CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Devon Gables Health Care Center **Provider** **vs.** **Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Arizona** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/96** **Review of:** **PRRB Dec. No. 2003-D19** **Dated: March 19, 2003**

This case is before the Administrator, Centers for Medicare and Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act). The parties were notified of the Administrator's intent to review this case. The CMS Center for Medicare Management (CMM) submitted comments requesting reversal of the Board decision. The Provider submitted comments requesting affirmation of the Board decision. Accordingly, this decision is now before the Administrator for final agency review.

BACKGROUND

Devon Gables Health Care Center (Provider) is a skilled nursing facility (SNF) located in Tuscon, Arizona. The State of Arizona furnishes long-term care services to Medicaid beneficiaries through a demonstration project known as the Arizona Health Care Cost Containment System and the Arizona Long Term Care System (hereinafter referred to as the "State Medicaid Program"). The State Medicaid program enters agreements with program contractors to enroll Medicare recipients. The program contractors also contract with providers to furnish care to enrollees. Generally, the program contractors reimburse providers for services rendered.

In this case, the Provider entered a contract with Pima Health System (PHS), a program contractor, to provide long-term care services to State Medicaid program beneficiaries. The Provider supplied medical services to a number of patients who were "dually eligible" for care under both the State Medicaid program and the Medicare Part A and B plans.

The contract stated in relevant part:

> Provider agrees to bill Medicare (Part A and B) and any other third party insurance for all potentially reimbursable goods and services provided to PHS patients under the terms of this agreement. PHS shall be obligated only to pay the difference between the amount the Provider receives from the third party payor and the charges agreed to in this agreement. Provider shall make a good faith effort to bill and collect reimbursement from known third party payors.
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> If patient has Medicare Part A, the Provider will be responsible for recovering payment for services covered by Medicare. PHS shall be responsible for the patient share, and shall reimburse Provider at the patient share, or PHS rates, whichever is less.[1]

The Provider calculated the difference between the PHS rate and the Medicare rate for its services and claimed this difference as Medicare bad debts for the cost reporting period in question. The Intermediary disallowed this claimed amount because the Provider did not bill the primary payor for the services rendered and accounts were written off less than 120 days after the Medicare remittance advice date.

The Provider appealed to the Board claiming that it could not bill PHS for additional coinsurance or deductible amounts, or it risked losing reimbursement for the entire claim and the termination of its contract. Therefore, the Provider requested that the Intermediary include the bad debts in its bad debt calculation. The Provider alternatively requested that if the Board concluded that the State Medicaid program was responsible for the coinsurance and deductible amounts, the Board should require the State Medicaid program to reimburse the Provider for such amounts.

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[1] Provider Exhibit 1

ISSUE AND BOARD'S DECISION

The issue before the Board was whether the Intermediary properly calculated the Provider's bad debts. The Board held that the program contractors, on behalf of the State Medicaid program, were obligated to pay the Medicare coinsurance and deductibles for State Medicaid and Medicare covered services. However, the State did not implement the necessary procedures to allow providers to recover these amounts. The Board found that because the Provider followed the steps available to it in pursuing its claims for Medicare coinsurance and deductibles from the State Medicaid program, the Provider may claim Medicare bad debt pursuant to Provider Reimbursement Manual (P.R.M) §§312 and 322. The Board rejected the Intermediary's argument that the expenses pertaining to nonperformance by the State and its subcontractors should be borne by the Provider.

The Board explained that the Provider properly determined that the claims pertained to dually eligible patients and the amounts were "uncollectible" under P.R.M §312. In addition, if the Provider filed coinsurance and deductible claims with PHS, PHS would have denied reimbursement pursuant to the contract between PHS and the Provider (on the basis that the amount that Medicare paid exceeded the PHS rate). Moreover, if the Provider filed such a claim, it would have risked losing payment for the entire service and the termination of its State Medicaid contract.

The Board noted that P.R.M. §322 identifies a situation where a State is obligated to pay deductible and coinsurance amounts but does not pay these claims because of budgetary ceilings. In this situation, any unpaid amounts are allowable as bad debts if the provider has otherwise complied with PRM §312. The Board found the situation in the instant case to be analogous.

Finally, as support for its position, the Board cited the District Court's decision in Community Hospital of Monterey Peninsula[2] in which the Court held that the "must bill" policy had no regulatory basis, was contradicted by the manual, was arbitrary and capricious, and violated Congress' prohibition against cost shifting.

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[2] Community Hospital of Monterey Peninsula v. Thompson, No. C-01-0142VRW, 2001 U.S. Dist. LEXIS 16938 (N.D. Cal. Oct. 16, 2001). This case was subsequently reversed by the Ninth Circuit Court of Appeals in Community Hospital of Monterrey v Thompson, 323 F. 3d 782 (9th Cir. 2003).

COMMENTS

CMM commented that the Administrator should reverse the Board's decision. CMM explained that the State Medicaid Program is liable for the bad debts claimed by the Provider. By not substantiating that the State was not obligated for the debts of the dually eligible patients, the Provider failed to comply with 42 C.F.R. §413.80 (e) and the requirements of P.R.M. Chapter 3. In addition, CMM commented that when AHCCCS-covered services are furnished out-of-plan, AHCCCS may require prior authorization for such services as a condition of Medicare cost sharing. Though Medicare could be liable under this scenario, it is the responsibility of the Provider to first bill AHCCCS and submit proper documentation to support its claims.

The Provider commented that the Board's decision should be affirmed. The Provider claimed that because the PHS rates ("the rate ceiling") were almost always less than the applicable Medicare rates, the Provider was prohibited from seeking additional coinsurance or deductible amounts from PHS or the patient.[3] In addition, the contract between PHS and the Provider stated that its "failure to submit accurate and complete reports as required" may result "at the option of the PHS, in forfeiture of right to payment."

The Provider also contended that the State imposed the payment ceiling in this case. The Provider continued that when a payment ceiling makes billing the Medicaid program futile, Providers are not obligated to bill the State Medicaid program to claim the amount as bad debt.[4] Moreover, the Provider speculated that if it knowingly submitted bills exceeding the contract rate, PHS could have interpreted them to be "false claims" in violation of both federal and state law.[5]

The Provider continued that although the State Medicaid program acknowledged that it was obligated to pay coinsurance amounts, contracted plans are not precluded from imposing payment ceilings. The Provider explained that as a capitation system, the State Medicaid program pays its contractors a capitated amount and plans are "at risk" for their own rate structures. The contracted providers must be free to establish their own rate structure. The Provider believes that prohibiting plans from imposing reduced rates or requiring plans to reimburse dually-eligible patients at a higher rate than State Medicaid program enrollees

[3] A.R.S §36-2903.01(L) and A.A.C. R9-22-702

[4] P.R.M. §§ 310,312, 322 and II-1102.3(L) as support.

[5] A.R.S. §36-2918(5).

would defeat the purpose of a capitated system. Here, acting as the state's agent, PHS imposed the payment limitation and the State Medicaid program, by its inaction, sanctioned the payment ceiling.

The Provider also alleged that the Intermediary's denial improperly shifts Medicare costs to non-Medicare patients. Finally, the agency's failure to comply with P.R.M. II§1102.3(L) constituted retroactive rulemaking in violation of the Administrative Procedures Act[6] and the decision in Bowen v. Georgetown Univ. Hosp..[7]

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and comments. The Medicare program primarily provides medical benefits to eligible persons over the age of 65, and consists of two parts: Part A [42 U.S.C. §1395(c)-1395(i)], which provides reimbursement for inpatient hospital and related post-hospital, home health and hospice care; and Part B [42 U.S.C. §1395(j)-1395(w)], which is a supplementary voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A. Medicare providers are reimbursed by the Medicare program through fiscal intermediaries for Part A and carriers for Part B, under contract with the Secretary.

To be covered by Part B, a Medicare–eligible person must pay limited cost-sharing in the form of premiums, and deductible and coinsurance amounts. Where a Medicare beneficiary is also a Medicaid recipient, (i.e. "dually eligible"), a State Medicaid agency may enter into a buy-in agreement with the Secretary. Under such an agreement, the State enrolls the poorest Medicaid beneficiaries, those eligible for Medicaid, in the Part B program by entering into an agreement with the Secretary and by paying the Medicare premiums and deductibles and coinsurance for its recipients as part of its Medicaid program. When a beneficiary incurs costs for services above the amount of the deductible (which the State is responsible for paying), Medicare (i.e., the Federal government) pays a certain percentage of the reasonable costs of any services that are covered by both Medicare and Medicaid.

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[6] 5 U.S.C. §553(b).

[7] 109 S.Ct. 468, 471-72 (1988).

Under §1861(v)(1)(a) of the Act, providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. That section defines "reasonable cost" as "the cost actually incurred, excluding from any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included…." The section does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters.

The principles set forth in the Act are reflected and further explained in the regulations. One of the underlying principles set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e. Medicare prohibits cross-subsidization of costs. This principle is reflected at 42 C.F.R. §413.9(c), which provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries. However, if the provider's costs include amounts not reimbursable under the program, those costs will not be allowed.[8]

Consistent with this principle, 42 C.F.R §413.80 (a) provides that bad debts, which are deductions in a provider's revenue, are generally not included as "allowable costs" under Medicare. The regulation at 42 C.F.R. §413.80(b)(1) defines "bad debts" as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are defined as designations for claims arising from the furnishing of services, and are collectable in money in the relatively near future.

However, the regulation at 42 C.F.R. §413.80 (d)(1) explains that to ensure that the cost of Medicare services are not borne by others, the costs attributable to the Medicare deductible and coinsurance amounts which remain unpaid are added to the Medicare share of allowable costs. The circumstances under which providers may be reimbursed for the bad debts derived from uncollectible deductibles and coinsurance amounts are set forth at paragraph (e). The regulation at 42 C.F.R. §413.80(e) states that to be allowable, a bad debt must meet the following criteria:

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[8] See generally 42 C.F.R. §413.20(a) which states "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program" and "(d) (1) The provider must furnish such information to the intermediary as may be necessary to (i) assure proper payment…(ii) receive program payments…"; 42 C.F.R. §413.24(a) which states "Providers receiving payments on the basis of reimbursable cost must provider adequate cost data…."

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 there was no likelihood of recovery at any time in the future.

The Provider Reimbursement Manual or "P.R.M." provides further guidance with respect to the payment of bad debts. Section 312 of the P.R.M. explains that individuals who are Medicaid eligible as either categorically or medically needy may be automatically deemed indigent. However, §312.C requires that: "The provider must determine that no source other than the patient would be legally responsible for the patients medical bills; e.g., title XIX, local welfare agency and guardian…."(Emphasis added). Finally, §312 also states that "once indigence is determined, and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 [reasonable collection effort] procedures. (See §322 of the P.R.M. for bad debts under State welfare programs.)" Relevant to this case, §322 of the P.R.M. states that

> 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 needy 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.
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> 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 (Emphasis added).[9]

For cases in which a payment "ceiling" exists, §322 provides a narrow "ceiling exception" to the above-noted policy and continues:

> In some instances the State has an obligation to pay, but either does not pay anything or pays only part of the deductible, or coinsurance because of a State payment "ceiling." For example assume that a State pays a maximum of $42.50 per day for the SNF services and the provider's cost is $60.00 a day. The coinsurance is $32.50 a day so that Medicare pays $27.50 ($60.00 less $32.50). In this case, the State limits its payment towards the coinsurance to $15.00 ($42.50 less $27.50). In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare provided that the requirements of §312 are met. (Emphasis added).

Section 322 of the PRM concludes by explaining that:

> If neither the title XIX plan, nor State or local law requires the welfare agency to pay the deductible and coinsurance amounts, there is no requirement that the state be responsible for these amounts. Therefore, any such amounts are includable in allowable bad debts provided that the requirement of §312, or if applicable, §310 are met.

Likewise, the instructions for filling out the HCFA-339, a questionnaire that must be filed with the cost report, states in relevant part:

> Evidence of the bad 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: Medicaid eligibility at the time services were rendered (via valid Medicaid eligibility number), and [n]on payment that would have occurred if the crossover claim had actually been filed with Medicaid (Emphasis added).[10]

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[9] See also §1862(a)(2) of the Act.

[10] P.R.M. §2-1102.3L

The parties do not dispute that in this case, the Arizona State Plan provides that the State Medicaid Program is obligated for the payment of the coinsurance and deductible amounts for the dually eligible patients at issue.[11] Therefore, the Administrator finds that §322 of the P.R.M. is applicable to this situation.[12] As the State is legally responsible for the coinsurance and deductibles, the Intermediary properly denied the costs as Medicare bad debts.[13] Not only does the State plan plainly require the State Medicaid program to pay for dually eligible coinsurance and deductibles, but the Provider also never submitted bills to the State/contractor nor took action that may have been available to ensure payment.

The Administrator recognizes that the Board suggested that the circumstance set forth at §322 of the P.R.M. involving a "budgetary" ceiling is "analogous" to this circumstance where the State, despite its obligation, has not paid the claim. However, the Administrator finds that the instant case is not analogous to the circumstances of a §322 "State payment ceiling." In the §322 payment scenario, the State has no obligation to pay for coinsurance and deductible amounts above the "State payment ceiling." In the present case, the State has a legal obligation to pay coinsurance and deductibles.

The Provider alleges that due to a "contractor imposed payment ceiling", even if it billed the contractor for its coinsurance and deductible amounts, the contractor would not have paid such claims. However, the State Medicaid program was obligated to pay the dually eligible patients'coinsurance and deductible, thus, Medicare is not liable for such amounts. Regardless of whether the Provider furnished services under the umbrella of a capitated contract, because the State is obligated under the State plan for payments, there is no Medicare liability for the bad debt.

The Provider also contends that P.R.M. §2-1102.3L exempts providers from filing claims when it would be futile to do so. However, the Administrator finds that the §2-1102.3L exemption is inapplicable in this case because the State Medicaid

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[11] See also Provider Position Paper at 3, 6; Intermediary Position Paper at 4 and 5.

[12] See also Medical Rehabilitation Services v. Shalala, 17 F.3d 828 (6th Cir. 1994).

[13] See also Village Green Nursing Home, CMS Adm. Dec. 2000-D59, aff'd, GCI Health Care Centers, Inc. d/b/a Village Green Nursing Home v. Thompson, No. 1:00-CV-2426 (CKK) (D.D.C. April 25, 2002) (mem. opinion)

program is obligated to pay the dually eligible copayment amounts. Section 2-1102.3L states, in relevant part:

> 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.

The Provider also alleges that the Intermediary's denial improperly shifts Medicare costs to non-Medicare patients in violation of Section 1861(v)(1)(A) of the Act and 42 C.F.R.§413.80(d). These sections outline general Medicare reimbursement principles. However, where the Provider has failed to establish that it is entitled to Medicare reimbursement, it cannot demonstrate that cost shifting has occurred.

We also note that, the Board cited the District Court's decision Community Hospital of Monterey Peninsula. However, the Ninth Circuit reversed this decision. The Court deferred to the Secretary's determination that the provisions of the P.R.M. required reasonable collection efforts, including billing for dually eligible patients.[14]

Accordingly, the Administrator finds that the Provider is not entitled to Medicare reimbursement of the bad debts related to the dually eligible patients at issue in this case. Regarding the Provider's alternative request that the Board require the State Medicaid program to reimburse the Provider for the bad debts, the Administrator finds that neither the Administrator, nor the Board, is authorized to direct such payments.

[14] See Community Hospital of Monterey Peninsula v. Thompson, 323 F.3d 782 (9th Cir. 2003).

DECISION

The Board's decision is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 5/19/03

/s/
Leslie V. Norwalk, Esq.
Acting Deputy Administrator
Centers for Medicare & Medicaid Services