PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D3

PROVIDER –
Hillcrest Specialty Hospital

Provider No.: 37-2007

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

DATE OF HEARING –
November 3, 2015

Cost Reporting Periods Ended -
August 31, 2007 and August 31, 2008

CASE NOs.: 09-0890 and 10-1102

INDEX

ISSUE STATEMENT:

Whether the Centers for Medicare and Medicaid ("CMS") must-bill policy applies to the Provider's crossover bad debts where the Provider did not participate in the Medicaid Program.

DECISION

After considering the law and program instructions, the evidence presented, and the parties' contentions, the Provider Reimbursement Review Board ("Board") affirms the Medicare Contractors' dual eligible bad debt adjustments when the provider chose not to enroll in the state Medicaid program (Kansas). The Board reverses the Medicare Contractors' dual eligible bad debt adjustments related to bad debt claims where the corresponding state's Medicaid program (Oklahoma) would not enroll a Long Term Care Hospital (LTCH) and remands those claims to the Medicare Contractor to determine the appropriate amount of bad debt reimbursement.

INTRODUCTION

Hillcrest Specialty Hospital ("Hillcrest" or "Provider") is a Medicare-certified LTCH located in Oklahoma which did not participate in the Oklahoma Medicaid program nor were they enrolled in the Kansas Medicaid program. The appeal periods at issue are 08/31/2007 and 08/31/2008. The Medicare contractor assigned to Hillcrest at the time of audit was Wisconsin Physicians Service ("Medicare Contractor").[1]

The Medicare Contractor disallowed the Provider's bad debts for FYs 2007 and 2008 for individuals who were eligible for both Medicare and Medicaid (referred to as "dual eligibles") based on the Centers for Medicare & Medicaid Services' ("CMS'") "must bill" policy. This policy requires providers to bill the relevant state Medicaid program for Medicare deductibles and copayments and receive a remittance advice ('RA") denying payment (in whole or in part) before the uncollectable amount can be reimbursed as a Medicare bad debt.[2]

The Provider filed the appeals timely with the Board and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1840 for a hearing before the Board.[3] A live hearing was held by the Board. The Provider was represented at the hearing by Jason M. Healy, Esq. of The Law Offices of Jason M. Healy PLLC. The Medicare Contractor was represented by Wilson C. Leong, Esq. of Federal Specialized Services.

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[1] The Medicare Contractor has since transitioned to Novitas Solutions, Inc.
[2] Provider's Final Position Paper at 6-7.
[3] The Provider's appeals for FY's 2007 and 2008 previously resided in group appeal # 10-1101GC. The group appeal contained only the one Provider for two FYE's, violating the Group Appeal regulation. Therefore, the Board reinstated the current individual appeals for Hillcrest Case # 09-0890 and #10-1102 by transferring the Bad Debt issue for each FY back to their respective individual appeals. The Board then closed Case # 10-1101GC as there were no remaining participants.

STATEMENT OF THE FACTS

A. MEDICARE'S BAD DEBT POLICY

Federal regulations at 42 C.F.R. § 413.89(e)(2009) specify the criteria that must be met for a provider to claim bad debt reimbursement on its Medicare cost report. Specifically, § 413.89(e) states:

> (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.[4]

CMS has provided extensive guidance on its bad debt policy in the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), §§ 308, 310, 312 and 322. PRM 15-1 § 308 requires that the provider make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible. PRM 15-1 § 310 states that a "reasonable collection effort" involves sending a bill on or shortly after discharge or death. However, this section by its own terms is not applicable to indigent patients and specifically refers to § 312 which allows providers to "deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined to be eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively." While this language absolves the providers from taking further steps to prove the dual eligible patient indigent, subsection C of § 312 nonetheless requires providers to "determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian."

Finally, PRM-I § 322 states that a provider may not claim Medicare bad debt reimbursement for that portion of the deductible and copayment amounts that "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" but may claim the "portion of deductible or coinsurance amounts that the State is not obligated to pay" provided that the requirements of § 312 or, if applicable § 310 are met.

On August 10, 2004, CMS issued the Joint Signature Memorandum ("JSM") JSM-370 to Medicare contractors to clarify and explain its "must bill" policy that the provider must bill and obtain an RA from the relevant state Medicaid program whenever a bad debt involves a dual eligible regardless of whether that program may owe nothing or only a portion of the dual eligible's Medicare deductible or co-payment.[5] The Ninth Circuit, in *Community Hosp. of the*

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[4] Provider Exhibit P-20.

[5] JSM-370 may be found at Provider Exhibit P-25. Specifically, JSM 370 states:

> 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

Monterey Peninsula v. Thompson ("*Monterey*"),[6] found CMS' must-bill policy to be a reasonable implementation of the bad debt reimbursement system and not inconsistent with the statute and regulations governing fiscal years 1989 through 1995.[7] In a subsequent case, *Cove Associates Joint Venture v. Sebelius*, the District of Columbia District Court again upheld the agency's must bill policy but noted that a provider that was unable to bill the state Medicaid program because it could not be enrolled as a Medicaid provider was in a "Catch-22" and remanded the case back to the agency to determine whether the providers were justified in relying on CMS' prior failure to enforce the must-bill policy with respect to dual-eligible reimbursement claims from non-participating Medicaid providers.[8]

B. MEDICARE BAD DEBTS ASSOCIATED WITH STATE COST SHARING OBLIGATIONS FOR DUAL ELIGIBLES

State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost-sharing (Medicare deductibles and copayments) on behalf of poor and low-income Medicare-eligible individuals. While a state may limit payment of cost sharing amounts for most dual eligible patients,[9] a state may be obligated to pay full cost sharing amounts for patients who qualify for Medicaid as Qualified Medicare Beneficiaries ("QMBs").[10] In general, to receive Medicaid reimbursement, a provider must enroll as a Medicaid provider. Some state Medicaid agencies do not allow enrollment of certain providers (*e.g.*, CMCHs, long term care hospitals, inpatient rehabilitation facilities) and, in those situations, the providers are unable to bill the state Medicaid program for Medicare cost sharing amounts.

Hillcrest is located in the State of Oklahoma, but is located within a few hours' drive from three different states—Kansas, Missouri and Arkansas.[11] Because there are only about 400 LTCH's nationwide, it is not unusual for patients to travel across state lines to receive services from an LTCH or to be admitted to the LTCH when visiting the state. At the hearing, the Board

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> 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 debts from Medicare. . . . 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).
> (citation omitted.)

[6] 323 F.3d 782, 785 (9th Cir. 2003).

[7] However, with respect to the time under review, the Court declined to apply § 1102.3L which was added to PRM 15-2 in 1995 to allow for certain documentation as an alternative to RAs. In CMS Memorandum, JSM-370, CMS withdrew § 1102.3L and reverted back to the pre-1995 language which required providers to bill state Medicaid programs before claiming Medicare bad debt..

[8] *848 F.Supp.2d 13, 30 (D.D.C.* 2012).

[9] 42 U.S.C. § 1396a(n)(2) allows states to limit the cost-sharing amount to the Medicaid rate and "essentially pay nothing toward the dual eligibles' cost sharing if the Medicaid rate is lower than what Medicare would pay for the service."

[10] However, 42 U.S.C. §1396d(p)(3), at least for a time, required state Medicaid programs to pay cost-sharing amounts for QMBs.

[11] See Exhibit P-46 (map showing the Provider's location relative to these three neighboring states, pursuant to the Board's request (see Transcript ("*Tr.*") at 149).

requested that the Provider identify any dual-eligible out-of-state patient who was discharged during the years in question. Hillcrest identified one out-of-state dual eligible patient who was discharged during the FYE 8/31/2008 cost reporting period with Kansas Medicaid coverage.[12] Hillcrest was not a participating provider in the Kansas Medicaid program and did not bill the Kansas Medicaid program for its dual eligible crossover claim and did not receive RAs for this patient.[13]

In its home state, Hillcrest was unable to enroll in the Oklahoma Medicaid program because Oklahoma did not cover LTCH services in any setting other than a licensed children's hospital.[14] As a result, Hillcrest could not bill Oklahoma Medicaid for its dual eligible crossover claims and, therefore, did not receive RAs from Oklahoma Medicaid. Hillcrest claimed these unpaid deductible and co-insurance amounts on its FYs 2007 and 2008 cost reports as "bad debts." The Medicare Contractor disallowed these dual eligible bad debts based on the CMS' "must bill" policy.

Previously the Medicare Contractor allowed Hillcrest to claim, and be paid for, dual eligible bad debts without billing the Oklahoma or Kansas Medicaid programs as long as other documentary evidence could be provided.[15] The Medicare Contractor exempted the Provider from the must-bill policy allowing the Provider to claim dual eligible bad debts by showing proof of the beneficiaries' Medicaid eligibility. Hillcrest believes that it was disadvantaged by the Medicare Contractor's reversal of the must-bill exemption and, for the first time, having the Medicare Contractor apply the must-bill policy denying bad debt claims without supporting RAs.[16]

DISCUSSION, FINDINGS OF FACT, CONCLUSIONS OF LAW:

STATES IN WHICH HILLCREST COULD NOT BE CERTIFIED AS A MEDICAID PROVIDER - OKLAHOMA

The Medicare Contractor maintains the Hillcrest's collection efforts do not meet the reasonable collection effort criteria for allowable bad debts stated in PRM-I §§ 308, 310 and 312(C); and 42 C.F.R. § 413.89.[17] The Medicare Contractor argues that Hillcrest did not properly bill Oklahoma Medicaid and did not obtain a state RA prior to claiming the bad debt reimbursement from Medicare.[18] The Medicare Contractor argues that the Oklahoma state agency's refusal to issue Hillcrest a Medicaid billing number does not relieve Hillcrest of the obligation to submit claims to Oklahoma Medicaid in order to claim bad debt reimbursement.[19] The Medicare Contractor asserts that, unless Hillcrest files the related claims, Oklahoma Medicaid has no basis

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[12] See Exhibits P-48. This patient was identified internally by patient number on the next to last line of the listing at Exhibit P-47. The internal insurance code in the second column refers to Kansas Medicaid. See Hillcrest Medical Center insurance plan codes at Exhibit P-48, at 5.
[13] Provider's Post-Hearing Brief at 3; *Tr.* at 16.
[14] See Oklahoma Admin Code 317:30-3-25 and 317:30-5-62 at Provider Exhibits P-7 and P-8 and *Tr*. at 17.
[15] See Exhibit P-35 through P-37.
[16] Provider's Final Position Paper at 6; Provider's Post-Hearing Brief at 10.
[17] Medicare Contractor's Final Position Paper at 6-7.
[18] *Id*. at 7.
[19] *Id* at 9-10.

to determine its payment obligation under the state's approved plan and Hillcrest has not met its obligation to determine third party liability.[20]

The Board's review of the record shows that Oklahoma did not allow Hillcrest to enroll in the Medicaid program for the time period at issue.[21] The Medicare Contractor's "no-exception" application of the must-bill policy is unfounded. Based on its review of similar cases, the Board is aware that Hillcrest's inability to obtain RAs is similar to the two exceptions to the "must bill" policy that the Secretary recognized in a brief that he filed in *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–0142 (N.D. Cal. Oct. 11, 2001). Specifically, the following excerpts from that brief describes "two unique instances where ***the Secretary*** permits providers to claim Medicare crossover bad debt without billing the State Medicaid agency"[22]

1. Community mental health centers ("CMHCs").—CMHCs "are allowed to claim Medicare crossover bad debts without billing the State agency because CMHCs cannot bill the State agency given that they are not licensed by the State and, therefore, have no Medi-Cal provider numbers."[23]

2. Institutions for mental diseases ("IMDs").—IMDs "are permitted to claim Medicare crossover bad debts without billing the State agency where the services are provided to patients aged 22-64. This is because the Medicaid statute and regulations categorically preclude payment for services provided to patient aged 22-64 in IMDs, and the state accordingly has absolutely no responsibility for the coinsurance/deductibles associated with those particular services."[24]

Consistent with the Secretary-recognized exceptions to the "must bill" policy, Hillcrest could not bill Oklahoma Medicaid as the state did not cover LTCH services except those rendered to children at a children's hospital.[25] Therefore, the Board concludes that Hillcrest's inability to obtain RAs from the Oklahoma Medicaid Program qualifies as an exception to the "must bill" policy.

In further support of this conclusion, the Board notes that Hillcrest clearly was caught in the same "Catch-22" described by the D.C. District Court in *Cove.*[26] Like the LTCHs in *Cove*, Hillcrest was unable to enroll in the local Medicaid program and, accordingly, could not bill the program and obtain Medicaid RAs in compliance with Medicare's "must bill" policy. As the *Cove* Court stated, in these situations providers "are left in the untenable position of either refusing to treat dual-eligible patients or absorbing the bad debts associated with those

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[20] *Id*.
[21] Provider Exhibits P-7 and P-8.
[22] Defendant's Memorandum in Reply to Plaintiffs' Opposition to Defendant's Motion for Summary Judgment at 9n.5, *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–0142, 2001 WL 1256890 (N.D. Cal. Oct. 11, 2001) (emphasis added). An example of prior Board decisions referencing these exceptions is *LifeCare Hosps v. Novitas Solutions, Inc.*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016), 2016 WL 6299489 at 4.
[23] *Id.* (citations omitted).
[24] *Id.* (citations omitted).
[25] *Tr.* at 17.
[26] *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).

patients."[27]

The Board recognizes that the Administrator has disagreed with the Board on this issue in two similar bad debt reimbursement cases. In both *Life Care Hospitals v. Novitas Solutions Inc.*, PRRB Decision No. 2016-D25 and *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups v. Novitas Solutions Inc.*, PRRB Decision No. 2016-D22,[28] the CMS Administrator specifically rejected the Board's determination that the excerpt from the *Monterey* brief created an "exception" from billing a state Medicaid program and obtaining an RA for providers that could not be certified as Medicaid providers. Rather, the Administrator took the position that the reference in the *Monterey* brief was to a very limited settlement agreement and "settlements are not admissible as evidence and would not be properly considered in the case."[29] Further the Administrator noted that, if such an exception existed, it should only be applied to non-Medicaid CMHCs located in California and not to non-Medicaid long term care hospital providers in Pennsylvania and North Carolina.[30]

The Board respectfully disagrees with the Administrator's characterization of the language from the *Monterey* brief and believes that this excerpt reflects the Secretary's policy because the Secretary made this statement in the brief without qualification and, in particular, neither cited to nor referenced any settlement agreement in that statement.

Likewise, the Administrator rejected the Board's position related to the "Catch 22" situation in which a provider finds itself when the state will not enroll that provider type. The Administrator in his decision stated:

> In instances where the State does not process a dual eligible claim, a Provider's remedy must be sought with the state. If a state does not have the ability to process a dual eligible beneficiary claims, for all types of Medicare providers, then the State is out of compliance with Federal statute and the state must be forced to comply. Where States are made aware of their duty and still refuse to enroll Providers for the purpose of billing and receiving remittance advices, or otherwise refuse to process non-enrolled providers' claims, then the appropriate course would be for the Providers to take legal action with their states."[31]

However, the Board is not convinced that requiring an individual provider to take legal action against its State is a viable means for the provider to obtain Medicare bad debt reimbursement. Rather, the Board highlights the concession of the agency's counsel in *Cove*, stating that "it is in

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[27] *Id.*

[28] *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups. v. Novitas Solutions, Inc*., CMS Adm'r Dec. at 17 (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D22 (Sept. 27, 2016). *See also LifeCare Hosps. v. Novitas Solutions, Inc.*, CMS Adm'r Dec. (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016).

[29] *LifeCare Hosps. v. Novitas Solutions, Inc.*, CMS Adm'r Dec. at 19 (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016), 2016 WL 7744986 at 15.

[30] *Id.* at 19-20.

[31] *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups. v. Novitas Solutions, Inc*., CMS Adm'r Dec. at 17 (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D22 (Sept. 27, 2016). *See also LifeCare Hosps. v. Novitas Solutions, Inc.*, CMS Adm'r Dec. (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016).

a better position than the providers to ensure that the states comply with the applicable regulations of the Medicaid program."[32] The *Cove* Court was "not willing to place a stamp of judicial approval on a policy that would put non-participating providers in the position of not being paid due to the delinquency of federally-funded state programs."[33]

Finally, the Administrator in his recent decisions also rejected any determination that the Medicare contractors' past practice of allowing bad debt claims for non-Medicaid providers "constitutes an explicit or affirmative agency action on policy" stating that such an allowance could happen only because of the constraints on the Medicare contractors to timely and correctly audit undocumented claims.[34] In this case, however, the exhibits[35] demonstrate the Medicare Contractor in these cases exempted the Provider from the must-bill policy until December 2008. Prior to December 2008, the Medicare Contractor allowed the Provider to claim dual eligible bad debts by showing proof of the beneficiaries' Medicaid eligibility.[36] Hillcrest had no reason to believe CMS or the Medicare Contractor would change its longstanding practice of exempting such providers from the must-bill policy. The Board finds that the Provider justifiably relied on the prior audit treatment that allowed these bad debts without billing the state.

Given the unique circumstances of this case, the Board finds that an exception to the "must bill" policy should be applied to Hillcrest for claims that could not be billed to Oklahoma Medicaid. Further, regardless of the application of the exception in this case, the Board concludes that Hillcrest's bad debts were uncollectible when claimed as worthless and that sound business judgment established that there was no likelihood of recovery at any time in the future. Hillcrest's Oklahoma bad debt claims have met the requirements of the regulation, 42 C.F.R. § 413.89(e).

STATES IN WHICH HILLCREST COULD BE CERTIFIED AS MEDICAID PROVIDERS BUT DID NOT ENROLL

Regarding the Kansas Medicaid patient, Hillcrest admits that it was not a participating provider in Kansas Medicaid[37] but argues that this is irrelevant because there is no legal requirement that a hospital enroll in Medicaid as a condition to obtain Medicare reimbursement for bad debt.[38] Hillcrest argues that, consistent with its handling of the Oklahoma Medicaid patients, the Medicare Contractor' prior audit treatment did not require providers to bill the out-of-state Medicaid program and receive a RA before they can be reimbursed for Medicare bad debts.

Hillcrest contends that it has met the requirements of 42 C.F.R. § 413.89(e) without billing Medicaid because all the patient accounts in question are for Medicaid eligible patients, who

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[32] *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).
[33] *Id.*
[34] *Select Specialty* Administrator's Decision at 18.
[35] Provider Exhibits 35-37.
[36] Provider's Post hearing brief at 46-47.
[37] Provider's Post hearing brief at 26.
[38] *Tr.* at 50; Provider's Final Position Paper at 10; Provider's Post-Hearing Brief at 14-15; 42 C.F.R. § 413.89 may be found at Provider's Exhibit P-20.

should have been deemed indigent under PRM 15-1 § 312. Once indigency has been determined, the facility can write off the bad debts without going through the normal collection process.[39]

The Provider argues that CMS has only recently recognized a regulatory conflict between the requirement imposed on the provider to bill a state Medicaid agency and the agency's refusal to issue RAs for non-participating Medicaid providers in a June 7, 2013 Informational Bulletin. This Bulletin, however, was issued years after the issuance of the NPRs in this appeal.[40]

The Provider acknowledges that CMS' must-bill policy was upheld by the Ninth Circuit in *Monterey* in the context of providers which participate in and are thus able to bill their state Medicaid programs for dual eligible patients' cost sharing amounts.[41] The Provider contends that *Monterey* is readily distinguishable from the facts in these cases.[42] In *Monterey*, the Provider believes the Court was persuaded by the fact that there was no evidence the Secretary had ever reimbursed crossover bad debt without a Medicaid RA. In these cases, the opposite is true--as Hillcrest was reimbursed for dual eligible bad debts without Medicaid RAs in prior periods until 2008.

While the Board understands the Provider's position on this issue, nonetheless, PRM 15-1 § 310 clearly established that providers have an obligation to bill "the responsible party"—and if a state Medicaid program can be billed on behalf of its enrollees, it should be. The Board recognizes that this decision differs from the Board's findings and conclusions in its 2010 decision in *Select Specialty '05 Medicare Dual Eligible Bad Debt Grp. v. Blue Cross Blue Shield Ass'n* ("*Select*").[43] However, the Board now has the benefit of considering several federal court decisions on this matter as well as the Administrator's decision upon remand of the *Select* case from the U.S. District Court for the District of Columbia.[44]

As previously discussed, PRM 15-1 § 322 confirms that, if the Medicaid state plan provides payment of Medicare coinsurance and deductibles (in whole or in part), then the amount of payment cannot be allowable as Medicare bad debt. This is a blanket requirement not predicated on whether the provider does or does not participate in the relevant state Medicaid program.[45] Further, the requirement of § 310 confirming that, *at a minimum*, the provider must "bill . . . the party responsible" is applicable to crossover claims (*i.e.*, claims involving dual eligibles).

Based on these PRM provisions, the Board disagrees with the Provider's assertions that, as a *non*-participating provider, it would not have to bill the State Medicaid program. In this regard,

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[39] *Tr*. at 63-64.
[40] Provider's Final Position Paper at 39-41; *Tr*. at 37; Provider's Post-Hearing Brief at 52-56; Provider's Exhibit P-32.
[41] *Tr*. at 32-33; Provider's Final Position Paper at 30-32; Provider's Post-Hearing Brief at 40-44.
[42] Providers' Final Position Paper at 30-31; Providers' Post-Hearing Brief at 39-44.
[43] PRRB Dec. No. 2010-D25 (Apr. 13, 2010), *rev'd,* CMS Adm'r Dec. (Mar. 2016).
[44] *Select Specialty '05 Medicare Dual Eligible Bad Debt Grp. v. Blue Cross Blue Shield Ass'n*, CMS Adm'r Dec. (Mar. 14, 2016), *on remand from*, *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp 2d. 13 (D.D.C. 2012).
[45] *See also Cove Assoc. Jt. Venture v Sebelius,* 848 F. Supp. 2d 13, 25 (D.D.C. 2012).

Hillcrest does not claim that the Kansas Medicaid program would not allow Hillcrest to become a Medicaid participating provider if it chose to apply—unlike the Oklahoma Medicaid program discussed above. Rather, it appears that Hillcrest made a discretionary business decision not to enroll in the Kansas Medicaid program even though such a choice precludes it from being able to bill the program and obtaining the required RAs to document the state's cost sharing liability.[46] As a result, any equity or fairness argument that the provider may have does not apply here. For this reason, the Board concludes the Medicare Contractor correctly denied bad debt reimbursement for the Kansas Medicaid bad debt.

DECISION AND ORDER:

After considering the law and program instructions, the evidence presented, and the parties' contentions, the Board affirms the Medicare Contractors' dual eligible bad debt adjustments when the provider chose not to enroll in the state Medicaid program (Kansas). The Board reverses the Medicare Contractors' dual eligible bad debt adjustments related to bad debt claims where the corresponding state's Medicaid program (Oklahoma) would not enroll a LTCH and remands those claims back to the Medicare Contractor to determine the appropriate amount of bad debt reimbursement.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Charlotte F. Benson CPA
Gregory Ziegler, CPA, CPC-A

FOR THE BOARD:

/s/
L. Sue Andersen
Chairperson

DATE: November 6, 2017

[46] In this regard, the Board notes that its review of the Texas Medicaid program in another case suggests that LTCHs could participate and enroll in the Texas Medicaid Program. *See LifeCare Hosps. V. Novitas Solutions, Inc.*, PRRB Dec. No. 2016D-25 (covering FYs 2005 to 2012).