PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2003-D19

PROVIDER –
Devon Gables Health Care Center
Tucson, Arizona

Provider No. 03-5145

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Arizona

DATE OF HEARING -
January 7, 2003

Cost Reporting Periods Ended
December 31, 1996

CASE NO. 99-0646

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ISSUE:

Whether the Intermediary properly calculated the Provider's Medicare bad debts?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Governing Statutes and Regulations:

This dispute arises out of the Intermediary's failure to reimburse the Provider the amount Provider claims is due under the Medicare program of the Social Security Act, 42 U.S.C. §§ 1395 et seq. The amount in contention relates to whether or not Medicare is responsible for reimbursing the provider for coinsurance and deductible amounts up to the full Medicare rate for "Qualified Medicare Beneficiaries ("QMBs") (beneficiaries who are dually eligible for both Medicare and Medicaid benefits and have an income level at or below the poverty level).

The Medicare program was established in 1965 under Title XVIII of the Social Security Act (the Act) to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395 – 1395cc. The Health Care Financing Administration ("HCFA") (now Centers for Medicare and Medicaid Services) ("CMS") is the operating component of the Department of Health and Human Services charged with administering the Medicare program.

The Secretary's payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by CMS. Id.

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 what portion of those costs are to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary audits the cost reports, determines the total amount of Medicare reimbursement due the provider and informs the provider in a notice of program reimbursement ("NPR") that sets forth the individual expenses allowed and disallowed by the intermediary. 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 NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

Under the Medicare statute, a provider is entitled to claim as a reimbursable cost "bad debts" attributable to amounts unpaid by beneficiaries for Medicare deductibles and coinsurance for the Medicare patients it services. 42 CFR § 413.80. At issue in the present dispute are bad debts related to services provided to patients eligible for both Medicare and Medicaid programs. The state Medicaid system has the responsibility of paying for a QMB patient's deductible and coinsurance for inpatient and outpatient services through

contractual arrangement.

Background:

Devon Gables Health Care Center ("Provider") owns and operates a skilled nursing facility consisting of 312 beds, of which 40 are certified under the Medicare Program. The Provider is located in Tucson, Arizona.[1]

The State of Arizona furnishes long-term care services to Medicaid beneficiaries through a demonstration project, known as the Arizona Long Term Care System ("ALTCS"), which is administered by Arizona Health Care Cost Containment System ("AHCCCS"), for acute care, outpatient and related services. AHCCCS was, at the time of the cost reporting period at issue, responsible for reimbursing providers for Medicare coinsurance and deductible amounts for QMBs (beneficiaries who are dually eligible for both Medicare and Medicaid benefits and have an income level at or below the poverty level) up to the full Medicare rate.[2]

The ALTCS is a managed care based system administered by program "contractors." These contractors function like health maintenance organizations and are responsible for entering into contracts with health care facilities and reimbursing providers for the health care services they render. All members who are enrolled in these contractors' plans are, by definition, AHCCCS eligible, and many are also QMBs.

During the fiscal year at issue in this appeal, the Provider entered into an agreement with Pima Health System ("PHS"), an ALTCS contractor, to provide long-term care services to ALTCS beneficiaries. The Provider believed, under the terms of the agreement, it was prohibited from billing PHS for any QMB coinsurance and deductible amounts if the Medicare reimbursement for the service exceeded the PHS rate for the service:[3]

> [p]rovider agrees to bill Medicare (Part A & 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 … If patient has Medicare Part A, the Provider will be responsible for recovering payment for services covered by Medicare. PHS shall be responsible for patient share, and shall reimburse Provider at the patient share, or PHS rates, whichever is less.

[1] See Intermediary's position paper at 1.
[2] See Provider's position paper at 3.
[3] See Provider's position paper at 4 and Exhibit P-1.

The contract also states that the Provider's "failure to submit accurate and complete reports as required" in the contract, "may result, at the option of the PHS, in forfeiture of right to payment." Id. If the Provider breached any term of the agreement, the Provider also risked losing its AHCCCS services contract.

It is uncertain why PHS imposed this payment limit for QMB coinsurance and deductible amounts. The Provider asserts that in most cases, however, the PHS contract rate was less than the Medicare Part A coinsurance rate for long term care services, and less than the 80% Medicare reimbursement rate for Part B services. The Provider calculated the difference between the PHS rate and the Medicare rate for its services and claimed this difference as Medicare bad debts on the cost reporting period in question.[4]

The Intermediary proposed adjustment number 7 ($35,243), disallowing the QMB bad debts claimed by the Provider on its as-filed cost report. The Intermediary determined that the bad debts were not allowable since the Provider did not bill the primary payor for services rendered and the accounts were written off less than 120 days after the Medicare remittance advice date.[5]

Blue Cross and Blue Shield of Arizona ("the Intermediary") issued the NPR on August 10, 1998. The Provider appealed the Intermediary's adjustment for the elimination of bad debts to the Board on November 20, 1998, and has met the jurisdictional requirements set forth in 42 C.F.R. §§ 405.1835-.1841. The Medicare reimbursement in controversy is approximately $35,243.[6]

The Provider was represented by Julie Mathis Nelson, Esquire, of Coopersmith Gordon Schermer Owens & Nelson P.L.C. The Intermediary's representative was Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that the Intermediary's refusal to reimburse it for its QMB bad debts violates Medicare regulations, violates HCFA's interpretive guidelines and is arbitrary and capricious. This refusal, based on the Provider's alleged failure to make a "reasonable collection effort," reflects the Intermediary's misinterpretation of applicable bad debt reimbursement rules, constitutes retroactive rulemaking, and improperly shifts Medicare costs onto non-Medicare patients.[7]

The Provider asserts that Medicare regulations and HCFA interpretive guidelines specify that a provider is entitled to claim QMB coinsurance and deductible amounts on its

[4] See Provider's position paper at 4.
[5] See Intermediary's position paper at 3 and Exhibit I-1.
[6] See Intermediary's position paper at 2.
[7] See Provider's position paper at 7.

Medicare cost report when the state is obligated to pay all or part of the QMB copayment amounts, but either does not pay anything or pays only part of the amount due to a payment ceiling as in accordance with HCFA Pub. 15-1 § 322.[8] The state's AHCCCS program was obligated to pay the QMB copayment amounts, but did not pay anything due to the contractor-imposed payment ceiling. As a result, the Provider was entitled to claim these amounts as bad debts, as long as the Provider put forth a "reasonable collection effort." The issue in this appeal is whether the Provider made such a reasonable collection effort.

The Provider cites HCFA Pub. 15-1 § 310, which states:

> [t]o 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 after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations.

The Provider contends that it applied similar collection efforts for all payor types including Medicare and non-Medicare patients covered by third party payors: the Provider did not file any coinsurance claims when third party payor contracts prohibited it from doing so.

The Provider emphasizes that HCFA Pub. 15-1 § 310 contemplates collection efforts against individuals, not third party payors that contract with a provider. First, the provision uses terms like "issuance of a bill," not payor terminology, such as "filing of a claim." Second, the provision requires the issuance of a bill and contemplates the use of a collection agency, without regard to written contracts with payor entities. In many cases, such as the Provider's, third party payors prohibit the provider from filing claims for certain services. Further, providers generally do not use collection agencies to obtain payment from third party payors. Since HCFA Pub. 15-1 § 310 does not address these "payor contract" issues, it could not have been intended to apply to these types of situations and does not govern the outcome of this appeal.

In contrast, the instructions for completing the form HCFA-339, does take payor contract issues into consideration.[9] It states:

> [a]ny portion of the deductible/coinsurance not paid by Medicare under (the criteria stated in HCFA Pub. 15-1 §§ 312 and 322) is a Medicare bad debt and may be claimed on the provider's cost report.

[8] See Provider's position paper at 7.
[9] See Provider's position paper Exhibit P-4.

This provision does not mention HCFA Pub. 15-1 § 310 and further states that while evidence of the bad debt "may include" a copy of the Medicaid remittance denying the claim:[10]

> [i]t 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, and
>
> - Non-payment that would have occurred if the crossover claim had actually been filed with Medicaid.

HCFA-339 Form Instructions (L).

Thus, CMS does not require providers to file claims with the Medicaid program if doing so would be futile (the "futility exception"). In other words, CMS has made a determination that, in certain circumstances, a "reasonable collection effort" may require the provider to make no collection efforts.

The Provider claims that in this case, they clearly meet the criteria of the futility exception. For the Intermediary to deny the Provider's claims without regard to CMS's own instructions on this subject exceeds the scope of the Intermediary's authority. CMS's failure to comply with its own instructions constitutes retroactive rulemaking in violation of federal law. There is no dispute of the claimed beneficiaries' Medicaid eligibility at the time the services were rendered, since they were AHCCCS plan enrollees. Furthermore, the Provider's contract with PHS clearly demonstrates that the Provider would not have been paid if it had actually filed the claim with the AHCCCS contractor, PHS.

The Intermediary relies on HCFA Pub. 15-1 §§ 308 through 312 and 322,[11] 42 C.F.R. § 413.80(e), and Section 300 of the AHCCCS Encounter/Claims Policy and Procedure Manual.[12] HCFA Pub. 15-1 § 308 and 42 C.F.R. § 413.80(e)[13] state:

> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

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[10] See Provider's position paper at 8.
[11] See Intermediary's position paper Exhibit I-2.
[12] See Intermediary's position paper at 3 and Exhibit I-4.
[13] See Intermediary's position paper Exhibit I-3.

(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.

The Intermediary contends that the Provider has not pursued adequate collection efforts as required by (2) above.

The Intermediary further contends that AHCCCS/ALTCS was responsible for the payment of deductible and coinsurance amounts based on the policy stated in Section 300 of the AHCCCS Policy and Procedure Manual.[14] It states that:

> [i]t is the policy of the AHCCCS Administration to reimburse the full Medicare deductible and coinsurance for AHCCCS - and Medicare -covered services provided to eligible recipients. AHCCCS is liable for the Medicare coinsurance and/or deductible less any amount paid by other third party payors.

The Intermediary directs the Board to a CMS Regional Office letter of April 23, 1997. It states that:[15]

> [t]o us, the State's obligation is a critical factor here. For QMB recipients, the State's policy (as furnished by you) has established its obligation to encompass full Medicare coinsurance and deductible amounts. For non-QMB recipients, the State is to reimburse Medicare coinsurance and deductible amounts for AHCCCS-covered services. The contracted plans are in this instance agents of the State and are subject to the State's crossover reimbursement policies. Coinsurance and deductible amounts unpaid by the contracted plans due to the plans failure to Implement State policy are not reimbursable as Medicare bad debts.

[14] See Intermediary's position paper Exhibit I-4.
[15] See Intermediary position paper at 5 and Exhibit I-5.

Another CMS Regional Office letter,[16] explains that in accordance with the Arizona State Plan Amendment ("ASPA") 96-013, AHCCCS and its plans are required to provide full cost sharing with the following exceptions:

> For non-QMBs, AHCCCS is not responsible unless the services are provided in the beneficiary's health plan or program contractors network. AHCCCS is also not responsible for non-QMB cost sharing when the services are not covered by AHCCCS under the State Plan.
>
> For QMB Duals, AHCCCS is not responsible for services provided outside of the beneficiary's health plan or program contractor network. However, with respect to services covered by Medicare but not by AHCCCS under the State Plan (e.g., chiropractic services), AHCCCS pays the Medicare coinsurance and deductible amounts regardless of whether the provider is in the beneficiary's health plan or program contractor network.

ASPA 96-013.

The Intermediary's argues that, despite the general AHCCCS policy of full cost sharing for QMB Onlys, non-QMBs and QMB Duals, there are situations under the State Plan in which AHCCCS is not obligated for full cost sharing and, therefore, prior authorization may be reasonable. For example, if AHCCCS-covered services are furnished out-of-plan, AHCCCS may require prior authorization for such services as a condition of Medicare cost sharing.

The Intermediary acknowledges that if the bad debt arises be as a result of being out-of-plan, Medicare may be liable for this debt. However, it is the responsibility of the Provider to submit adequate documentation in support of this claim. For the bad debts in question in the instant case, the Intermediary asserts that it has not received any documentation or support to indicate that the bad debts in question fall under this ruling.

The Intermediary also relies on the Communi-Care Pro Rehab, Inc. v Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Virginia, PRRB Case No. 97-D24,[17] January 29,1997, Medicare and Medicaid Guide (CCH) ¶ 45,053, rev'd, HCFA Administrator, March 31, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,231, ("Communi-Care") in which the HCFA Administrator states that HCFA Pub. 15-1 § 312 clearly requires that a provider must determine that no source other than the patient would

[16] See Intermediary position paper at 5 and Exhibit I-5.

[17] See Intermediary's position paper at 5.

be legally responsible for the patient's medical bill, e.g. Title XIX. It states that "the Administrator finds that the Provider failed to request payment from the Commonwealth or NFs (nursing facilities) for deductibles and coinsurance amounts attributable to Medicare/Medicaid patients which the Commonwealth was obligated to pay, those and accounts are not properly included as bad debts under 42 C.F.R. § 413.80(e)."[18] The Intermediary contends that a similar conclusion is proper in the instant case.

The Intermediary further contends that AHCCCS was responsible for payment of the deductible and coinsurance amounts for dual eligible patients. The Provider did not request payment from AHCCCS. Therefore, the bad debts are not allowable.

The Provider counters that the CMS Administrator Decision is distinguishable from this case in many respects. For example, the state in that case did not establish a payment ceiling. Here, AHCCCS did establish a payment ceiling as evidenced by the PHS contract. Furthermore, Communi-Care did not address the bad debt billing instructions which explicitly allow the providers to not file claims, when filing would be futile. The provider in Communi-Care also did not have explicit instructions from the Medicaid program not to bill for coinsurance and deductible claims as did the Provider in this case. Finally, Communi-Care that case, the provider could not substantiate its claims for coinsurance and deductible amounts. Here, the Intermediary acknowledges that had the Provider followed policy and properly billed the AHCCCS program, the bad debts should have been reimbursed.[19]

The Provider claims 42 U.S.C. § 1395x(v) and 42 C.F.R. § 413.80 make clear that the purpose of bad debt reimbursement is to ensure that the costs of services furnished to Medicare beneficiaries are not borne by persons not covered by that program.[20] If a provider does not collect revenue related to its services, then the provider has not recovered the cost of its services, and these costs must then be borne by non-Medicare patients. Here, the Provider has not received any reimbursement for its coinsurance and deductible amounts attributable to its QMBs for the fiscal year in question, thus illegally shifting the burden for these costs onto non-Medicare patients.

After the fact, AHCCCS implied that it should have paid these coinsurance and deductible amounts, but the time for filing such claims has long since passed and AHCCCS has not given providers any opportunity to obtain reimbursement for what it now views as its contractor's violation of state policy.[21]

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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[18] Also see Intermediary's position paper Exhibit I-6 and HCFA Administrator, March 31, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,231, at 53,744.

[19] See Provider's position paper at 9.

[20] See Provider's position paper at 13.

[21] See Provider's position paper at Exhibit P-2.

1. Law – 42 U.S.C.:

§ 1395 et seq.	-	Payment to Hospitals for Inpatient Hospital Services

2. Regulations - 42 C.F.R.:

§§ 405.1835-.1841	-	Right to Board Hearing - Time Place, Form and Content of Request for Board Hearing
§ 405.1803	-	Intermediary Determination and NPR
§ 413.80 et seq.	-	Bad Debts
§ 413.20	-	Financial Data and Reports.

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub.15-1):

§ 308	-	Criteria for Allowable Bad Debts
§ 310	-	Reasonable Collection Effort
§ 312 et seq.	-	Indigent or Medically Indigent Patients
§ 322	-	Medicare Bad Debts Under State Welfare Programs

4. Cases:

Communi-Care Pro Rehab, Inc. v Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Virginia, PRRB Case No. 97-D24, January 29, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,053, rev'd, HCFA Administrator, March 31, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,231

Community Hospital of Monterey Peninsula v. Tommy G. Thompson, 259 F.3d 1071 (9th Cir. 2001)

5. Other:

HCFA Form 339 Instructions

AHCCCS Encounter/Policy and Procedure Manual § 300

ASPA 96-013

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the parties' contentions and evidence presented, finds and concludes as follows:

The record contains evidence that the State Medicaid program's policy[22] was to pay the full Medicare coinsurance and deductibles for AHCCCS and Medicare covered services provided to eligible recipients; however, the State did not enforce the terms of the contract with PHS to allow providers to recover these amounts. Neither the State of Arizona nor the program contractor, PHS, ever paid the coinsurance and deductibles to the Provider for the fiscal year at issue. The Board finds that where the Provider properly sought payment and the State Medicaid agency and its representative have not paid the claim, the Provider may properly receive them as bad debts. See HCFA Pub. 15-1 § 312.

The Board finds that the Provider took reasonable steps to collect coinsurance and deductibles before claiming them as bad debts. First, the Provider determined that the claims pertained to dually eligible indigent patients, and the amounts could be deemed uncollectible under 42 C.F.R. § 413.80(e) and HCFA Pub. 15-1 § 312. Second, the Provider sought to determine whether the State Medicaid agency was obligated to pay the claims as required by HCFA Pub. 15-1 § 322. The express language of the Provider's contract with PHS prohibited the Provider from billing any amounts that exceeded the PHS contract rate.[23] Since the Medicare paid amounts exceeded the PHS contract rates, PHS would have denied the Provider's additional claims. Therefore, if the Provider had filed these coinsurance and deductible claims with PHS, it would have risked losing payment for the entire service, and more importantly, termination of its AHCCCS contract.

The record indicates that program contractors on behalf of AHCCCS were liable for the coinsurance and deductible amounts.[24] The record contains considerable correspondence from the CMS Regional Office, the Intermediary, and the AHCCCS administration directed at clarifying the responsibility of the state to pay for coinsurance and deductible amounts and ensuring that the policy be implemented.[25]

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[22] See Intermediary's position paper Exhibit I-2.
[23] See Provider's position paper at 9 and Exhibit P-2.
[24] See Intermediary's position paper Exhibit I-2.
[25] See Intermediary's position paper Exhibit I-3 and Provider's position paper Exhibit 1.

The Board finds, however, that despite the recognition of the State Medicaid program's obligation, there is no evidence that CMS or the State intended to enforce the State's contractual responsibility, and the program contractor has not paid the Provider for its claims at issue. In correspondence from the CMS Regional Office it notes that despite recognition that the program contractors were to have paid these claims, they are still refusing to pay them.[26] The Board rejects the Intermediary's argument that the expenses pertaining to non-performance by the State and its subcontractor should be borne by the Provider.

The Board also notes that HCFA Pub. 15-1 § 322 also 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 HCFA Pub. 15-1 § 312 and the debt remains unpaid. The Provider has complied with HCFA Pub. 15-1 § 312 and should be allowed to claim the unpaid coinsurance and deductibles as bad debts under Medicare.

In support of its findings the Board refers to Community Hospital of Monterey Peninsula v Tommy G. Thompson, 259 F.3d 1071 (9th Cir. 2001), where the court held that the Secretary's insistence on a must bill requirement does not have a basis in the text of the regulations and is contradicted by manual provisions. The Court concluded that a per se must bill requirement pursuant to a crossover payment ceiling is arbitrary and capricious because this requirement violates Congress' prohibition of cost-shifting in Medicare as expressed in 42 U.S.C. § 1395 x(v)(1)(A) and 42 C.F.R. § 413.80(d).

The Board finds that the Provider followed the steps available to it in pursuing the claims for Medicare coinsurance and deductibles from the State Medicaid program in which it participated.

In summary, the Board finds that the Provider did properly seek to recover these costs from the state Medicaid program in accordance with HCFA Pub. 15-1 § 312 and 42 C.F.R. § 413.80(e) and despite its obligation, the state has not made payment. The Board finds that the Provider is entitled to claim the unpaid coinsurance and deductible amounts as bad debts under HCFA Pub. 15-1 § 322.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the Provider's bad debts was improper. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Stanley J. Sokolove

[26] See Intermediary's position paper Exhibit I-3.

Dr. Gary Blodgett
Martin W. Hoover, Jr., Esquire

Date of Decision – March 19, 2003

FOR THE BOARD

Suzanne Cochran, Esquire
Chairman