PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D13

PROVIDER –
Royal Coast Rehabilitation Center

Provider No.: 10-1440

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
First Coast Service Options, Inc.

DATE OF HEARING –
April 2, 2009

Cost Reporting Period Ended -
December 31, 2004

CASE NO.: 06-1800

INDEX

ISSUE:

Was the Intermediary's adjustment disallowing bad debts arising from coinsurance and deductibles for dual eligible Medicare and Medicaid beneficiaries proper?

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 interpretive guidelines published by CMS. 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.

Qualified Medicare Beneficiaries (QMBs) are individuals who are entitled to Medicare Part A, whose family incomes do not exceed 100 percent of the federal poverty line (FPL), and whose resources do not exceed twice the resource-eligibility standard for Supplemental Security Income (SSI). 42 U.S.C. §1396d(p). QMBs are eligible for payment of Medicare Part B (supplementary medical insurance) premiums and Medicare and Part A cost sharing (deductibles and coinsurance), regardless of whether they are eligible for full Medicaid benefits. 42 U.S.C. §1396d(p)(3).

"[A] State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare cost-sharing to the extent that payment under subchapter XVIII of this chapter for the service would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a Medicare beneficiary." 42 U.S.C. §1396a(n)(2). In the case in which a State's payment for Medicare cost-sharing for a qualified Medicare beneficiary with respect to an item or service is reduced or eliminated, the amount of payment made under Title XVIII plus the

amount of payment (if any) under the State plan shall be considered to be payment in full for the service, and the beneficiary shall not have any legal liability to make payment for the service. 42 U.S.C. §1396a(n)(3).

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)[1] requires that to be allowable bad debts must meet the following criteria:

(1) The debt must be related to covered services and derived from deductible and co-insurance 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

[1] Redesignated from 42 C.F.R. §413.80 at 69 FR 49254, Aug. 11, 2004.

> 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.

The dispute in this case involves the reasonableness of the Provider's collection effort and the determination that the debts of Medicare/Medicaid dual eligible patients were uncollectible.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Royal Coast Rehabilitation Center, Inc. (Provider) is a Medicare-certified Community Mental Health Center (CMHC) with a Partial Hospitalization Program (PHP) located in Miami, FL. First Coast Service Options, Inc. (Intermediary) is the Provider's Medicare fiscal intermediary.

In its Medicare Cost Report for the fiscal year ended (FYE) December 31, 2004, the Provider claimed $679,930 as Medicare reimbursable bad debts for co-insurance and deductibles for its dual eligible patients. The Intermediary reviewed the Provider's Medicare cost report and issued an NPR on December 13, 2005. The NPR included an adjustment reducing the amount of allowable bad debt expense. The Provider appealed the Intermediary's determination to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841.

The Provider was represented by Christopher A. Parrella, Esquire, of The Health Law Offices of Anthony C. Vitale, P.A. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' STIPULATIONS:

The Provider and Intermediary agreed to and submitted the following stipulations prior to the hearing concerning the disposition of the single issue in dispute in this appeal:

1. The parties have stipulated to an issue statement as:

   > Was the Intermediary's adjustment disallowing bad debts arising from coinsurance and deductibles for dual eligible Medicare and Medicaid beneficiaries proper?

2. The Provider, located in Miami, Florida, is certified for Medicare participation as a Community Mental Health Center (Regulation 42 C.F.R. §410.2) or CMHC. It became certified for Medicare participation on November 14, 2003.

3. As a CMHC, the Provider furnishes the outpatient mental health services as also set forth in Regulation 42 C.F.R. §410.2, to Medicare beneficiaries and other patients.

4. Many of the Provider's patients who are enrolled in Medicare are also enrolled in Florida's Medicaid program at the same time. Such patients are commonly referred to as dual eligibles.

5. There are different categories of dual eligibles depending on income. One such category is "Qualified Medicare Beneficiaries." Qualified Medicare Beneficiaries ("QMB") are defined at 1905(p)(1) of the Social Security Act ("the Act"). QMBs are entitled to have their Medicare deductible and co-insurance covered by Medicaid, without regard to whether the services would be covered as Medicaid benefits, if Medicaid was the primary coverage. However, §1902(n)(1) of the Act permits a state, for QMBs to set a payment rate whereby a state could establish a payment limit, so it would not pay an amount for the co-insurance that would result in a combined payment no greater than what would be paid for a Medicaid beneficiary who was not a dual eligible. Under this authority to establish a payment ceiling, a state would still be responsible for the deductible.

6. In 1998, consistent with Florida law, Florida's Medicaid State Plan was amended to eliminate any coverage responsibility for QMB co-insurance and deductibles for the type of services furnished by the appealing Provider and similarly situated CMHCs. The Health Care Financing Administration (HCFA) approved the amendment.

7. As a result of the amendment to the State Plan, all existing CMHCs were dissenrolled or dropped as participating Medicaid providers (see Exhibit P-28).

8. As a further result of the Amendment to the State Medicaid Plan, CMHCs who came into existence after the Amendment were not permitted to participate in the State Medicaid Program (see Exhibits P-5 through P-11).

Therefore, the Florida Medicaid Program did not have a mechanism in place to accept bills from CMHCs. Accordingly, Medicaid Remittance Advices (RAs) could not be issued.

9. In its Medicare Cost Report for the fiscal period of January 1, 1994 [sic 2004] to December 31, 2004 (FYE December 31, 2004), the Provider claimed $679,930 as Medicare reimbursable bad debts for co-insurance and deductibles for its dual eligible patients.

10. The bad debts claimed were disallowed as not being in compliance with CMS's MUST BILL POLICY. The reference was to the Center's [sic]for Medicare and Medicaid Services ("CMS"), JSM-370, 08-03-04, dated August 10, 2004 (see Exhibits P-3, P-4 and P-17).

11. On March 28, 2006, the Deputy Secretary for Medicaid at Florida's Agency for Health Care Administration (AHCA) was advised by CMS that the 1998 amendments that eliminated co-pay liability for QMB's [sic] was approved in error and the plan must be corrected at risk of loss of Federal Financial Participation ("FFP") (see Exhibit I-6).

12. The Florida legislature removed the statutory impediment to covering such co-payments for QMB's [sic] in 2008 (see Exhibit I-7).

13. The Provider has furnished a list that identifies its patients who make up the dual eligible bad debt claim, the service dates, and amounts of the disallowed sum of $679,930. While the list has not been audited, it is readily auditable should the Provider prevail.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary is improperly holding the Provider responsible for complying with CMS's "must bill" policy of August 2004 and that this policy is factually and legally flawed as it applies to the State of Florida.

First, the Provider argues that a provider must possess a Florida Medicaid provider number in order to submit a claim for coinsurance and deductibles that would generate a remittance advice or denial. To obtain such a number, a CMHC-PHP must submit a Medicaid application along with a "current contract for the provision of community mental health services pursuant to the provision of Chapter 394, F.S., or the provision of substance abuse services pursuant to Chapter 397, F.S., from the Department of Children and Families/Alcohol, Drug Abuse, and Mental Health (ADM) district or region program office." However, a moratorium on ADM contracts has prohibited the issuance of such a contract since 1996.[2] Further, as stated in a letter to providers from the State of Florida Agency for Health Care Administration, "Since Florida Medicaid does not cover services provided by special hospital/ outpatient rehabilitation facilities (freestanding

[2] See Provider Supplemental Position Paper pg. 6.

psychiatric hospitals and comprehensive outpatient rehabilitation facilities), partial hospitalization providers, and psychologists, these provider types must be disenrolled from Medicaid effective July 1, 1998."[3] Therefore, there is no legal mechanism to obtain a Medicaid number or to pursue a remittance advice or denial from the State of Florida. As such, the Provider concludes that sound business judgment would dictate that the bad debt was uncollectible when claimed.

Second, the Provider contends that there is a CMS internal memorandum dated March 27, 2006[4] that addresses the situation in Florida and instructs the intermediaries to suspend the prior "must bill" instructions in JSM-370, and continue to reimburse for bad debts for PHP dual enrollees. Specifically, JSM-06345, 03-24-06, states:

> On August 10, 2004, the Centers for Medicare & Medicaid Services (CMS) issued a directive regarding Medicare's policy for reimbursement of bad debts for dual eligible beneficiaries (Joint Signature Memorandum (JSM)-370), requiring a provider to bill the State and receive a remittance advice before allowing a bad debt.
>
> The CMS recently became aware of instances in which the Florida Medicaid Agency disenrolled freestanding psychiatric hospitals as Medicaid providers and indicated that it will not accept claims filed by such hospitals (or issue Remittance Advices) because of the facilities' disenrollment as Medicaid providers. The CMS is currently investigating the extent to which disenrollment in the Medicaid Program affected these hospitals and other Medicare providers in Florida.
>
> Until further notice, the CMS is instructing fiscal intermediaries not to reduce tentative settlements to the affected freestanding psychiatric hospitals for bad debts not billed to the State of Florida. If a tentative settlement made since August 10, 2004, reduced bad debts because the State of Florida was not billed, you must issue a revised tentative settlement to temporarily pay these bad debts. In addition, interim payments to the affected freestanding psychiatric hospitals in Florida should be immediately reviewed and adjusted, if necessary, to reflect bad debts not billed to the State of Florida. Until we provide further guidance, do not final settle cost reports for the affected hospitals or reopen any cost reports for this issue.

Finally, with regard to the requirements listed at 42 C.F.R. §413.89(e) and PRM-I §308, the Provider contends that there is no dispute that the clinical services in this matter were Medicare covered PHP services rendered to dual enrollees and the bad debts are derived from deductible and coinsurance amounts. The Provider argues that "reasonable collection efforts" as described in PRM-I §310 are not required since, pursuant to PRM-I

[3] See Provider Exhibits P-25 and P-28.
[4] Obtained through Freedom of Information Act (FOIA) request. See Provider Exhibit P-14.

§312, these beneficiaries are deemed indigent and the debt is "de facto" uncollectible. In addition, the Provider argues that partial hospitalization services are non-covered in the State of Florida, so in accordance with PRM-I §322, Florida Medicaid has no obligation to make payment for deductibles and coinsurance amounts for the dual enrollees.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the critical criterion in this case is whether the Provider is obligated to pursue collection from the party responsible for the beneficiary's financial obligations, including State Welfare Programs per PRM-I §322 in the case of a dual-eligible beneficiary. The Intermediary asserts that the State cannot shift its cost sharing responsibility by structuring its Medicaid Program to avoid payment of a legal obligation.

The Intermediary argues that the must-bill policy is a reasonable reading of the regulations and long-standing CMS policy[5] that has been upheld by the CMS Administrator and the courts. The Intermediary cites GCI Health Care Center v. Thompson, 209 F.Supp 2d 63 (D D.C. 2002)[6] in which the Court affirmed the Administrator's decision that denied Medicare bad debt reimbursement for deductible and coinsurance amounts the Arizona Medicaid Program was obligated to pay. The Intermediary also cites Community Hospital of the Monterey Peninsula v. Thompson, 323 F.3d 782 (9th Cir. 2003), which led to the issuance of JSM-370.

The Intermediary also relies on JSM-370, 08-03-04, which states in part:

> In order to fulfill the requirement that a provider make a "reasonable" collection effort with respect to the deductibles and co-insurance amounts owed by dual-eligible patients, our bad debt policy requires the provider to bill the patient or entity legally responsible for the patient's bill before the provider can be reimbursed for uncollectible amounts. This "must bill" policy was recently upheld by the federal Ninth Circuit Court of Appeals in ***Community Hospital of the Monterey Peninsula v Thompson***, 323 F.3d 782 (9th Cir. 2003). The "must bill" policy states that if a patient is determined by the provider to be indigent or medically indigent, the provider does not need to attempt to collect from the patient. However, the provider must make certain that "no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency . . . " prior to claiming the bad debt from Medicare.
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> With respect to "dual-eligibles," Section 1905(p)(3) of the Social Security Act ("Act") imposes liability for cost-sharing amounts for Qualified Medicare Beneficiaries on the States, though Section 1902(n)(2) allows the states to limit that amount to the Medicaid rate

[5] See Tr. at 81-83.

[6] The Administrator's decision was Village Green Nursing Home v. BlueCross and BlueShield Association, August 3, 2000, (2000-D59)

> and essentially pay nothing toward dual eligibles' cost-sharing if the Medicaid rate is lower than what Medicare would pay for the service. However, in those instances where the state owes none or only a portion of the dual-eligible patient's deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State Remittance Advice). Even if the State Plan Amendment limits the liability to the Medicaid rate, by billing the State, a provider can verify the current dual-eligible status of a beneficiary and can determine whether or not the State is liable for any portion thereof.

In addition, the Intermediary cites the State Medicaid Manual, CMS Pub. 45 §3490.14(A), which states that the state agency must pay for Medicare Part A and Part B deductibles and coinsurance for Medicare services, whether the services are covered in the Medicaid State plan. A state can establish a rate for payment of its deductible obligation at less than 80% of the Medicare rate as long as the rate is found to be reasonable by CMS in approving the state plan.[7]

In March 2006, Florida Medicaid was notified by CMS of a deficiency in its State plan.[8] The letter from CMS made it clear that even when a service is not provided under the Medicaid State Plan, the State is responsible for paying the Medicare coinsurance and deductibles for all services covered under Medicare part A, B and C for eligible QMBs. The Intermediary contends that the fact that Florida has "dodged" the obligation to pay deductibles and coinsurance for services furnished by the Provider to QMBs does not eliminate the existence of the obligation. Florida's Medicaid Program remains responsible.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Provider has met the requirement for a reasonable collection effort related to the dual eligible beneficiaries as required by 42 C.F.R. §413.89 and the Manual instructions.

The Intermediary suggested at the hearing that state liability was an absolute bar to Medicare recovery of a bed debt. This provision is not identified in statute or regulation, but only in PRM-I §322. The Board finds that §322 is consistent with the regulations in that it describes what constitutes a "reasonable collection effort" as that phrase is used in 42 C.F.R. §413.89(e)(2). Where a provider can bill and the state is obligated to pay, the provider must implement reasonable collection efforts to obtain payment from the state under PRM-I §322. However, to read §322 as an absolute bar, regardless of the collection effort, would conflict with the statute and regulation allowing payments for Medicare bad debts. In addition, the Intermediary's standard is inconsistent with the requirements imposed for all other payors and is inconsistent with the concept of

[7] See Intermediary Exhibit I-4.
[8] See Intermediary Exhibits I-6 and I-4.

reimbursement for bad debts, which is premised on the inability to collect, despite reasonable collection effort, from a payor with a legal obligation.

Assuming arguendo that a state's liability constitutes an absolute bar to recovery of a bad debt, the Board does not find clear evidence that the State had an absolute obligation to pay. Although Title XIX section 1905 appears to impose an obligation, section 1902(n) permits states to limit payment, at least to some extent. The State of Florida passed legislation in 1998 eliminating any obligation for payment toward the Medicare deductible and coinsurance for any service that is not covered by Medicaid, including the specific services furnished by the appealing Provider. CMS' interpretation that such State action was proper is evidenced by the fact that CMS approved the State Plan. Even after potential problems were raised, CMS nevertheless acquiesced to the State's changing the payment obligation only prospectively. If resolution in the future retroactively clarifies the State obligation and installs a process by which the Provider could bill and document payments received, then cost report requirements would ultimately result in restitution to Medicare through bad debt recoveries.

Therefore, the ultimate question for the Board is whether the Provider has met the requirements of 42 C.F.R. §413.89 and PRM-I §308. The Intermediary alleges that reasonable collection effort was not satisfied because JSM-370 makes the act of billing and the receipt of a remittance advice the exclusive evidence acceptable to prove the state's obligation, or lack of obligation, to pay. The Board finds that while a remittance advice is one source of documentary evidence to support a reasonable collection effort, it is not the only reliable source. Moreover, the Providers in this case cannot be held to the "must bill" requirement as described in the JSM for the reasons discuss below.

First, the Board finds that a JSM is an inappropriate vehicle to set policy and is therefore entitled to less deference than regulations and Manual instructions. The Division of Change and Operations[9] describes a Joint Signature Memorandum (JSM) as a memorandum/letter communicated to all or a select group of Medicare fee-for-service Fiscal Intermediaries and Carriers that must be signed by at least two group directors. Relevant here is what CMS says a JSM is <u>not</u> to be used for: conveying new instructions or providing clarification of existing requirements that affect contractor operations. In those situations, Manual instructions should be submitted through the formal Change Management/Change Request process.

Second, JSM-06345,03-24-06 instructs the Florida Intermediaries to suspend the prior "must bill" instructions in JSM-370, 08-03-04. The Board notes that the two signatories on the original JSM are also on the subsequent JSM. Even though the NPR in this case had already been issued, the subsequent JSM modification nevertheless shows CMS' recognition that the JSM-370 "must bill" requirements may not be reasonable in some circumstances. No evidence was offered to show that the second JSM directive was

[9] Board Members asked the Intermediary to explain what a JSM was, the process for approval, and the weight to be given this document (See Tr. 69-72). The Intermediary was not able to answer the question during the hearing and did not provide a response post-hearing. The Board searched the CMS intranet for a definition. See http://cmsnet.cms.hhs.gov/hpages/cmm/dcm/aboutjsm.htm.

withdrawn or modified. Contrary to Community Hospital of the Monterey Peninsula v Thompson, the authorization of an alternative to billing is relevant in this case because it was not possible for CMHC providers to bill Florida's Medicaid program.

Third, the Florida statute regarding Medicaid Provider Fraud at §409.920(2)(b) states that it is unlawful to "[k]nowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program . . . A person who violates this subsection commits a felony of the third degree, . . ."[10] The Parties have stipulated that consistent with Florida law, Florida's Medicaid State Plan was amended to eliminate any coverage responsibility for coinsurance and deductibles for the type of services furnished by the appealing Provider and similarly situated CMHCs. The Board finds it would be unreasonable to place the Provider in legal jeopardy to bill in accordance with JSM-370 to collect Medicare bad debts.

Fourth, the Board finds that the Medicare requirement to bill and obtain a remittance advice was a matter of impossibility for the Provider. The impossibility is made more compelling because CMS participated in the "errors" that created the impossibility by initially approving the amendment to the State Plan and then requiring modifications to be made only prospectively. The Intermediary ultimately conceded that the Provider took all reasonably necessary steps to obtain a remittance advice.[11] The Provider is the only stakeholder not at fault in this situation.

Based on the above, the Board finds that the Provider has met the requirement for a reasonable collection effort related to the dual eligible beneficiaries as required by 42 C.F.R. §413.89 and the Manual instructions. Given the unique circumstances in the State of Florida, the Board also finds that the associated bad debts were actually uncollectible when the Provider claimed them as worthless and that sound business judgment established that there was no likelihood of recovery at any time in the future.

DECISION AND ORDER:

The Intermediary improperly disallowed the bad debts arising from coinsurance and deductibles for dual eligible Medicare and Medicaid beneficiaries. 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.

[10] See Provider Exhibit P-28.
[11] See Tr. at 109-110.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: January 29, 2010