PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D10

PROVIDER -
Kindred Healthcare '05 Bad Debts (Write Off Dates)

Provider Nos.:
19-5350, 11-5612, 15-5473 and 11-5535

vs.

INTERMEDIARY -
Wisconsin Physicians Service (formerly Mutual of Omaha)

DATE OF HEARING -
August 7, 2008

Cost Reporting Periods Ended – July 31, 2005, November 30, 2005 and December 31, 2005

CASE NO.: 07-1969G

INDEX

ISSUE:

Whether the Intermediary's adjustments to disallow Medicare bad debts written off by Kindred Healthcare and claimed as worthless after the year end date of the terminating cost report it filed for each skilled nursing facility, due to change of ownership, were 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and 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) 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; and
> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

The procedures constituting "reasonable collection efforts" are outlined in CMS Provider Reimbursement Manual ("PRM") 15-1, section 310. The section incorporates PRM 15-1, section 312 for the determination of indigence of patients. Section 312, states in pertinent part:

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

The general rule for charging off bad debts is set forth at 42 C.F.R. § 413.89(f) which states:

> The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless.

See also PRM (CMS Pub. 15-1) §314 ("Uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless.")

When a provider undergoes a change of ownership, the Medicare regulations state that the existing provider agreement will automatically be assigned to the new owner. 42 C.F.R. §489.18(c). The old owner must file a terminating cost report after the effective date of the change of ownership which must cover the provider's participation in the Medicare program before the change of ownership. See PRM (CMS Pub. 15-1) §1500. There are certain "items which must be taken into account in the final cost report of a provider." PRM (CMS-Pub. 15-1) §1503. Included in this list are allowable administrative costs incurred after a change of ownership, and a cross reference to PRM (CMS-Pub. 15-1) §2176 is provided. PRM (CMS-Pub. 15-1) §1503.9. The cross-referenced provision—PRM (CMS-Pub. 15-1) §2176—discusses costs related to patient care; specifically, administrative costs incurred after a provider terminates participation in the program or a change of ownership. It describes costs that are incurred after a change of ownership which are allowable, including administrative and bad debt costs. It states:

> When a provider terminates its participation in the program, either voluntarily or involuntarily, or a change of ownership occurs (see Health Insurance Regulations section 405.626), administrative costs associated with the preparation and settlement of cost reports with an intermediary and other third parties will be incurred after the effective date of termination. The direct administrative

> costs that are reasonable and related to the settlement of reimbursement for patient care rendered while the provider was participating in the program and bad debts resulting from coinsurance and deductibles billed to Medicare patients are allowable.

The PRM goes on to permit allowable direct administrative costs to be included in the provider's terminating cost report for the period ending on the effective date of the change of ownership, as long as they are "necessary, proper, and reasonable," and states that they are "subject to cost allocation and apportionment." PRM (CMS-Pub. 15-1) §2176.1. For additional allowable direct administrative costs that are incurred after filing of the terminating cost report, upon notice to the intermediary, the intermediary "may adjust the final cost report or require the provider to file an amended cost report, depending on the materiality of the adjustments." PRM (CMS-Pub. 15-1) §2176.2.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The providers ("Providers") are Medicare-certified skilled nursing facilities located in three states that were operated by subsidiaries of Kindred Healthcare, Inc. (Kindred) and sold during fiscal year ("FY") 2005. While Kindred operated the skilled nursing facilities, it provided health care services to Medicare beneficiaries who were indigent and were thus dually eligible to receive Medicaid benefits. During the time it operated the skilled nursing facilities, Kindred incurred bad debt in the form of uncollectible Medicare deductibles and coinsurance amounts. The bad debt was written off once Medicaid remittance advices ("RAs") were issued denying payment for the Medicare cost sharing amounts, and collection efforts had thus been exhausted.

The Intermediary, formerly Mutual of Omaha and currently Wisconsin Physicians Service Insurance Corporation ("WPS"), issued Notices of Program Reimbursement ("NPRs") dated October 30, 2006, January 8, 2007, May 15, 2007, and May 17, 2007 disallowing all bad debts claimed with write-off dates after the fiscal year end. The total reimbursement denied by the adjustments at issue is $219,292.

The Providers' appealed the adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835- 405.1841. The Providers were represented by Jason M. Healy, Esquire of Reed Smith LLP. The Intermediary was represented by Stacey Hayes of Wisconsin Physicians Service Insurance Corporation.

PROVIDERS' CONTENTIONS:

The Providers contend that Medicare should reimburse Kindred Healthcare for bad debts it incurred for services provided to dually eligible beneficiaries during the cost report period, where that bad debt was deemed uncollectible after the fiscal year end of the cost report, but before the cost report was filed. The Providers explain that Kindred, as the operator of the skilled nursing facilities on the relevant dates of service, is the proper entity to be reimbursed for the disputed bad debts.

The Providers note that all of the bad debt at issue meets the criteria for allowability set forth in 42 C.F.R. §413.89(e). Specifically, the disputed bad debts resulted from deductibles and coinsurance amounts, related to Medicare-covered services provided to Medicare and Medicaid dual eligible beneficiaries by Kindred Healthcare before each skilled nursing facility changed ownership. They were properly deemed uncollectible when the state Medicaid program issued remittance advices (RAs) to Kindred denying payment of the Medicare cost sharing amounts. The Providers further contend that the disputed bad debts were written off by Kindred before it filed the terminating cost report for each skilled nursing facility.

The Providers argue that the only issue in dispute is that certain bad debt amounts had write-off dates after the fiscal year end of the terminating cost reports which coincided with the effective date of the changes of ownership. The Providers contend that this bad debt was disallowed by the Intermediary on the basis that Medicare should reimburse the new operator, since the facilities had changed ownership and the new operator had assumed the Medicare provider agreement for each facility. The Providers argue there is no regulatory support for the Intermediary's position -- the Intermediary justifies it position only through its own interpretation of the Medicare rules. The Providers further contend that the Intermediary's interpretation is inconsistent with the Medicare rules on terminating cost reports when there is a change of ownership. The Intermediary's interpretation also conflicts with: clear, written guidance from the CMS Central Office (CO) to the Intermediary; the Intermediary's internal audit policy group determination; the Intermediary's prior written guidance to Kindred; and the Intermediary's previous practice of reimbursing former operators for such bad debt.

The Providers state that Medicare program requires the former owner to file a terminating cost report ending with the date of the change of ownership for the purpose of determining the "final program cost settlement after termination." The rationale for this policy is that reimbursement for Medicare-covered services should be made to the entity that provided those services to Medicare beneficiaries.

The Providers refer to the documents they obtained from the Intermediary through discovery, which indicate that the Intermediary requested guidance from CMS on its interpretation of this issue. CMS central office staff responded in writing and clearly did not agree with the Intermediary. CMS explained that the terminating cost report is used to reimburse the former owner for bad debts determined to be worthless after the date of the change of ownership where the new owner assumed the existing Medicare provider agreement and number, even though the bad debt regulation at 42 C.F.R. §413.89(f) could be interpreted to suggest otherwise.[1] In summary, the Providers contend that the Intermediary has no support for its interpretation and that the Intermediary's adjustments were therefore arbitrary and capricious.

[1] See Provider Exhibit P-5.

INTERMEDARY'S CONTENTIONS:

The Intermediary states that the audit adjustments made to remove bad debts written off after the effective date of the change of ownership were proper. Because such amounts were deemed uncollectible after the change of ownership effective date, they should be reimbursed to the new owner even though they relate to dates of service prior to the change of ownership.

The Intermediary contends that the general rule found at 42 C.F.R. §413.89(f) regarding the charging off of bad debts controls the issue of dual eligible bad debts written off after the effective date of a change of ownership without exception. The exceptions CMS has established to this general rule for direct administrative costs and for bad debts recognized after the fiscal year end date where there has been a provider termination or a change of ownership in §2176 of the PRM do not apply because it contains a cross reference to an outdated Medicare change of ownership regulation. The Intermediary contends that the current Medicare change of ownership regulation allows for automatic assignment of a Medicare provider agreement. Since the Providers' Medicare provider agreements were assumed by the new owners, the Intermediary believes the Medicare program is no longer obligated to reimburse Kindred (the former owner) for allowable costs it incurred while providing covered services to Medicare beneficiaries and can reimburse only the new owner for such costs. The Intermediary further contends that parties to a change of ownership must contract to transfer all accounts receivable, including reimbursement for bad debts and that §2176 of the PRM only applies to program terminations.

The Intermediary concedes it requested guidance from the CMS CO on this issue and received conflicting emails from CMS regarding the proper handling of bad debts deemed uncollectible after a change of ownership. The Intermediary contends however, that the first e-mail it received from CMS in November of 2006[2] is controlling rather than the latter e-mail from April of 2007[3] which revised the earlier analysis. The Intermediary further explains that regardless of what the emails say, they express only the "thoughts and beliefs" of a single CMS employee and do not represent CMS policy. In addition, the Intermediary testified that after receipt of the two conflicting emails, it followed up verbally with CMS CO on its interpretation of the policy, and CMS CO was in agreement with the Intermediary's adjustments.[4] The Intermediary further argues that the emails between CMS and its sub-contractor are privileged and objected to the PRRB's order to release this information to the Providers.[5]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law, program instructions, the evidence presented and the parties' contentions, the Board finds and concludes as follows:

[2] See Intermediary Exhibit I-15.
[3] See Intermediary Exhibit I-16.
[4] See Transcript, pgs 130-132.
[5] See Intermediary Exhibit I-19.

The Providers incurred bad debts during the time they owned and operated skilled nursing facilities in the form of uncollectible Medicare deductible and coinsurance payments related to covered services provided to Medicare and Medicaid dual eligible beneficiaries. The Providers subsequently underwent a change of ownership therefore requiring the Providers to each file a terminating cost report which included claims for bad debts.

Some of the bad debt that the Providers incurred was written off after the effective date of the change of ownership, which was the fiscal year end date of the terminating cost reports but prior to the filing of these cost reports. Based on the provisions of 42 C.F.R. §413.89 and PRM 15-1, section 310, the only mechanism by which Medicare could reimburse this allowable bad debt to the terminating providers was through each Provider's terminating cost report.

The purpose of a terminating cost report is to determine the "final program cost settlement after termination." Medicare General Information, Eligibility, and Entitlement Manual (CMS Pub. 100-01) Ch. 5, §10.5; see also Medicare Intermediary Manual (CMS Pub. 13) Ch. VI, § 4509 (instructing Medicare intermediaries that "[o]nce the reimbursement effects of the change of ownership are determined, the final settlement of the affected provider cost reports may begin").

The Intermediary's contention that automatic assignment of the Medicare provider agreement to the new owner upon a change of ownership per 42 C.F.R. § 489.18(c) renders the former owner ineligible to receive reimbursement for bad debts related to dates of service prior to the change of ownership, is not consistent with CMS policy. Automatic assignment eliminates neither the requirement to file a terminating cost report upon a change of ownership nor the rationale for terminating cost reports. The Board finds no support for the notion that the Medicare program would eliminate the Providers' rights to reimbursement as of the change of ownership effective date.

The Board finds that under the applicable authority, there is no distinction between providers that are terminating their Medicare participation or providers that experience a change of ownership to the extent that they are both required to file terminating cost reports and are entitled to the same allowable costs. 42 C.F.R. § 413.24(f)(1). Section 2176 of the PRM directly addresses costs incurred or recognized by a Medicare provider after the effective date of termination from participation in the Medicare program or a change of ownership. It establishes an exception to the general rule that bad debts are to be claimed in the cost reporting year in which they are deemed uncollectible. It states:

> When a provider terminates its participation in the program, either voluntarily or involuntarily, or a change of ownership occurs (see Health Insurance Regulation section 405.626), administrative costs associated with the preparation and settlement of cost reports with an intermediary and other third parties will be incurred after the effective date of termination. The direct administrative

> costs that are reasonable and related to the settlement of reimbursement for patient care rendered while the provider was participating in the program and bad debts resulting from coinsurance and deductibles billed to Medicare patients are allowable.

The plain language of the above paragraph establishes that it applies to both program terminations and changes of ownership. The language of the second sentence, which specifically addresses Medicare bad debts, refers to program participation, which encompasses providers both before program termination and a change of ownership. Therefore, the Board rejects the Intermediary's contention that PRM §2176 does not apply to changes of ownership.

The Intermediary's claim that bad debts are recognized in the reporting period in which they were deemed worthless is valid where the provider continues to be owned or operated by the same legal entity, but ignores the exception articulated in PRM §2176 for changes of ownership. The fact that PRM §2176 cites "Health Insurance Regulation section 405.626"—a Medicare change of ownership regulation that is no longer in effect—does not invalidate the entire policy. With respect to any outstanding costs incurred by the former owner that relate to dates of service prior to the change of ownership, whether they are bad debts or direct administrative costs, CMS's policy is that they should be reimbursed to the former owner through the terminating cost report.

The Board finds that the Providers are the proper parties to be reimbursed for bad debts related to services they provided to dually eligible beneficiaries while they operated the skilled nursing facilities. The Board concludes that it was erroneous for the Intermediary to disregard clear guidance it received from CMS on the issue of the Providers' disputed bad debts in April 2007. The Board rejects the Intermediary's contention that, because it had previously received contradictory information, it was not bound by the revised statement of CMS policy it received in April 2007. Based on the timing and content of the two e-mails, the Board finds that the latter e-mail from CMS dated April 2007 was intended to replace or supersede the preliminary e-mail dated October 2006 on which the Intermediary relies.

DECISION AND ORDER:

The Intermediary's failure to reimburse the Providers for allowable bad debts incurred was inconsistent with Medicare laws, regulations, and program guidance. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith Braganza, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: February 27, 2009