PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2018-D10

PROVIDER –
Progressive Health Center, Inc.

Provider No.: 19-4653

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

HEARING DATE –
February 6, 2014

Cost Reporting Period Ended -
December 31, 2006

CASE NO.: 09-0233

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ISSUE STATEMENT:

Was the Medicare Contractor's[1] adjustment to the Provider's bad debts claimed proper?[2]

DECISION

After consideration of Medicare law and guidelines, the parties' contentions, and the evidence in the record, the Provider Reimbursement Review Board ("Board"):

1) reverses the Medicare Contractor's decision to remove dual eligible bad debts from Alabama, Florida, Kentucky, Mississippi, Missouri, North Carolina, and Illinois where Progressive documented the states' Medicaid program would not enroll Community Mental Health Centers ("CMHCs");
2) affirms the Medicare Contractor's dual eligible bad debt adjustment for Louisiana where the state retroactively enrolled and allowed retroactive billing of CMHC claims and Progressive did not submit remittance advises ("RAs") to support its bad debts; and
3) affirms the Medicare Contractor's dual eligible bad debt adjustment for all other states because Progressive either chose not to enroll in the state's Medicaid program or failed to document the state's refusal to enroll CMHCs.

The Board remands this case back to the Medicare Contractor to determine the appropriate amount of bad debt reimbursement.

INTRODUCTION

Progressive Health Center, Inc. ("Progressive" or "Provider") is a CMHC located in Zachary, Louisiana which did not participate in the Medicaid program. The Provider claimed bad debts on its cost report for Medicare beneficiaries who were also eligible for Medicaid benefits under various state Medicaid programs (*i.e.*, dual eligible beneficiaries).

The Medicare Contractor disallowed the Provider's bad debts for FY 2006 for dual-eligible beneficiaries based on the Centers for Medicare and Medicaid Services' ("CMS'") "must bill" policy. This policy requires providers to bill the respective state Medicaid programs for Medicare coinsurance and deductibles and receive a RA denying payment (in whole or in part) before the uncollectable amount can be reimbursed as a Medicare bad debt.[3]

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[1] During FY 2006, the Provider's Medicare Administrative Contractor was TriSpan Health Services, Inc. Currently, the Provider's Medicare Administrative Contractor is Novitas Solutions, Inc. Collectively, they will be referred to as the "Medicare Contractor."

[2] Provider's Final Position Paper at 5.

[3] On August 10, 2004, CMS issued the Joint Signature Memorandum ("JSM"), JSM-370, to Medicare contractors to clarify and explain CMS' "must bill" policy. 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 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.

The Provider filed a timely appeal disputing the disallowance of the dual-eligible bad debts and met the jurisdictional requirements of 42 C.F.R §§405.1835-1840. The Board approved the parties' request for a hearing on the record. Christopher C. Johnston, Esq., from Gachassin Law Firm represented Progressive. Robin Sanders, Esq., of the Blue Cross and Blue Shield Association represented the Medicare Contractor.[4]

STATEMENT OF THE FACTS

A. MEDICARE'S BAD DEBT POLICY

Medicare regulations governing bad debts are located at 42 C.F.R. § 413.89 (2004).[5] Subsection (a) establishes the general rule that bad debts are deductions from revenue and are not to be included in allowable costs. However, in order to ensure that Medicare-covered costs are not shifted to individuals who are not covered by the Medicare program, subsection (d) specifies that bad debts attributable to Medicare deductibles and coinsurance are reimbursable as allowable costs. Bad debts must meet the following criteria specified in subsection (e) to be considered 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 any time in the future.

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."

> . . . 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). (citations omitted.)

[4] BlueCross BlueShield Association has subsequently been replaced by Federal Specialized Services as the Medicare Contractor's representative.

[5] Redesignated from 42 C.F.R. § 413.80 pursuant to 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

Finally, PRM-I § 322 states that a provider may not claim Medicare bad debt 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 include 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 means that the provider must bill and obtain an RA from the relevant state Medicaid program whenever a bad debt involves a dual eligible whether or not that program owes nothing or only a portion of the dual eligible's Medicare deductible or co-payment.[6] The Ninth Circuit in *Community Hosp. of the Monterey Peninsula v. Thompson* ("*Monterey*")[7] 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.[8] In 2012, the federal district court in the District of Columbia 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 enroll 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.[9]

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 coinsurances) 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,[10] a state may be obligated to pay full cost sharing amounts for patients who qualify for Medicaid as Qualified Medicare Beneficiaries ("QMBs").[11]

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[6] On August 10, 2004, CMS issued the Joint Signature Memorandum ("JSM"), JSM-370, to Medicare contractors to clarify and explain CMS' "must bill" policy. 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 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). (citations omitted.)

[7] 323 F.3d 782, 785 (9th Cir. 2003).

[8] 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..

[9] *Cove Associates Joint Venture v. Sebelius, 848 F.Supp.2d 13, 30 (D.D.C.* 2012).

[10] 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."

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

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.

Progressive was not enrolled in the Medicaid programs for the states in this appeal. Louisiana imposed a moratorium on CMHCs until July 1, 2008 which prohibited CMHCs from billing Louisiana Medicaid.[12] Progressive was unable to bill other state Medicaid programs for its out of state patients as these Medicaid programs either denied its request for Medicaid enrollment, or failed to respond to Progressive's request to enroll as a Medicaid provider.

The sole issue in this case is whether the Medicare Contractor's denial of dual–eligible bad debts is proper based on CMS' "must Bill" policy.

DISCUSSION, FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The Provider contends that it *did* establish the "uncollectible" nature of these bad debts in accordance with 42 C.F.R. § 413.89 and that neither 42 C.F.R. § 413.89 nor PRM 15-1 contain a requirement to bill the State Medicaid program. Progressive argues that CMS' "must bill" policy was issued in August 2004 only to Medicare contractors and providers were never notified of the JSM 370 itself or that this new policy required providers to bill the relevant state Medicaid program and receive a RA.[13] The Provider argues that this "must bill" policy goes beyond existing statutory and regulatory requirements, is arbitrary, and is in violation of the Administrative Procedure Act ("APA"), 5 U.S.C. §706 (2)(A) and 42 U.S.C. § 405.[14]

Further, the Provider maintains that it could not have followed the requirements of JSM 370 in 2008 as the Provider could neither bill the Louisiana Medicaid program,[15] nor any of the relevant out-of-state Medicaid programs.[16] Complying with the must bill policy was impossible and caused the program costs of Medicare beneficiaries to be borne by non-Medicare beneficiaries contrary to the statute.[17]

The Medicare Contractor maintains the Provider'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. The Medicare Contractor argues that Progressive did not properly bill the state Medicaid programs and did not obtain a state RA prior to claiming the bad debt reimbursement from Medicare.[18]

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[12] LA Revised Statute 28:567.
[13] Provider's Final Position Paper at 8-9 and affidavit of Don J. Davezac (August 27, 2013) at 3. *See* Provider's May 11 2016 letter to the Board incorporating the Davezac affidavit prepared for case # 09-0233 into case # 11-0142.
[14] Provider's Final Position Paper at 8.
[15] Affidavit of Don J. Davezac at 4. Also see the moratorium in Louisiana Revised Statute 28:567.
[16] Provider's Final Position Paper at 8.
[17] *Id.*
[18] Medicare Contractor's Final Position Paper at 5-6.

The Medicare Contractor asserts that CMS' "must bill" policy was simply a clarification of the "reasonable collection efforts" contained in 42 C.F.R. § 413.89(e), and to ensure that states share the costs for dual eligible Medicare beneficiaries.[19] The Medicare Contractor states that the "must bill" policy requires providers to document billing efforts and to ensure that no other payment source such as Medicaid, a local welfare agency, or some other state funding source, is legally responsible for the patient's medical bill prior to claiming the bad debt.[20] The Medicare Contractor alleges that numerous courts have upheld the "must-bill" policy, and that the policy's legal basis has been clearly articulated.[21]

STATES IN WHICH PROGRESSIVE COULD NOT ENROLL AS A MEDICAID PROVIDER

The Board finds evidence in the record that Progressive as a CMHC was unable to enroll in the Medicaid program in Alabama, Florida, Kentucky, Mississippi, Missouri, North Carolina, and Illinois.[22] Based on its review of similar cases, the Board is aware that Progressive's inability to obtain RAs is similar to the two exceptions to the "must bill" policy that the Secretary recognized in a brief that she filed in connection with *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–0142 (N.D. Cal. Oct. 11, 2001) ("*Monterey").* 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"[23]

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."[24]

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."[25]

Consistent with the Secretary-recognized exceptions to the "must bill" policy, Progressive could

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[19] *Id*. at 7-8.
[20] *Id*. at 8.
[21] Medicare Contractor's Final Position Paper at 11-15.
[22] *Affidavit of Don J. Davezac* (August 27, 2013) – Exhibit A containing documentation from 7 state Medicaid agencies that they will not enroll Progressive. A letter from Oklahoma Medicaid s also included in this exhibit but the Board finds this letter does not support Progressive's position that Oklahoma would not enroll CMHCs as the letter states Progressive's application was incomplete because it was missing a certification from an accrediting body.
[23] 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), *modified by*, CMS Adm'r Dec. (Nov. 28, 2016).
[24] *Id.* (citations omitted).
[25] *Id.* (citations omitted).

not bill the Medicaid programs in Alabama, Florida, Kentucky, Mississippi, Missouri, North Carolina, and Illinois as these states did enroll CMHCs and Progressive clearly was caught in the same "Catch-22" described by the D.C. District Court in *Cove Assocs. Jt. Venture v. Sebelius* ("*Cove*").[26] Like the long term care hospitals in *Cove*, Progressive was unable to enroll in these Medicaid programs and, accordingly, could not bill the programs 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 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 *Monterrey* 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 *Monterrey* 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 a provider finds itself in when the state will not enroll that provider type. The Administrator's 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

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[26] *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).
[27] *Id.*
[28] Adm'r Dec. dated November 28, 2016 in *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups*, PRRB Dec. No. 2016-D22 and Adm'r Dec. dated November 28, 2016 in *Life Care Hospitals v. Novitas Solutions Inc.*, PRRB Decision No. 2016-D25.
[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).
[30] *Id.* at 19-20.

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 a State is a viable means for the provider to obtain Medicare bad debt reimbursement. Rather, the Board points to *Cove*, where the agency's counsel conceded "it is in 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]

Given the unique circumstances of this case, the Board finds that an exception to the "must bill" policy should be applied to Progressive for claims that could not be billed to the Medicaid Programs in the states of Alabama, Florida, Kentucky, Mississippi, Missouri, North Carolina, and Illinois where, for the year under appeal, these states would not enroll CMHCs.

STATES IN WHICH PROGRESSIVE COULD ENROLL AND BILL AS A MEDICAID PROVIDER

The Board finds that pre-1987 bad debt policy in the PRM clearly established that providers have an obligation to bill "the responsible party." 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*").[34] 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 ("D.C.").[35]

Three federal circuit courts of appeal have reviewed CMS' "must bill" policy. The First Circuit concluded that "some version" of a "must bill" policy has generally been enforced and that a general requirement (as opposed to a *per se* requirement) to obtain a Medicaid RA for crossover claims is entitled to deference where "the Secretary has made exceptions and accepted the alternative documentation *from the State* where circumstances warranted the exception."[36] Similarly, the D.C. Circuit found that it is "sensible for the Secretary to require that the state determine in the first instance the Medicaid eligibility of the claims and the appropriate amount of state payment owed."[37] Finally, the Ninth Circuit deferred to the Secretary's reasonable determination that "the must bill policy is a 'fundamental requirement to demonstrate' . . . that

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[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). √
[32] *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).
[33] *Id.*
[34] PRRB Dec. No. 2010-D25 (Apr. 13, 2010), *rev'd,* CMS Adm'r Dec. (Mar. 2016).
[35] *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).
[36] *Maine Med. Ctr. v. Burwell,* 775 F.3d 470, 475, 480 (1st Cir.2015) (emphasis in original).
[37] *Grossmont Hosp. Corp. V. Burwell,* 797 F.3d 1079, 1085 (D.C. Cir. 2015), *reh'g en banc denied*, (D.C. Cir. Oct. 19, 2015).

reasonable collection efforts [have been] made and that 'the debt was actually uncollectible when claimed [as worthless].'"[38]

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. Significantly, this is a blanket requirement that is not predicated on whether the provider does or does not participate in the relevant state Medicaid program.[39] This excerpt cross-references the requirement of § 310 confirming that, *at a minimum*, the § 310 requirement to "bill . . . the party responsible" is applicable to crossover claims (*i.e.,* claims involving dual eligibles).

The Board's review of the record shows that Louisiana's State Medicaid program began enrolling CMHCs in July 2008. Progressive's enrollment with Louisiana's State Medicaid program was approved July 14, 2008 with a retroactive effective date of January 1, 2005.[40] In addition Louisiana's State Medicaid program allowed CMHCs to submit claims for services provided back to the retroactive effective date.[41] Progressive states in its response to the Board's April 15, 2015 letter "[t]he Provider did submit claims in August 2008 back to the date of Medicaid enrollment… it does not appear that any of the retroactive crossover claims were paid."[42] However, the record does not contain RAs or any other any documentation to support this statement. As Medicare regulations[43]require providers to maintain sufficient documentation to support their costs, the Board concludes that these bad debts were properly disallowed by the Medicare Contractor.

Additionally the Board's review of the record finds no evidence to show that Progressive as a CMHC was barred from enrolling in the Medicaid program in any state other than the 7 states of Alabama, Florida, Kentucky, Mississippi, Missouri, North Carolina, and Illinois.[44] As there is no evidence to indicate that Progressive attempted to enroll or was barred from enrolling in any other states' Medicaid program the Board concludes it was Progressive business decision not to enroll. As a result Progressive cannot demonstrate their compliance with the requirement to determine that "no other source other than the patient would be legally responsible for the patient's medical bill" as is required by Medicare bad debt policy.[45] The Board concludes that the Medicare Contractor's disallowance of Progressive's bad debts was proper for all states other than Alabama, Florida, Kentucky, Mississippi, Missouri, North Carolina, and Illinois.

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[38] *Community Hosp. of Monterey Peninsula v. Thompson,* 323 F.3d 782, 792, 796 (9th Cir. 2003).
[39] *See also Cove Assoc. Jt. Venture v Sebelius,* 848 F. Supp. 2d 13, 25 (D.D.C. 2012).
[40] Provider's Comments in Response to the Letter Dated April 15, 2015 at Exhibit 1.
[41] See Attachment to Board's April 15, 2015 letter to Mr. Johnston and Ms. Sanders at 3.
[42] Provider's May 8, 2015 Comments in Response to Letter Dated April 15, 2015; page 2 at 4 and 5.
[43] 42 C.FR§ CFR 413.20
[44] *Affidavit of Don J. Davezac* (August 27, 2013) at 7 stating that Progressive does not have documentation from 8 other states. Also the Board finds the May 22, 2009 letter from Oklahoma Medicaid attached to this affidavit doesn't support the Provider's position that Oklahoma doesn't enroll CMHCs as it states Progressive's application was returned because it was missing information. Also see Provider's May 8, 2015 Comments in Response to Letter Dated April 15, 2015 at Exhibit 2 for Arkansas' enrollment effective 7/29/2008 and for Tennessee's enrollment effective 6/1/2009. The Board finds no evidence in the record to indicate enrollment in either of these states would have been denied in 2006.
[45] PRM 15-1 Chapter 3 §312.

DECISION

After consideration of Medicare law and guidelines, the parties' contentions, and the evidence in the record, the Board:

1) reverses the Medicare Contractor's decision to remove dual eligible bad debts from Alabama, Florida, Kentucky, Mississippi, Missouri, North Carolina, and Illinois where Progressive documented the states' Medicaid program would not enroll CMHCs. The Board remands these bad debts back to the Medicare Contractor to determine the appropriate amount of bad debt reimbursement;
2) affirms the Medicare Contractor's dual eligible bad debt adjustment for Louisiana where the state retroactively enrolled and allowed retroactive billing of CMHC claims and Progressive did not submit RAs to support its bad debts; and
3) affirms the Medicare Contractor's dual eligible bad debt adjustment for all other states because Progressive either chose not to enroll in the state's Medicaid program or failed to document the state's refusal to enroll CMHCs.

The Board remands this case back to the Medicare Contractor to make the necessary adjustments.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Charlotte F. Benson C.P.A.
Gregory H. Ziegler, C.P.A., C.P.C.-A

FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: December 28, 2017