PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D29

PROVIDERS –
Hope Horizon Center, Inc.
Provider No.: 10-1406

and

Homestead Behavioral Clinic, Inc.
Provider No.: 10-1416

vs.

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

DATE OF HEARING –
May 1, 2009

Cost Reporting Periods Ended –
See Appendix I

CASE NOs.: 08-1848, 09-1547, 10-0106, 06-1773, 07-2384, 08-2266, 09-1565

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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 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 the 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.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs 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 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 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 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 Providers' collection effort and the determination that the debts of Medicare/Medicaid dual eligible patients were uncollectible.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hope Horizon Center, Inc. and Homestead Behavioral Clinic, Inc. (Providers) are Medicare-certified Community Mental Health Centers (CMHCs) with Partial Hospitalization Programs (PHP) located in Florida.[2] First Coast Service Options, Inc. (Intermediary) is the Provider's Medicare fiscal intermediary.

The Intermediary reviewed the Providers' Medicare cost reports and issued NPRs reducing the Providers' claimed amount of allowable bad debt expense attributable to dual eligible patients. The Providers appealed the Intermediary's determinations to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841.

The Providers were represented by E. Michael Flanagan, Esquire, of The Law Offices of E. Michael Flanagan.[3] The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

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[2] Subsequent to the hearing for PRRB Case No. 08-1848 involving Hope Horizon Center, Inc., held May 1, 2009, the Parties submitted consolidation requests for two additional fiscal years for Hope Horizon Center, Inc. and for four fiscal years for Homestead Behavioral Clinic, Inc. The Parties agreed to rely on the record established in Case No. 08-1848 and to be governed by the decision issued by the Board in Case No. 08-1848. See Appendix I.

[3] Mr. Flanagan was formerly of the law firm Polsinelli Shughart.

PARTIES' STIPULATIONS:

The following facts were established by stipulations:[4]

- As CMHCs, the Providers furnish outpatient mental health services as set forth in 42 C.F.R. §410.2, to Medicare beneficiaries and other patients.

- Many of the Providers' 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.

- There are different categories of dual eligibles depending on income. One such category is "Qualified Medicare Beneficiaries." Qualified Medicare Beneficiaries (QMBs) are defined at 1905(p)(1) of the Social Security Act (the Act). QMBs are entitled to have their Medicare deductible and coinsurance covered by Medicaid, without regard to whether the services would be covered as Medicaid benefits, if Medicaid were the primary coverage. However, §1902(n)(1) of the Act permits a State to set a payment rate for QMBs that would serve as a payment ceiling. In this way, a State is able to limit its dual eligible copayment obligation to an amount that will not exceed what the State is obligated to pay for a Medicaid recipient that is not a dual eligible. Under this authority to establish a payment ceiling, a State would still be responsible for the deductible.

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

- As a result of the amendment to the State plan, all existing CMHCs were dissenrolled or dropped as participating Medicaid providers (see Exhibit P-1).

- Despite being dropped as a participating Medicaid provider, Providers continued to receive remittance advices from the Florida Medicaid Program indicating coinsurance and deductible payment amounts of $0 for each dual eligible.

- On or about October 2003, Providers were notified by the Florida Medicaid Program they would no longer be receiving remittance advices.

- In its Medicare Cost Report for the fiscal period of December 1, 2005 through November 30, 2006, (FYE November 30, 2006), Hope Horizon Center, Inc.

[4] The stipulations were originally submitted by Hope Horizon Center, Inc. and the Intermediary; however, the Representatives in their consolidation requests also argued that the facts were representative of material facts for the additional provider and fiscal years. Data specific to the additional provider and fiscal periods were submitted to the Intermediary for audit.

claimed $541,117 as Medicare reimbursable bad debts for coinsurance and deductibles for its dual eligible patients.

- Of the $541,117 in Medicare reimbursable bad debts claimed by Hope Horizon Center, Inc., $501,325 was disallowed by the Intermediary as not being in compliance with CMS's "must bill policy." The Intermediary referenced Centers for Medicare and Medicaid Services (CMS), JSM-370, 08-03-04 dated August 10, 2004.[5]

- 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 QMBs was approved in error and the plan must be corrected at risk of loss of Federal Financial Participation (FFP) (see Exhibit I-6).

- The Florida legislature removed the statutory impediment to covering such co-payments for QMBs in 2008 (see Exhibit I-7).

- Hope Horizon Center, Inc. has furnished a list that identifies its patients who make up the dual eligible bad debt claim, the service dates, and the amounts of the disallowed sum of $501,325. While the list has not been audited, it is readily auditable should the Provider prevail.

The Board reviewed the record and found the stipulations to be supported and, except for patients and financial data specific to Hope Horizon Center, Inc., representative of the additional provider and fiscal years consolidated without Case No. 08-1848.

PROVIDERS' CONTENTIONS:

The Providers contend that denying bad debts pursuant to the "must bill" policy is inconsistent with Medicare law and argues that they have established the uncollectible nature of the amounts they claimed as bad debts in accordance with 42 C.F.R. §413.89(e). The Providers claim they have done everything required by the Medicare regulations and program instructions to perfect their requests for crossover payments of Medicare coinsurance and deductible amounts from the Florida Medicaid program and any further attempts would be unavailing.

In 1998, the Florida Legislature passed a law prohibiting Florida Medicaid from making payment toward the Medicare deductible and coinsurance for any services that are not covered by Florida Medicaid. As stated in a May 22, 1998, 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 psychiatric hospitals and comprehensive outpatient rehabilitation facilities),

[5] JSM refers to Joint Signature Memorandum.

partial hospitalization providers, and psychologists, these provider types must be disenrolled from Medicaid effective July 1, 1998."[6]

Despite the unavailability of payments for dual-eligible patients, the Providers argue that they have not varied their billing practices from 1997 to present. Through the automatic crossover of electronic claims from Medicare to Medicaid, the Providers continued to submit bills to the Florida Medicaid program; therefore, they were without fault in their inability to obtain Medicaid remittance advices for the cost reports in question. The Providers also dispute the probative value of the Medicaid remittance advices in this instance because it is undisputed that had the remittance advices been issued, they would have indicated zero payments.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the critical criterion in this case is whether the Providers are 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 a 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 manual instructions and that this policy 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)[7] 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 CMS JSM-370.

In addition, the Intermediary cites the State Medicaid Manual, CMS Pub. 45 §3490.14(A), which provides that the State agency is "required to 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.[8]

In March 2006, Florida Medicaid was notified by CMS of a deficiency in its State plan.[9] 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

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[6] See Provider Exhibit P-3.
[7] The Administrator's decision was Village Green Nursing Home v. BlueCross and BlueShield Association, August 3, 2000, (2000-D59)
[8] See Intermediary Exhibit I-5, p. 2.
[9] See Intermediary Exhibit I-6.

Intermediary contends that the fact that Florida has "dodged" the obligation to pay deductibles and coinsurance for services furnished by the Providers 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 Providers have 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 asserted at the hearing that State liability was an absolute bar to Medicare recovery of a bad debt, relying on PRM-I §322. There is no provision to that effect in the statute or regulation. 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 reimbursement for bad debts, which is premised on the inability to collect, despite reasonable collection effort, from a payor with a legal obligation for the debt.

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 Providers. CMS' interpretation that such State action was proper is evidenced by the fact that CMS approved the State plan. Even after the error was discovered and the State notified, CMS nevertheless acquiesced to the State's changing the payment obligation only prospectively. If resolution in the future retroactively clarifies the State obligation and implements a process by which the Providers 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 Providers have met the requirements of 42 C.F.R. §413.89 and PRM-I §308. The Intermediary alleges that a reasonable collection effort was not made because Joint Signature Memorandum-370 makes the act of billing and the receipt of a remittance advice the exclusive evidence acceptable to prove a reasonable collection effort. 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 discussed 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 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 not 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.[10]

Second, JSM-06345, 03-24-06[11] 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. The subsequent JSM modification shows CMS' recognition that the JSM-370 "must bill" requirements may not be reasonable in some circumstances.

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, . . ."[12] The Parties have stipulated that consistent with Florida law in 1998, Florida's Medicaid State plan was amended to eliminate any coverage responsibility for QMBs coinsurance and deductibles for the type of services furnished by the appealing Providers and similarly situated CMHCs. The Board finds it would be unreasonable to place the Provider in jeopardy of a criminal action by requiring it 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 Providers. 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 reluctantly conceded that the Providers took all reasonably necessary steps to obtain a remittance advice.[13] The Providers are the only stakeholders not at fault in this situation.

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[10] See Royal Coast Rehabilitation Center v. BlueCross and BlueShield Association, January 29, 2010, (2010-D13), p. 10. The Board searched the CMS intranet for a definition of a JSM and weight to be given this document. See http//cmsnet.cms.hhs.gov/hpages/cmm/dcm/aboutjsm.htm

[11] See Royal Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, Janaury 29, 2010 (2010-D13), p. 7. Royal Coast obtained JSM-06345 through a Freedom of Information (FOIA request).

[12] See Royal Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, Janaury 29, 2010 (2010-D13, p. 11.

[13] See Tr. at 80-81.

Fifth, the Board finds the Intermediary's reliance on Monterey Peninsula to be misplaced because the court did not deal with circumstances existing here that make billing impossible. Monterrey Peninsula involved a Medicaid state plan that applied a payment ceiling which limited the amount of payment or resulted in no payment for coinsurance and deductibles. Because payments were small, the provider sought to use its own calculations showing the payment that would have been received from the State. It argued that the amounts it could potentially receive were so small they did not justify the expense of billing. The Court noted that while the existence of a ceiling might make the payment amount predictable, in many cases it would be unclear whether the State would pay and, if so, how much. The Court found the Secretary was authorized to determine what supporting documentation will be required so long as it is not inconsistent with the statue and regulation, and is a reasonable implementation thereof. Under the circumstances presented in that case, the Court found that billing the State was the most straightforward and reliable way of determining whether and, if so, how much the State would pay. Therefore, it could not say the must-bill policy was inconsistent with the statute or regulations nor was it an unreasonable implementation of them. There is nothing in Monterrey Peninsula to indicate the Court considered billing impossibility or, if those circumstances had been presented, the must-bill requirement would have been found to be a reasonable implementation of the regulation and manual provisions.

Based on the above, the Board finds that the Providers have 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 adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: May 18, 2010

Appendix I

Case No.	Provider No.	Provider	Cost Reporting Period Ended
08-1848	10-1406	Hope Horizon Center, Inc.	November 30, 2006
09-1547	10-1406	Hope Horizon Center, Inc.	November 30, 2007
10-0106	10-1406	Hope Horizon Center, Inc.	November 30, 2008
06-1773	10-1416	Homestead Behavioral Clinic, Inc.	December 31, 2004
07-2384	10-1416	Homestead Behavioral Clinic, Inc.	December 31, 2005
08-2266	10-1416	Homestead Behavioral Clinic, Inc.	December 31, 2006
09-1565	10-1416	Homestead Behavioral Clinic, Inc.	December 31, 2007