement for bad debt.[4] Additionally, the Provider noted that as stipulated by the parties, a nursing facility's participation in the Arizona Medicaid program is voluntary.[5]

The Provider contends that the Intermediary's notice dated November 2004 refers to those providers which participate in the Medicaid program and which have the practical ability to submit bills to Medicaid and obtain Medicaid RAs.[6] The Provider argues that since it does not participate in the Medicaid program, the notice could not be directed at it, and therefore the notice does not amount to a meaningful notice of CMS rule change.[7] Indeed, the Provider asserts that the must-bill policy was not applied to the Provider or similarly situated providers before or immediately after the Intermediary published the notice of November 2004. For example, in a letter dated January 15, 2002, the Intermediary stated that it would accept documentation of a dual eligible's Medicaid eligibility in lieu of a Medicaid RA to support a South Carolina facility's Medicare bad debt claims because South Carolina had announced that

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[2] Transcript (Tr.) at 20-21.
[3] Stipulation No. 8.
[4] Tr. at 18- 19; Provider Post-Hearing Brief at 11.
[5] Stipulation No. 6.
[6] Provider Exhibit P-3.
[7] Provider Post-Hearing Brief at 17.

as a matter of state policy it would not pay for Medicare cost-sharing amounts.[8] Next, a letter from Life Care to the Intermediary, dated August 21, 2002, confirms that a non-Medicaid-participating facility in Colorado could claim Medicare bad debts based on documentation of Medicaid eligibility without providing a Medicaid RA.[9] Finally, up to May 2006, the Provider asserted the Intermediary exempted it from the must bill-policy, because as a non-Medicaid-participating provider, the Provider could not obtain a Medicaid RA from the state.[10] The Provider contends that because the Intermediary was reimbursing its dual eligible bad debts without Medicaid RAs until May 2006, there was no reason to attempt to bill Medicaid before or during its 2004 and 2005 cost reporting periods, the periods under appeal.[11] However, as of May 2006, the Provider contends the Intermediary abruptly changed its policy and began requiring Medicaid RAs, even from non-Medicaid participating providers. The Provider asserts that the Intermediary's abrupt change in applying the must-bill policy was improper because it was implemented without prior notice.[12] Moreover, the policy is arbitrary and capricious as it imposes requirements, i.e. obtaining a Medicaid RA, that are impossible for non-Medicaid participating providers to satisfy.[13]

The Provider acknowledges that the must-bill policy was upheld in the 9th Circuit decision *Community Hospital of the Monterey Peninsula v. Thompson* 323 F.3d 782 (9th Cir. 2003) ("*Monterey Peninsula*").[14] The Provider contends *Monterey Peninsula* is readily distinguishable from the facts in this case.[15] First, in *Monterey Peninsula* the providers participated in the state Medicaid program.[16] However in this case, the Provider did not participate in the state Medicaid program.[17] Next, the court found that although the providers consistently claimed Medicare bad debt reimbursement without Medicaid RAs, it was consistently denied Medicare reimbursement of that bad debt.[18] The Provider believes the court was persuaded by the fact that there was no evidence the Secretary ever reimbursed crossover bad debt without a Medicaid RA. In this case, the opposite is true. The Provider consistently claimed Medicare bad debt reimbursement for dual eligibles without Medicaid RAs and was consistently reimbursed by Medicare for those bad debts in prior periods. Finally, in *Monterey Peninsula,* the court concluded that the Medicare prohibition on cost shifting was not violated because only the cost of billing a state Medicaid program was at issue.[19] The court found that the cost of the bad debt itself would have been paid by the Medi-Cal program if below the state ceiling or by Medicare if above it. However, in this case, the actual cost of the bad debt was shifted to the Provider as a result of the Intermediary's denials because the state could not even process any billings from the Provider and therefore Medicare would never pay those amounts either. The Provider contends that this amounts to a violation of Medicare's cost-shifting prohibition.

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[8] Provider Exhibit P-8; Tr. at 77.
[9] Provider Exhibit P-9; Tr. at 81.
[10] Tr. at 12 - 13.
[11] Tr. at 14.
[12] Tr. at 13; Provider Post-Hearing Brief at 15.
[13] Tr. at 51; Provider Post-Hearing Brief at 12.
[14] Intermediary Exhibit I-2 contains a copy of the court decision.
[15] Tr. at 10.
[16] Provider Final Position Paper at 13.
[17] Stipulation No. 5.
[18] Provider Final Position Paper at 14 (case no. 07-0459); Tr. at 10-11; Provider Post-Hearing Brief at 15.
[19] Provider Final Position Paper at 17; Tr. at 11-12; Provider Post-Hearing Brief at 19.

In sum, the Provider asserts that the must-bill policy's absolute requirement that the Provider bill the state Medicaid program and receive a Medicaid remittance advice (RA) prior to claiming Medicare bad debts is legally invalid, as it fails to recognize the limitations of non-Medicaid participating providers and amounts to a violation of Medicare's statutory prohibition against cost-shifting.

The Intermediary contends that the adjustments to the Provider's bad debts were in accordance with CMS' must-bill policy. The Intermediary asserts that billing the state Medicaid program and obtaining the RA is important for two reasons.[20] First, it verifies that a Qualified Medicare Beneficiary (QMB) patient has a dual eligible status. Second, it determines what portion of liability, if any, the state has for the patient's deductible and coinsurance amounts. The Intermediary argues that it is not feasible and is outside its scope of knowledge to be familiar with each state's Medicaid program. Consequently, requiring the providers to submit claims to the state Medicaid program is the most practical approach to ensure that the Medicare program is not reimbursing bad debts for which other sources are liable.[21]

Contrary to the Provider's contentions, the Intermediary asserts that the Provider was properly notified of the must-bill policy by virtue of CMS' Change Request (CR) 2796, dated September 12, 2003, which was made available to both providers and intermediaries on CMS' website.[22] The Intermediary also asserts that CMS issued the Joint Signature Memorandum (JSM) 370, dated August 10, 2004, which reiterated the must-bill policy as upheld in *Monterey Peninsula*.[23] The Intermediary asserts that the JSM 370 was referenced in a policy letter issued to the Provider in November 2004.[24]

The Intermediary maintains that the Provider's voluntary decision not to participate in the state Medicaid program does not exempt it from the must-bill policy. The Intermediary argues that nothing in the policy suggests that providers that do not voluntarily participate in their state's Medicaid program would be exempt from the requirement to bill dual eligible claims for their QMB patients.[25] Moreover, the Intermediary contends of the Provider's decision not to participate in the state's Medicaid program results in it foregoing Medicaid reimbursement and defeats a positive finding of a reasonable collection effort as required under 42 C.F.R. § 413.89(e).[26] The Intermediary argues that by foregoing Medicaid reimbursement the Provider forfeits Medicare payment for the balance of the coinsurance.[27]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions, and the evidence presented, the Board finds and concludes as follows:

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[20] Intermediary Final Position Paper at 6; Tr. at 26 - 27.
[21] Intermediary Final Position Paper at 7.
[22] Intermediary Final Position Paper at 8; Intermediary Exhibit I-4.
[23] Tr. at 23-24; Intermediary Exhibit I-3.
[24] Tr. at 23; Provider Exhibit P-3.
[25] Intermediary Final Position Paper at 6.
[26] Intermediary Post-Hearing Summary at 8.
[27] Tr. at 33.

The primary issue before the Board is whether there was an absolute requirement that the Provider bill the state Medicaid program and receive a Medicaid remittance advice (RA) prior to claiming unpaid deductible and coinsurance amounts as bad debts for Medicare/Medicaid dual eligible patients. The Board examined the regulations at 42 C.F.R. §413.89 and the program guidance at PRM-I §§308, 310, 312, and 322 that govern the recognition of Medicare bad debts. The Board examination included the newsletters and agency alerts cited by the parties in their respective presentations.

Based on the Board's examination of the regulation at 42 C.F.R. §413.89 and the program guidance at PRM-I §308, it finds that neither contained a requirement to bill, rather, the sections require that the provider make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible. PRM-I §310 provides guidance on establishing reasonable collection efforts. However, the section by its own terms, is inapplicable to the determination of reasonable collection efforts for indigent patients and specifically refers to §312 for guidance as to indigent and or medically indigent patients. Section 312 states in pertinent part:

> Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, (emphasis added) the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines: . . .

The plain language of the above section establishes that Medicaid eligible beneficiaries are deemed indigent and that a provider is not required to take further steps to prove their indigence. However, the language of subsections A through D of §312 is convoluted. Subsection C states:

> The provider must 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 . . .

A common sense reading of this guideline suggests that it imposes a universal requirement to collect the debt from responsible third parties. That requirement appears applicable except for the use of the term "otherwise" in the first paragraph which effectively makes the application of subsections A through D applicable to situations other than Medicare/Medicaid dual eligible beneficiaries. Further, the duty demanded by subsection C to collect from responsible third parties still does not rise to a specific billing requirement. Nowhere does the language of the section support the conclusion that uncollectibity can only be established by submission of a bill and receipt of a remittance advice.

PRM-I, §322 addresses "Medicare Bad Debts Under State Welfare Programs." The section requires that deductible and coinsurance amounts not covered by state title XIX plans may be claimed as Medicare bad debts if they meet the requirements of §312. Section 322 states in pertinent part:

> 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 the requirements of §312 or, if applicable, §310 are met.

As in §§310 and 312, the Board could find no specific billing requirement in PRM-I §322. Accordingly, the Board concludes that no billing requirement is imposed by either the regulations or the Manual.

The Provider is a Medicaid non-participating provider.[28] The Board recognizes that 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. Furthermore, if a Provider is not participating in Medicaid the Board finds Medicaid will not pay even if bills are submitted. For these reasons, the Board finds the aforementioned Manual provisions on bad debt are not intended to apply to dual eligible bad debt claims of non-Medicaid participating providers.

The Board also notes the CMS must-bill policy requirement was issued to the intermediaries through a Joint Signature Memorandum (JSM) 370 dated August 10, 2004.[29] The Intermediary subsequently released the JSM to the provider community in November 2004.[30] The JSM is not an appropriate vehicle to set policy and therefore is given little weight.[31] Consequently, the Board finds the Intermediary changed its policy inappropriately because it disallowed bad debts based upon the JSM that should not be used as a means to convey new instructions or provide clarification of existing requirements to intermediaries. Moreover the Board finds that even if the JSM was an appropriate vehicle to change the must-bill policy, the Provider still prevails because the State is not legally responsible for paying the bad debts to non-participating Medicaid providers.

Next, the Board finds the Intermediary's reliance on Monterey Peninsula to be misplaced because the court did not deal with circumstances existing here that make billing impossible. *Monterey Peninsula* involved a Medicaid state plan that applied a payment ceiling which limited the amount of payment or resulted in no payment for coinsurance and deductibles. Because payments were small, the provider sought to use its own calculations showing the payment that would have been received from the state. It argued that the amounts it could potentially receive

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[28] See Stipulations No. 5

[29] Intermediary Exhibit I-3.

[30] Exhibit P-3.

[31] The Board recognizes that a JSM is not issued to the general public. CMS states it is used by CMS to communicate internally with its contractors. It is used for the purpose of announcing a contract award; emergency alert, and/or a one-time request for information. A JSM is not to be used to convey new instructions or provide clarification of existing requirements that impact contractor operations. *See*, CMS Division of Change & Operations Management CMS/CMM/Medicare Contractor Management Group, *About Joint Signature Memorandums (JSMs) and Technical Direction Letters (TDLs)*, available at http://cmsnet.cms.hhs.gov/hpages/cmm/dcm/agoutjsm.htm (accessed September 2, 2009).

were so small they did not justify the expense of billing. The Court noted that while the existence of a ceiling might make the payment amount predictable, in many cases it would be unclear whether the state would pay and, if so, how much.[32] The Court found the Secretary was authorized to determine what supporting documentation will be required so long as it is not inconsistent with the statue and regulation, and is a reasonable implementation thereof. Under the circumstances presented in that case, the Court found that billing the state was the most straightforward and reliable way of determining whether, and, if so how much the state would pay. Therefore, it could not say the must-bill policy was inconsistent with the statute or regulations nor was it an unreasonable implementation of them.[33] The Court was also persuaded by the fact that there was no evidence in that case the Secretary had ever reimbursed crossover bad debt without an RA; the provider's requests were consistently denied. It also noted that PRRB cases had consistently denied reimbursement pursuant to the must-bill policy.[34] There is nothing in *Monterey Peninsula* to indicate the Court considered billing impossibility or, if those circumstances had been presented, the must-bill requirement would have been found to be a reasonable implementation of the regulation and manual provisions. In addition, the evidence showed that in this case, the Secretary allowed payment for crossover bad debts without RAs under the regulation and manuals prior to issuance of the JSM. The opposite fact is true in this case evidence shows that CMS allowed payment without RAs under the regulations and manuals prior to the JSM.

Based on the foregoing conclusions, the Board finds the Intermediary's application of the bad debt collection policy to include an absolute requirement that the Provider obtain a Medicaid remittance advice (RA) prior to claiming Medicare bad debts is unsupported by the applicable law, regulations and manual provisions, as it fails to recognize the non-Medicaid participating provider's inability to comply.

DECISION AND ORDER:

The Intermediary's must-bill policy has no foundation in law and is beyond the requirements of the regulations and manual. Application of the must-bill policy to dual-eligible bad debts when the Provider did not participate in the Medicaid program is improper. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A.

[32] 323 F.3d at 796.
[33] Id at 793.
[34] Id at 796.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: March 31, 2010