PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D20

PROVIDER – SD 94/95/96-97 Inpatient Crossover Bad Debts Groups/Sharp HC 97 Inpatient Unproc Crossover Bad Debts Grp
San Diego County, California

Provider Nos: See Appendix I, (Pages 10-13)

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ National Government Services, Inc.

DATE OF HEARING -
January 17, 2008

Cost Reporting Periods Ended -
See Appendix I

CASE NOs.: 00-4034G, 00-4035G; 00-4036G; 05-0157G

INDEX

ISSUE:

Whether the Providers have been properly paid for bad debts for Medicare deductible and coinsurance amounts associated with Medicaid eligible inpatients for services between May 1, 1994 and June 30, 1998.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due providers 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 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. §§405.1835-1837.

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 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 anytime in the future.

The Provider Reimbursement Manual (PRM) Part II, §1102.3L, offers implementing guidance for debt collection activities and specifically addresses crossover bad debts. It states in relevant part:

[1] Redesignated from §413.80 on 8/11/2004 in 69 FR 49254.

> 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:
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> - Medicaid eligibility at the time services were rendered (via valid Medicaid eligibility number), and
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> - Nonpayment that would have occurred if the crossover claim had actually been filed with Medicaid.

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

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Providers participating in each group appeal are non-profit acute care hospitals located in San Diego County, California. During the cost reporting periods in question, the Providers participated in the Medicare program and in the California Medicaid program (commonly referred to as Medi-Cal) as providers of hospital services. National Government Services (Intermediary), under either its current name or former names, served as the intermediary for the Providers during the cost reporting periods in the group appeals.

The State of California operates the Medi-Cal program pursuant to a state plan approved by the Centers for Medicare and Medicaid Services (CMS) under Title XIX of the Social Security Act. For patients eligible for both Medicare and Medicaid benefits, the Medicare program is primary and the Medi-Cal is secondary in order of payment. Until May 1994, Medi-Cal generally paid 100% of the coinsurance and deductibles for Medicare covered services furnished to hospital patients who were eligible for both Medicare and Medicaid.

In the case of inpatient hospital services, claims submitted by hospitals to the Medicare fiscal intermediary automatically "crossed over" to Medi-Cal for payment of the Medicare coinsurance and deductible amounts. The Medicare fiscal intermediary transmitted information from the Medicare claim to Medi-Cal pursuant to coordination of benefit agreements.[2] As of May 1, 1994, Medi-Cal discontinued payment for Medicare coinsurance and deductibles for inpatient crossover claims based on a new policy. Under the new policy, the Medi-Cal payment was limited to the Medicaid payment rate for the services provided to QMB Plus and "other" Medicaid patients. In implementing this policy, Medi-Cal assumed that the Medicare payment for inpatient hospital services equaled or exceeded the Medicaid payment rate and did not perform claim-by-claim comparison of the actual Medicare payment and the Medi-Cal payment

[2]See Providers Exhibit P-11.

rate. Medi-Cal implemented this policy before obtaining approval of an amendment to its state plan from CMS.[3] As a result, hospitals began receiving little or no payment from Medi-Cal for the Medicare coinsurance and deductibles of crossover inpatients.

Even though Medi-Cal refused to pay for the inpatient crossover Medicare deductibles and coinsurance amounts, the Intermediary and CMS did not allow any Medicare reimbursement for these amounts as bad debts.[4] The rationale for Medicare's position was that the State was obligated to make payment for Medicare coinsurance and deductibles under its state Medicaid plan.[5] Therefore, Medicare took the position that the unpaid amounts could not be reimbursed as Medicare bad debts under PRM, Part I, §322 until the State could properly determine its share of payment in accordance with the state plan.

On February 28, 1996, CMS formally approved State Plan Amendment 94-008 retroactively to May 1, 1994, which authorized Medi-Cal to pay for Medicare deductibles and coinsurance only if and to the extent that the Medicaid payment rate exceeded the Medicare primary payment.[6] Although CMS agreed with Medi-Cal's new policy limiting payment for inpatient crossover claims, Medicare nevertheless continued to refuse any bad debt reimbursement.

In the meantime, several California hospitals filed a lawsuit in United States Federal Court against the California Department of Human Services, the state agency responsible for Medi-Cal, seeking prospectively to compel full payment of Medicare coinsurance and deductibles for all QMB claims. Initially, the hospitals obtained a favorable United States District Court ruling enjoining Medi-Cal from paying less than the full amount of the Medicare coinsurance and deductibles. Beverly Community Hospital, et al. vs. Belshe, Medicare & Medicaid Guide (CCH) ¶44,507 (C.D. Cal Dec. 19, 1995).

In the Balanced Budget Act of 1997 (BBA) Congress amended the Medicaid statute to permit states to pay less than 100% of Medicare coinsurance and deductibles for QMBs.[7] In a decision dated December 2, 1997, the Court of Appeals for the Ninth Circuit held that this statutory amendment applied to the California litigation concerning Medi-Cal's new payment limit on inpatient crossover claims and reversed the district court decisions. Beverly Community Hospital Association vs. Belshe, 132 F.3d 1259 (9th Cir. 1997).

Thus, Medi-Cal discontinued payment of the full Medicare coinsurance and deductibles for inpatient crossover claims under a policy that was eventually approved by CMS, and ultimately by Congress, retroactively to May 1, 1994. Medicare refused to allow any bad debt reimbursement for the unpaid amounts – initially because Medi-Cal's action was inconsistent with the terms of its state plan and then (after CMS approved the state plan amendment

[3] See CMS Regional Office to Blue Cross of California dated March 3, 1999 (Intermediary Exhibit I-2).
[4] Tr. at 224.
[5] See CMS Regional Office Letter at p. 2; Intermediary Exhibit I-2.
[6] See CMS Regional Office Letter at p. 1; Intermediary Exhibit I-2.
[7] BBA, Pub. L. No. 105-33, §4714, amending 42 U.S.C. §1395a(n).

retroactively) because Medi-Cal did not perform a proper claim-by-claim comparison of the Medicare payment with the Medi-Cal payment rate.

This impasse continued until 1999, when Medi-Cal furnished reports to the Intermediary showing the claim-by-claim comparison of the amount paid by Medicare and the Medicaid payment rate for inpatient crossover claims. Based on these reports, the Intermediary made lump-sum payments to hospitals for the unpaid Medicare coinsurance and deductibles retroactively to May 1, 1994.[8] Meanwhile, from these reports, Medi-Cal recouped all payments it made on inpatient crossover claims under the invalidated district court order in the Beverly case that were in excess of the Medi-Cal payment rates, and also made payments, up to the amount of the Medi-Cal rate, on those inpatient crossover claims that had not been paid.

The final reports produced by Medi-Cal and relied on by the Intermediary for the lump-sum payments of inpatient crossover bad debts were not furnished to the providers until late August 1999.[9] Upon review of the reports, the Providers believed that the lists did not include all inpatient crossover claims during the period allegedly covered by the lump-sum payments, i.e., May 1, 1994 through April 4, 1999.[10] The Providers contacted the state Medi-Cal agency to attempt to resolve the apparently missing crossover claims.[11] In a letter dated October 19, 1999, the Providers' representative submitted a request for correction of data included in the report for Grossmont Hospital, [12] one of the Providers in these group appeals. The State of California never took action on this request. The only response the Providers received from Medi-Cal was an informal comment from agency staff that the agency lacked manpower and resources to address the issue.[13]

PARTIES' CONTENTIONS:

The Providers contend that the inpatient crossover bad debts are reimbursable as Medicare bad debts under Medicare Program instructions. Medicare regulations provide for reimbursement of a hospital's bad debts related to Medicare deductibles and coinsurance amounts. 42 C.F.R. §§412.115(a), 413.80.[14] Medicare reimbursement for uncollected Medicare deductible and coinsurance amounts is based on the statutory prohibition against cross-subsidization, which directs CMS to ensure that the methods of determining reasonable cost do not shift the costs of services furnished to Medicare beneficiaries to other patients (and vice-versa). 42 U.S.C. §1395x(v)(1)(A) (last sentence). See also 42 C.F.R. §413.9(b)(1). The regulation governing Medicare bad debt recognizes that beneficiary nonpayment of Medicare deductibles and coinsurance "can result in the related costs of covered services being borne by other than

[8] See Intermediary Exhibits I-1 & I-2; Providers Exhibit P-2.
[9] See Providers Exhibit P-2; Hearing Tr. at 89-91.
[10] See Hearing Tr. at 91-92, 118-119; Affidavit of Joseph Gemperline dated Nov. 3, 2008, ¶11 (Providers Exhibit P-11).
[11] Hearing Tr. at 99-102.
[12] See Providers Exhibit P-4.
[13] Hearing Tr. at 100-101, 105, 182-185.
[14] Since the periods under appeal, Section 413.80 has been redesignated at 42 C.F.R. §413.89. The prior designation of the regulation in effect during the periods in question is used herein.

Medicare beneficiaries." 42 C.F.R. §413.80(d). Thus, the regulation provides for reimbursement of "the costs attributable to the deductible and coinsurance amounts which remain unpaid" in order to assure that such costs of Medicare covered services are not borne by other patients and payers. Id.

Under the Medicare requirements for reimbursement of Medicare bad debts, the provider ordinarily must establish that it made reasonable efforts to collect these amounts. 42 C.F.R. §413.80(e); PRM, Part I, §310. In the case of indigent patients, however, normal collection efforts need not be followed. PRM, Part I, §312. Providers can deem Medicare beneficiaries to be indigent when those beneficiaries have also been determined to be eligible for Medicaid benefits. Id.

The Providers rely on the Manual language asserting that it provides that a provider's Medicare bad debts can include any Medicare deductible and coinsurance amounts for such dual eligible patients that the state Medicaid program is not obligated to pay. PRM, Part I, §322. Furthermore, the Manual expressly states that any portion of Medicare deductible and coinsurance amounts not paid by a state Medicaid program because of state payment limits can be included in the provider's Medicare bad debts. Id. Accordingly, Medicare deductible and coinsurance amounts that exceed the payment limit set by the Medi-Cal program which CMS approved retroactively to May 1, 1994 are reimbursable as Medicare bad debts. Under that limit, Medi-Cal will not pay any portion of the deductibles and coinsurance that exceeds the difference between the Medicaid payment rate and the Medicare payment.

The Providers have identified the Medicare deductible and coinsurance amounts for crossover inpatients in the fiscal years under appeal that remain unpaid by Medi-Cal.[15] The Providers identified all inpatients eligible for Medicaid and Medicare utilizing the Medicaid eligibility lists furnished by the California Department of Health Services and the Providers Statistical and Reimbursement System (PS&R) reports furnished by the Intermediary.[16] From the PS&R reports, the Providers also identified the Medicare primary payments and Medicare deductibles and coinsurance for covered services furnished to the Medicaid eligible inpatients. If the Medi-Cal payment rate was equal to or less than the Medicare payment, no portion of the Medicare deductible and coinsurance would be payable by Medi-Cal. If the Medi-Cal payment rate exceeded the Medicare payment, the amount exceeding the Medicare payment would be the amount payable by Medi-Cal for the Medicare deductibles and coinsurance, up to the total Medicare deductibles and coinsurance.[17] As with the lump-sum payment methodology utilized by the Intermediary, the Provider contends the remaining portions of Medicare deductible and coinsurance amounts not payable by Medi-Cal constitute the Providers' reimbursable Medicare bad debt for crossover inpatients.

The Intermediary argues that the Providers' claims for inpatient crossover bad debts must be rejected because the Providers were required to bill the state Medicaid program but failed to do so. It relies on the decision of the Ninth Circuit Court of Appeals in Community Hospital of

[15] See Providers Exhibit P-6 for each appeal.
[16] Tr. at 114, 120.
[17] See Hearing Tr. at 90—91, 113-114.

Monterey Peninsula vs. Thompson, 323 F.3d 782 (9th Cir. 2003) (Community Hospital), which upheld CMS's refusal to reimburse outpatient bad debts for dual eligible patients based on a "must-bill" policy.[18] The Providers counter that their claims are not precluded by the must-bill policy and that the Community Hospital decision is inapplicable to these appeals.

The Providers assert that, during the periods under appeal, Medicare and Medi-Cal utilized an automatic crossover claims process to simplify coordination of benefits for inpatient hospital services. Subsequent to the hearing before the Board, the parties confirmed with the claims manager for the Intermediary during the relevant period that the Intermediary had a system to automatically transfer Medicare claims data to the Medicaid program for dual eligible patients.[19] Under this process, the Medicare claim data crossed over to Medi-Cal for processing of payment, if any, for Medicare deductibles and coinsurance of dual eligible patients. Hospitals did not submit separate bills to Medi-Cal requesting payment of these amounts. The Medicare claim served as the bill for these amounts under the crossover process.[20]

The Providers assert that they should be held harmless because they followed Medicare cost reporting instructions and used the Intermediary's methodology for determining inpatient crossover bad debts for the period in question.[21] Medicare cost reporting instructions relating to Medicare bad debts, in effect during the relevant periods, permitted a provider to furnish alternative documentation of Medicaid eligibility and the non-payment that would have occurred on a dual eligible patient claim in lieu of billing the state Medicaid program.[22] The Providers' documentation identifying inpatient crossover bad debts includes documentation of Medicaid eligibility from the State and documentation of the amount remaining unpaid after taking into account the amount that Medi-Cal would have paid.

The Intermediary contends that PRM, Part I §322 requires that where a state is obligated either by statute or under the terms of its plan to pay for Medicare deductible and coinsurance, these amounts are not allowable as bad debts under Medicare. CMS Pub. 15-1 §322 also requires that for any portion of Medicare bad debts not paid by the State, Medicare can reimburse a provider as long as the requirements of PRM §312 or, if applicable, §310 are met.

In 1994, the State of California stopped paying deductibles and coinsurance amounts for inpatient crossover claims. The Intermediary contends that Medicare bad debts related to crossover claims are controlled by the settlement entered between CMS, the State of California and the plaintiff hospitals.[23] Providers were informed that any disagreement with the detailed claims data of the reprocessed crossover claims should be taken up with the State of California. Providers could not make additional new claims after the settlement. The Intermediary urges the

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[18] See Hearing Tr. at 71.
[19] See Intermediary's letter to Board dated Sept. 17, 2008; Providers' letter to Board dated Nov. 3, 2008; Providers Exhibit P-11.
[20] Tr. at 84-85, 132-133.
[21] See Hearing Tr. at 109-113.
[22] PRM, Part II, §1102.3L (Providers Exhibit P-1)
[23] Tr. at 65-69. The Providers dispute this fact – that they were a party to the negotiated settlement or agreement

Board to rule as the 9th Circuit U.S. Court of Appeals in Community Hospital. That decision required providers to "bill" for Medi-Cal patient services rendered.

The Providers respond saying the fact that the State and CMS may have "negotiated" certain understandings about claim-to-claim comparisons of the Medicaid payment rate and Medicare payment, and about reports to be furnished to the Intermediary, does not absolve the Intermediary or CMS from following Medicare Manual instructions and regulations regarding reimbursement of Medicare bad debts. Furthermore, contrary to the Intermediary's implications, the Providers did not enter into any settlement that restricted their inpatient crossover bad debt reimbursement to the lump sum payment amounts.[24] The Intermediary offered no documentation that the Providers had executed settlement agreements restricting them to the lump sum payments.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence and parties' contentions, the Board finds and concludes that the Intermediary improperly disallowed the Providers' claim for Medicare bad debts. The Board is bound to follow the requirements of the Medicare regulations. The Board is not bound by agreements for bad debt payments negotiated between the State of California and CMS, especially when the Providers were not parties to the agreement.

The Medicare regulations and program instructions provide requirements for determining allowable Medicare bad debt reimbursement. The issue in this case is whether the Providers made a reasonable collection effort. The Board finds that the contractual agreement between the State of California and CMS did define a process for determining bad debts. CMS' San Francisco Regional Office issued instructions to Blue Cross of California on March 3, 1999[25] and July 20, 1999[26] on how to recognize inpatient crossover bad debts. After reviewing the record, the Board finds that both the Providers and Intermediary appropriately followed CMS directives as well as the process. The Board finds that the Provider complied with the above requirements and notified the State of California Department of Health Services[27] in October, 1999 that a correction of data was required for Grossmont Hospital, one of the Providers in these group appeals. In uncontroverted testimony, the Providers stated that the State never took action on this request. The only response was an informal comment from a Medi-Cal agency staff member that the agency did not have proper manpower to address the issue.[28] Based on this evidence, the Board concludes that the Provider made an effort to request reimbursement for all Medicare deductible and coinsurance amounts attributable to dual eligible patients from the State.

[24]Tr. at 103-104.
[25]See, Intermediary Exhibit I-2.
[26] See, Intermediary Exhibit I-3.
[27]See, Provider Exhibit P-4.
[28]See Provider's Post Hearing Brief at p. 6.

The Board finds that all the bad debts at issue were billed by the Providers as supported by Medicare PS&R reports. In addition, the inpatient crossover claims data was directly transferred to the state Medicaid agency, Medi-Cal, by the Intermediary. In a letter dated November 3, 2008,[29] the Providers stated that the claims manager of United Government Services, the relevant Intermediary, confirmed that the Intermediary did have a system to automatically transfer Medicare claims data to the Medicaid Program. This was corroborated in the September 17, 2008 letter from the Intermediary's representative at the hearing.[30] Thus, the Board concludes that the Providers complied with the Medicare billing requirements.

The Board further finds that the Intermediary incorrectly used PRM, Part I §322 to deny crossover bad debts. That section interprets the Medicare bad debt regulation at 42 C.F.R. §413.80 to provide that where the State is obligated to pay all or any part of the Medicare deductibles or coinsurance amounts, the amounts are not allowed by Medicare. It further states that any portion of such amounts that the state is not obligated to pay can be included. The Board finds that based on the Agreement, the process of automatic transfer of claims data and accountability of bad debts in the PS&R reports, the Intermediary could easily determine the amounts which the state is not obligated to pay. If any refunds result after Medicare bad debts have been determined, the Intermediary can later offset those recoveries when they are received.

DECISION AND ORDER:

The Intermediary improperly denied the Providers the right to claim additional Medicare bad debts. The Intermediary's adjustments are 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.

FOR THE BOARD

Suzanne Cochran, Esquire
Chairperson

DATE: March 18, 2010

[29] See Provider Exhibit P-11.
[30] Id.

Appendix I

SD 94 Inpatient Cross-Over Bad Debts
Appeal Year 1994

SUMMARY OF PROVIDERS AND AMOUNTS DUE

05-0233	Sharp Cabrillo Hospital	9/30/1994	$62,428
05-0222	Sharp Chula Vista Medical Center	9/30/1994	$144,989
05-0026	Grossmont Hospital	6/30/1994	$32,846
05-0026	Grossmont Hospital	9/30/1994	$130,165
05-0100	Sharp Memorial Hospital	9/30/1994	$143,204
05-0128	Tri-City Medical Center	6/30/1994	$6,910
			$520,542

Appendix I

SD 95 Inpatient Cross-Over Bad Debts
Appeal Year 1995

SUMMARY OF PROVIDERS AND AMOUNTS DUE

05-0233	Sharp Cabrillo Hospital	9/30/1995	$95,611
05-0222	Sharp Chula Vista Medical Center	9/30/1995	$368,831
05-0026	Grossmont Hospital	9/30/1995	$217,335
05-0100	Sharp Memorial Hospital	9/30/1995	$318,525
05-0128	Tri-City Medical Center	6/30/1995	$36,799
			$1,037,101

Appendix I

SD 96 Inpatient Cross-Over Bad Debts
Appeal Years 1996-98

SUMMARY OF PROVIDERS AND AMOUNTS DUE

05-0233	Sharp Cabrillo Hospital	1/31/1996	$30,928
05-0100	Sharp Memorial Hospital	1/31/1996	$72,673
05-0128	Tri-City Medical Center	6/30/1996	$31,427
05-0222	Sharp Chula Vista Medical Center	9/30/1996	$66,181
05-0026	Grossmont Hospital	9/30/1996	$63,767
05-0100	Sharp Memorial Hospital	9/30/1996	$30,137
05-0128	Tri-City Medical Center	6/30/1997	$41,312
05-0128	Tri-City Medical Center	6/30/1998	$33,021
			$369,446

Appendix I

SD 97 Inpatient Cross-Over Bad Debts
Appeal Year 1997

SUMMARY OF PROVIDERS AND AMOUNTS DUE

05-0222	Sharp Chula Vista Medical Center	9/30/1997	$53,503
05-0100	Sharp Memorial Hospital	9/30/1997	$67,925
05-0026	Grossmont Medical Center	9/30/1997	$60,222
			$181,650