PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2020-D17

PROVIDER-
Sentara Healthcare Bad Debt CIRP Groups

Provider Nos.: Various

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc.

HEARING DATE –
April 6, 2017

Cost Reporting Period Ended –
2010-2011, 2012, 2013

CASE NOs. 16-0408GC, 16-0409GC, 16-2238GC

INDEX

ISSUE STATEMENT:

Whether the Medicare Administrative Contractor improperly denied Medicare reimbursement for the Providers' Medicare bad debt for indigent patients.[1]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("PRRB" or "Board") majority ("Board Majority") finds that the Medicare Contractor improperly adjusted Sentara's (collectively identified as "Providers" or "Sentara") bad debt claims for indigent patients and remands the fiscal year 2010 – 2013 cases to the Medicare Contractor to reverse the adjustments and conduct a further review[2] of Sentara's indigent bad debt determinations, for accounts less than $10,000, as follows:

1. For those patients, unmarried or married, that Sentara qualified through its Charity by Application procedure (either written or telephonic), the Medicare Contractor will review the available documentation to verify the patient's income; if family income is less than 200% of the Federal Poverty Level, the Medicare Contractor should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims;

2. For those unmarried patients that Sentara qualified through its Charity by Model procedure and, based on its Charity Care Policy, identified as ***not needing*** an asset check completed,[3] the Medicare Contractor will review the available documentation to verify the patient's income. If the sole source of documentation is an Equifax score and report, the Board finds that the Equifax score and report comport with Sentara's written Charity Care Policy regarding income verification for this subset of patients. If the unmarried patient's income is less than 200% of the Federal Poverty Level, the Medicare Contractor should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims;

3. For those unmarried patients that Sentara qualified through its Charity by Model procedure and, based on its Charity Care policy, identified as ***needing*** an asset check completed,[4] the Medicare Contractor will review the available documentation to verify a completed asset check and the patient's income. If the sole source of the documentation is the Equifax score and report, the Board finds that the Equifax score and report comport with Sentara's written Charity Care Policy regarding asset check and income verification for this subset of patients. If the unmarried patient's income is less than 200% of the Federal Poverty Level and there are insufficient assets available to pay the Sentara debt,

[1] Transcript of Proceedings ("Tr.") at 6-7.
[2] The Medicare Contractor should conduct its further review under its normal audit methodology, whether that be a sampling or a case-by-case review.
[3] Exhibits P-2 ¶ 3 and P-22 ¶ 3.
[4] *Id.*

the Medicare Contractor should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims;

4. For those married patients that Sentara qualified through its Charity by Model procedure, the Medicare Contractor will review the available documentation[5] to verify the family's income; if the married patient's family income is less than 200% of the Federal Poverty Level, the Medicare Contractor should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims. However, for those married patients that Sentara qualified through its Charity by Model procedure, and the *sole source* of the documentation is the Equifax score and report, the Board finds that the Equifax score and report do ***not*** comport with Sentara's written Charity Care Policy regarding income verification for this subset of patients; and, the Board finds that, for these claims, the Medicare Contractor's denial of bad debt reimbursement was proper;

5. For those patients Sentara qualified as eligible for Charity Care due to "extraordinary circumstances,"[6] the Medicare Contractor will verify the documentation supporting the "extraordinary circumstances" and ensure that Charity Care approval was made by the Vice President - Revenue Cycle, Director - Patient Accounts, Manager - Patient Accounts, or Chief Collection Counsel, in accordance with Sentara's written Charity Care Policy. If the Medicare Contractor verifies the appropriate management employee approved the Charity Care determination based on an internal determination of extraordinary circumstances, the Medicare Contractor should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims.

INTRODUCTION:

The providers in these group appeals consist of Medicare-certified acute care hospitals located in the Commonwealth of Virginia, each of which are under the common ownership or control of Sentara.[7] National Government Services (hereinafter "Medicare Contractor"[8]) denied Medicare reimbursement for all of the Providers' Medicare indigent patient bad debts, regardless of the methodology utilized by Sentara for making the indigency determination.[9] The Medicare Contractor contends that its disallowance was proper because the Providers failed to "follow[]

[5] A non-exhaustive list of non-Equifax documentation, other than a Charity Care application, includes admission forms, Financial Information Sheet, Medicaid Eligibility, documentation that the patient qualifies as a Specified Low-Income Medicare Beneficiary ("SLMB") (where individuals qualify as SLMBs if their individual or family income is 100-120% of the federal poverty level), qualifies for federal housing assistance, etc.
[6] Exhibits P-2 at 3 and P-22 at 3.
[7] Providers' Consolidated Final Position Paper at 2.
[8] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[9] *See* Medicare Contractor's Final Position Paper at 4 (PRRB Case No. 16-0408GC). The Medicare Contractor filed separate, virtually identical Final Position Papers all three cases and, unless otherwise noted, citations are to the Final Position Paper submitted for PRRB case number 16-0408GC. *See also* Medicare Contractor's Post Hearing Brief at 16.

the prescribed criteria for verifying indigency in accordance with CMS regulations and to document that verification accordingly."[10] More specifically, the Medicare Contractor states that it disallowed the bad debts at issue "due to the Providers' lack of due diligence in establishing [patient indigence] by not performing an asset analysis as instructed by PRM 15-1, § 312."[11] Sentara argues that "[h]ospitals are free to develop their own customary methods for determining and documenting a beneficiary's indigence[,]"[12] and that the plain language of the controlling rules allow Medicare bad debt reimbursement with respect to Medicare patients who are determined to be indigent under the hospital's customary methods. In addition, Sentara claims that the credit reports and scores that it uses in its indigency determinations "provide a reliable and accurate means of assessing income, assets, expenses and liabilities . . . ."[13]

Sentara timely filed PRRB appeals of the final determinations for the various fiscal years at issue and the appeals meet the jurisdictional requirements for a Board hearing. The Board held a live hearing on April 6, 2017.[14] Sentara was represented by Christopher L. Keough Esq., Suzanne Cochran Esq., and Jack Burns, Esq., of Akin Gump Strauss Hauer & Feld LLP. The Medicare Contractor was represented by Edward Y. Lau, Esq., of Federal Specialized Services.

STATEMENT OF THE FACTS AND RELEVANT LAW:

The regulation governing bad debt is located at 42 C.F.R. § 413.89.[15] Under 42 C.F.R. § 413.89(a), Bad debts attributable to the patients' Medicare deductibles and coinsurance amounts are reimbursable under the Medicare program. The regulatory text at 42 C.F.R. § 413.89(d) explains that the failure of Medicare beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of services being borne by individuals other than Medicare beneficiaries. To avoid such situations, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. The regulation at 42 C.F.R. § 413.89(e) establishes Medicare's criteria for an allowable bad debt:

> (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.

[10] Medicare Contractor's Final Position Paper at 5; *see also* Medicare Contractor's Post Hearing Brief at 2.
[11] Medicare Contractor's Final Position Paper at 4; Medicare Contractor's Post Hearing Brief at 2.
[12] Providers' Consolidated Final Position Paper at 2.
[13] *Id.* at 12.
[14] The 2013 Sentara Group, in case number 16-2238GC was not complete prior to the live hearing date. On October 13, 2017 the Providers notified the PRRB that the Group was complete. On November 13, 2017 the parties submitted a signed stipulation requesting that PRRB case number16-2238GC be decided together with, and based on the record for case numbers 16-0408GC and 16-0409GC.
[15] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

The Centers for Medicare & Medicaid Services ("CMS") provides guidance on its bad debt policy in the Provider Reimbursement, Manual ("PRM"), CMS Pub. No. 15-1 ("PRM 15-1"). Pursuant to PRM 15-1 § 310, a provider must undertake a "reasonable collection effort" unless it determines that a patient is indigent. The guidance under PRM § 312 allows a provider or hospital to "deem" a Medicare beneficiary indigent or medically indigent if the individual has been determined eligible for Medicaid as categorically needy or medically needy. Otherwise, the provider should apply its customary methods for determining the indigence of Medicare patients using the following guidelines:

A. The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;

B. The provider should take into account a patient's total resources, which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

C. The provider must 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; and

D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

Lastly, PRM § 312 states that once indigence has been determined and the provider concludes that there have been no improvements in the patient's financial condition, the debt may be deemed uncollectible without applying the reasonable collection efforts procedures under PRM § 310.

Sentara provides financial assistance to certain low income patients who qualify for such help, and uninsured patients regardless of income.[16] As noted within its written Charity Care Policy,[17] Sentara provides full charity care write-off of account balances less than $10,000 for patients whose household income is 200% or less of the Federal Poverty Level,[18] and sliding scale discounts for those uninsured patients whose household income is above 200% of the FPL.[19] The issue in these appeals involves Sentara's indigent patient determinations and Sentara's corresponding write-offs of patients' full account balances, ***not*** its sliding scale discounts.

[16] Exhibit P-23.
[17] Exhibits P-2 and P-22.
[18] Known as "Sentara Charity." *See id.* and Exhibit P-1.
[19] Providers' Consolidated Final Position Paper at 6.

Sentara's written charity care policies, located at Providers' Exhibits P-2 and P-22,[20] describe its procedures for determining the amount of charity care, if any, for qualifying patients with account balances under $10,000.[21] Sentara identifies potential charity care patients through either direct contact with a patient or a review of a patient's Equifax credit report data and scoring.[22] Specifically, Sentara describes three methods for granting charity care: (1) Sentara's Charity-by-Application procedure, in which a prospective charity care patient applies for charity care by either submitting an application or completing an application by phone;[23] (2) Sentara's Charity-by-Model procedure in which prospective charity care patients who have ***not*** completed a written or telephonic application are identified through other means, including Equifax credit reporting and scores;[24] and, (3) Sentara's "extraordinary circumstances" policy in which certain Sentara managers[25] are permitted to document approval of charity care for applications that do not meet all guidelines.[26]

During its audits for the fiscal years at issue, the Medicare Contractor disallowed 100% of Sentara's inpatient and outpatient indigent bad debts due to Sentara's "lack of due diligence" in determining patient indigence.[27] More specifically, the Providers' "indigent bad debts and outpatient indigent bad debts were not allowable due to the Providers' lack of due diligence in establishing an indigency determination by not performing an asset analysis as instructed by PRM 15-1 § 312."[28] The Medicare Contractor asserts that in its reviews, it "must be furnished auditable information in which to ensure the Provider is in fact following the guidelines established in the Medicare regulations."[29] The Contractor argues that Sentara failed to provide such auditable information with respect to its indigent determinations and, as a result, the Contractor disallowed Sentara's indigent Medicare bad debt.[30]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Sentara's Contentions and Arguments

Sentara notes that in § 312 of PRM 15-1, CMS declares that a provider "should apply its customary methods for determining the indigence of patients."[31] Sentara avers that, during the fiscal years at issue, its indigent determinations for both Medicare and non-Medicare patients were completed using Sentara's "customary methods" as documented within its Charity Care

[20] Exhibit P-22 appears to be Sentara's updated Charity Care Policy as of February 2012. As is explained *infra*, although the two policies contain some different language, the Board Majority finds that the policies set out in the two documents are essentially the same and will discuss the policies as one, hereinafter known as the "Charity Care Policy."
[21] Exhibits P-2 at 1 and P-22 at 1.
[22] Providers' Consolidated Final Position Paper at 7.
[23] *Id.* at 10-11. *See also* Exhibits P-2 at ¶ 1 and P-22 at ¶ 1; Tr. at 246-247.
[24] Providers' Consolidated Final Position Paper at 11-12. *See also* Exhibits P-2 at ¶ 3 and P-22 at ¶ 3.
[25] Providers' Consolidated Final Position Paper at 6.
[26] Exhibits P-2 at 3 and P-22 at 3.
[27] Medicare Contractor's Final Position Paper at 4.
[28] *Id.*
[29] *Id.* at 9.
[30] *See id.* at 9-11.
[31] Providers' Consolidated Final Position Paper at 4.

Policy.[32] Under Sentara's Charity Care Policy, patients may be identified as "Prospective Charity" through written applications, telephone applications, telephone screening or "Charity Model" (i.e., Charity-by-Model) qualification.[33] The Charity-by-Model qualification relies heavily, if not exclusively, on Equifax credit scores and reports.[34] Once a patient has been identified as Prospective Charity, a Financial Assistance or Charity Application is sent to the patient.[35] Sentara's Charity Care Policy states that "[a]pplicants who do not provide the requested information necessary to completely and accurately assess their financial situation will not be eligible for Sentara Charity Care . . . ."[36]

If a Prospective Charity patient responds to Sentara's request for information through the application process or telephone screening, Sentara is able to determine qualification for charity care through the information and documentation submitted by the patient (including self-reported information regarding income, assets, liabilities and expenses, and documents such as tax returns, bank statements, Social Security statements , W-2s, etc.).[37] With these Charity-by-Application patients, Equifax scores and reports are used primarily to verify the patient's self-reported information.[38]

Prospective Charity patients identified by Sentara's Charity-by-Model qualification involve patients with Equifax "scores" that fall within certain parameters.[39] Under the Charity-by-Model method, patients may still be approved for charity care even if those patients fail to complete a Financial Assistance or Charity Application, participate in telephone screening or respond to requests for information.[40] Sentara states that "[t]his method uses data available from other sources . . . typically furnished by Equifax. . . ."[41] Sentara "evaluates the financial data obtained through the Equifax report and any additional sources of information available"[42] to verify a patient's indigent status.[43] Sentara states that the Equifax scores and reports that it uses are "designed specifically for medical providers attempting to collect for medical services."[44] Sentara uses three scores from Equifax: the income predictor score, the payment predictor score and the bankruptcy navigator index.[45] Sentara states that "[d]ata for the scoring is drawn from the individuals' current and historical financial and credit transactions maintained in a multitude of databases that Equifax draws upon and is designed to take into account characteristics statistically associated with healthcare patients."[46] As such, Sentara argues that, when making its

[32] *Id.* at 23.
[33] Exhibits P-2 and P-22.
[34] Sentara uses Equifax reports and scores with both its Charity-by-Application determinations and its Charity-by-Model determinations, but the latter relies almost exclusively on those Equifax reports and scores in determining a patient's indigent status. Providers' Post-Hearing Brief at 22.
[35] Providers' Consolidated Final Position Paper at 10.
[36] Exhibits P-2 at ¶ 2 and P-22 at ¶ 2.
[37] Providers' Consolidated Final Position Paper at 10.
[38] *Id.* at 11.
[39] *Id. See also* Exhibit P-47 at 6-7.
[40] *See* Exhibits P-2 and P-22.
[41] Providers' Consolidated Final Position Paper at 11.
[42] *Id.*
[43] Tr. at 244-246.
[44] Providers' Consolidated Final Position Paper at 7.
[45] *Id.* at 7-8.
[46] *Id.* at 8-9.

patient indigence determination, the use of these Equifax scores is as accurate and complete, if not more so, than the information self-reported by patients.[47]

In denying Sentara's indigent patient bad debt, the Medicare Contractor claims that § 312 of PRM 15-1 creates a mandatory asset test that Sentara failed to perform during its indigent patient determinations.[48] Specifically, the Medicare Contractor states that Sentara's "reliance on the Equifax data alone in the Charity by Model does not follow the Medicare guidelines establishing that a provider should take into account a patient's total resources when determining patient indigent status[,] [as the]Equifax system only assesses an individual's ability and propensity to pay a debt."[49] Sentara counters this assertion by arguing that within the plain language of § 312 of PRM 15-1, CMS suggests—but does not mandate—that providers perform an asset test when conducting its indigent patient determinations.[50] Notwithstanding, Sentara also claims that, even if CMS mandates an asset test be performed in such situations, Equifax's reports and scores "provide a reliable and accurate means of assessing income, assets, expenses and liabilities. . . ."[51] Sentara asserts that "[w]ithout the third party Equifax data that the Providers used under their customary methods for determining Medicare patient indigence, Sentara would have no way to evaluate charity eligibility for patients who do not respond to information requests. . . ."[52]

Medicare Contractor's Contentions and Arguments

As described more fully below, the Medicare Contractor offered three bases for its disallowance of 100% of the Providers' claimed bad debts: (1) Section 312 of PRM 15-1 "provides specific instructions for determining indigence[,]"[53] (2) not only are providers required to "follow[] the prescribed criteria for verifying indigency in accordance with CMS regulations[,]" but they are also required to document that verification for audit,[54] and (3) "the use of and reliance on Equifax scoring to determine indigency does not meet the requirements under the [r]egulations and the PRM due to the inherent flaws and problems with the Equifax process and scoring system . . . ."[55]

With respect to Medicare bad debts, the Medicare Contractor asserts that, although CMS permits providers to "develop and apply" their own customary methods for determining patients' indigent status, "providers are [still] required to follow certain procedures in making indigency determination[s]," as set out within the pertinent regulations and the PRM.[56] The Medicare Contractor explains that § 312 of PRM 15-1 provides specific instructions for determining indigence[57] including the use of a mandatory "asset" test. The asset test is defined as an accounting of a patient's total resources, including, but not limited to, an analysis of assets,

[47] Providers' Post-Hearing Brief at 21.
[48] Medicare Contractor's Final Position Paper at 8-11.
[49] Medicare Contractor's Supplemental Final Position Paper at 10.
[50] Providers' Post-Hearing Brief at 4.
[51] Providers' Consolidated Final Position Paper at 12.
[52] *Id.* at 14.
[53] Medicare Contractor's Final Position Paper at 10.
[54] *Id.* at 5.
[55] Medicare Contractor's Post Hearing Brief at 3
[56] Tr. at 356-357; Medicare Contractor's Final Position Paper at 11.
[57] *Id.* at 10.

liabilities, and income and expenses.[58] In addition, the Contractor states that not only are providers required to "follow[] the prescribed criteria for verifying indigency in accordance with CMS regulations[,]" but they are also required to document that verification for audit.[59] In support of its assertions, the Contractor points to the Medicare reasonable cost reimbursement regulation at 42 C.F.R. § 413.24(a) which states, in part, that providers receiving Medicare payment on the basis of reimbursable cost must provide adequate cost data based on the providers' financial and statistical records which must be capable of verification by qualified auditors.[60]

In the instant appeal, the Medicare Contractor disallowed "100 percent of the Provider's indigent bad debts . . . due to lack of documentation to support that a review of assets, liabilities, income and expenses were performed by the Provider."[61] Specifically, the Contractor explains that the indigence determinations under Sentara's Charity-by-Model procedure were primarily made by using Equifax scores and reports,[62] with Sentara relying "almost exclusively on the use of Equifax credit scoring to self determine the indigency of patients."[63] The Medicare Contractor states that "[a]s the use of the Equifax process is [a]n integral part of the Providers' charity care policy, the Equifax process and work product must be scrutinized to determine if it is reliable, subject to verification, and meets CMS auditing standards."[64] However, the Medicare Contractor states that "none of [the] three [Equifax] scores [used by Sentara] are capable of proper audit, as the scores are based on a cryptic method of statistical sampling and not based on an actual analysis of the patient's income, resources and assets."[65] The Contractor claims that "[t]he formula or methodology employed by Equifax is not known" but, rather, is proprietary information and a "well-guarded" trade secret with an unknown error rate for the various predictor scores,[66] thus the Medicare Contractor is unable to "perform any sort of competent audit" regarding the Equifax data and not able "to verify the reliability or accuracy of these predictive scores."[67] As such, the Medicare Contractor concludes that "the use of and reliance on Equifax scoring to determine indigency does not meet the requirements under the [r]egulations and the PRM due to the inherent flaws and problems with the Equifax process and scoring system . . . ."[68] The Contractor states that its disallowance of 100% of the indigent bad debt—including the indigent determinations made using the Charity-by-Application procedure—was due to the error rate within the audit sample.[69]

---

[58] Medicare Contractor's Post Hearing Brief at 12-14.
[59] Medicare Contractor's Final Position Paper at 5.
[60] *Id.* at 9; *see* 42 C.F.R. § 413.24(a).
[61] Tr. at 341; Medicare Contractor's Post Hearing Brief at 2 (". . . the MAC determined that inpatient indigent bad debts and outpatient indigent bad debts were not allowable due to the Providers' lack of due diligence in establishing an indigency determination by not performing an asset analysis as instructed by PRM 15-1, § 312 (Exhibit I-2).").
[62] Tr. at 357.
[63] Medicare Contractor's Post Hearing Brief at 2.
[64] *Id.* at 4.
[65] *Id.* at 4.
[66] Medicare Contractor's Post Hearing Brief at 8-9; Tr. at 141.
[67] The Medicare Contractor's specific arguments with respect to the accuracy and reliability of the Equifax scores and reports are set out extensively in the Medicare Contractor's Position papers and was discussed at length during witness testimony in the Board hearing.
[68] Medicare Contractor's Post Hearing Brief at 3.
[69] Tr. at 420-421, 439; Medicare Contractor's Post Hearing Brief at 16.

In addition, the Medicare Contractor argues that Sentara failed to follow its own written Charity Care Policy in that the policy states that in order to be eligible for Sentara charity care, patients must "agree to complete the Charity Application[,]" furnish information and documentation when required[,]" and "complete the application process." The Contractor argues that patients identified by the Charity-by-Model process have "not cooperated"[70] with the application process nor provided financial information and documentation as the policy requires,[71] thus these patients should not be eligible for Sentara charity care.

Lastly, the Medicare Contractor argues that Sentara's Charity Care Policy requires the Providers to consider total "family income" when making its indigent patient determinations, but the Equifax scores and reports only consider individual patient resources, not the total "family income of the patient."[72] In addition, the Contractor claims that "the use of Equifax data [does not] identify whether another party is responsible for the patient's medical bills, a requirement of PRM 15-1 . . ."[73] The Contractor also argues that "Equifax does not . . . uncover if there are any 3rd party payors, eligibility for other governmental programs, whether the patient has a tort claim, or whether the patient is a beneficiary of a trust, life insurance, or if there is a probate estate, etc."[74]

Board's Analysis

The Board Majority's analysis begins with the regulatory provisions and sub-regulatory guidance regarding Medicare bad debt reimbursement. In general, CMS considers bad debts, charity and courtesy allowances as deductions from revenue that are, thus, not included in a provider's allowable costs; however, those costs attributable to Medicare beneficiaries' deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs.[75] The regulation at 42 C.F.R. § 413.89(e) establishes Medicare's criteria for an allowable bad debt: (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; and (4) sound business judgment established that there was no likelihood of recovery at any time in the future.

The Secretary's pertinent sub-regulatory guidance, the PRM, contains non-binding, interpretive guidelines regarding certain Medicare regulations,[76] including those bad debt regulations relevant to the instant appeal. The PRM addresses bad debt in § 300 of PRM 15-1. PRM 15-1 § 308 "mirrors" the criteria set out at 42 C.F.R. § 413.89(e), while § 310 addresses what CMS considers a "reasonable collection effort" under 42 C.F.R. § 413.89(e)(2) and § 312 sets out CMS' policy with respect to indigent patient bad debt. Specifically, PRM 15-1 § 312 permits providers to "deem" patients indigent when such individuals have also been determined eligible for Medicaid. PRM 15-1 § 312 goes on to state that otherwise, the provider should apply its

[70] Medicare Contractor's Post Hearing Brief at 3.
[71] *Id.* at 16.
[72] *Id.*; Tr. at 288-290.
[73] Medicare Contractor's Final Position Paper at 10.
[74] Medicare Contractor's Post Hearing Brief at 12 (citing to Tr. at 169-171).
[75] 42 C.F.R. § 413.89(a).
[76] *Battle Creek Health Sys. v. Leavitt*, 498 F.3d 401, 404 (6th Cir. 2007).

customary methods for determining indigence of patients to the case of the Medicare beneficiary under the guidelines set out within the section. Once a provider has determined that a patient is indigent and concludes that there has been no improvement in the patient's financial condition, the patient's debt may be deemed uncollectible without applying the reasonable collection procedures described under § 310.

In the instant appeal, the indigent patient bad debt at issue does not concern Medicare beneficiaries determined eligible for Medicaid. Rather, the indigent patient determinations being challenged here are determinations made after the provider has applied its customary methods for determining indigence of patients to the case of Medicare beneficiaries.

As noted above, CMS requires providers to utilize their "customary method" for determining patient indigence with respect to Medicare beneficiaries under the aforementioned § 312 guidelines. CMS also uses this "customary" language in PRM 15-1 §§ 310(B) and 310.1, regarding reasonable collection efforts, in which CMS states that a "provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.[,]" and that if, "after reasonable and *customary* attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."[77] As thoroughly explained in prior decisions on the issue of the reasonableness of bad debt collection efforts, the Board has interpreted this "reasonable and customary" language to require that a provider have a written debt collection policy to memorialize the process for its "collection effort," and that the provider follows its policy in the debt collection process.[78] As a provider's customary method for determining patient indigence is part of a provider's overall debt collection policy, a provider's indigent patient policy must also be in writing and followed by the provider for both Medicare and non-Medicare patients alike.[79]

PRM 15-1 § 312(B), "Asset Test" in Indigent Patient Determinations

Throughout much of the Medicare Contractor's position papers, it argues that CMS' indigent patient determination criteria set out at PRM 15-1 § 312, specifically at § 312(B), create a ***mandatory*** asset test that must be included in a provider's indigent patient policy. The Medicare Contractor points specifically to the CMS Administrator's decision in *Baptist Regional Medical Center*[80]. In that decision, the Administrator states that "Sections 310 and 312 of the PRM set forth procedures that *must* be followed and criteria that must be met in order to be in compliance with the regulations."[81] The Administrator goes on to declare that "Section 312 of the PRM does create a mandatory asset test."[82] In addition, the Administrator noted that "within the context of

[77] (Emphasis added).
[78] *Marian Health Center v. Blue Cross & Blue Shield*, PRRB Dec. 85-D110 (Sept. 23, 1985); *St. John Health 2004-2005 Bad Debt Moratorium CIRP Group v. National Gov't Servs.*, PRRB Dec. 2014-D19 (Aug. 27, 2014); *Momence Meadows Nursing and Rehabilitation Center, LLC v. National Gov't Servs.*, PRRB Dec. 2018-D23 (Feb. 12, 2018).
[79] *See Baptist Healthcare System v. Sebelius*, 646 F. Supp. 2d 28, 33 (D.D.C. 2009).
[80] *Baptist Regional Medical Center v. BlueCross BlueShield Ass'n/National Government Servs.* Adm'r Dec. 2008-D12 (Feb. 8, 2008).
[81] *Id.* at 7.
[82] *Id.*

the regulation and the PRM, 'should' is synonymous with 'must.'"[83] While the Medicare Contractor acknowledges that the United States District Court for the District of Columbia overturned the Administrator's decision in *Baptist*,[84] the Contractor asserts that "the regulations have not changed . . . [t]herefore, the MAC . . . must follow the interpretation of the Secretary for this issue."[85]

For its part, Sentara argues that the Medicare Contractor's insistence that "a hospital must consider assets, liabilities, income, and expenses in determining patients' indigence under its customary methods, is plainly wrong for two fundamental reasons."[86] First, Sentara argues that the Medicare Contractor "is misapplying the rule as if its establishes a mandatory requirement to consider all these resource categories [when] [i]t does not[, it] only suggests that a hospital 'should' consider total resources." Sentara cites to the court's *Baptist* decision in support of its assertions.[87] Second, Sentara insists that "[j]ust as the rule does not *require* a hospital to consider total resources, it also does not dictate *how* a hospital should take resources into account, and it certainly does not preclude a hospital from using a 'statistical analysis technique' [i.e., Equifax data] to do so."[88] Lastly, Sentara adds that its "customary methods making use of Equifax data provide a commercially reasonable and accurate representation of patients' financial situation."[89]

With respect to the Medicare Contractor's assertion that PRM 15-1 § 312(B) creates a mandatory asset test, in *Baptist Regional Medical Center*[90], the Board found that § 312(B) "does not create a mandatory asset test[,] [but,] [r]ather, each determination of indigence must take into consideration each patient's circumstances." The Board's decision emphasizes that "[i]n some instances, [a patient's circumstances] will require an asset test while other circumstances may obviate the need for that test."[91] After the CMS Administrator overturned the Board's decision in *Baptist*, the Provider requested review in district court. In its decision, the district court for the District of Columbia went through an extensive analysis of the Secretary's use of the words "must" and "should" within PRM 15-1 § 312 and concluded that the "words *must* and *should* do not carry the same meaning in context of Section 312 of the PRM."[92] The district court agreed with the Board's overall interpretation of § 312(B), explaining that the drafters of the PRM "used the word *should* as a suggestion of the ideal criteria a provider could use[;]" that § 312(B) is "best construed as [a] strong, but non[-]compulsory recommendation[;]" and ultimately concluded that the hospital was not *required* to perform an asset test when determining whether a Medicare beneficiary was indigent.[93]

---

[83] *Id.* at 8 n.3.
[84] *See Baptist Healthcare System v. Sebelius*, 646 F. Supp. 2d 28 (D.D.C, 2009).
[85] Medicare Contractor's Post Hearing Brief at 14.
[86] Providers' Post-Hearing Brief at 4.
[87] *Id*.
[88] *Id*. (emphasis in original).
[89] *Id*.
[90] *Baptist Regional Medical Center v. BlueCross BlueShield Ass'n/National Government Servs-Kentucky*, PRRB Dec. 2008-D12 (Dec. 10, 2007)
[91] *Id.* at 6.
[92] 646 F. Supp. 2d at 35.
[93] *Id.* at 34-35. The Board also notes that in *Harris County Hosp. Dist. v. Shalala*, 863 F.Supp. 404 (S.D. Tex. 1994), the District Court came to the same conclusion regarding the language in PRM 15-1 § 312(B). In that decision, the

The Medicare Contractor attempts to distinguish the district court's *Baptist* decision from the instant appeal by citing three facts specific to this appeal: (1) all of the patients in *Baptist* submitted applications, whereas the Charity-by-Model patients at issue here have no applications; (2) *Baptist* did not involve the use of Equifax scoring; and (3) in *Baptist*, the Provider's charity care policy was not at issue, while in the instant appeal, the Medicare Contractor is "asserting that the Providers have not followed their own written charity care policies that appear in [Exhibits] P-1 through P-4."[94] The Board notes, however, that the three facts cited by the Contractor have no bearing on the issue decided in *Baptist*. Specifically, the district court states "[a]t issue in this case is the application of paragraph B of Section 312 of the PRM when a provider seeks reimbursement of bad debts for indigent Medicare beneficiaries."[95] Sentara's use of patient applications, Equifax data or questions about Sentara's Charity Care policy have absolutely no bearing on whether or not PRM 15-1 § 312(B) creates a mandatory asset test for providers seeking reimbursement for Medicare indigent bad debt. For these reasons, with respect to the instant appeal, the Board rejects the Medicare Contractor's and the Administrator's dismissal of the D.C. district court's holding in *Baptist* and once again finds that PRM 15-1 § 312 does not create a mandatory asset test.

PRM 15-1 § 312, "Verification" Requirement When Making Indigent Patient Determinations

The Medicare Contractor "asserts that the Providers are required to follow the prescribed criteria for *verifying* indigency in accordance with CMS regulations and to document that *verification* for audit by the MAC.".[96] According to the Medicare Contractor,

> Under the PRM and the regulations, the Provider must make a reasonable attempt to ascertain the income, resources and assets of each specific patient account. As the use of the Equifax process is [a]n integral part of the Providers' charity care policy, the Equifax process and work product must be scrutinized to determine if it is reliable, subject to verification, and meets CMS auditing standards.
>
> The MAC asserts that the Equifax reports are vague, unreliable, not capable of verification by a MAC auditor, and do not meet CMS auditing standards.[97]
> [Thus, t]he underlying question in this case is whether the Equifax scoring data [is] a reasonable and reliable methodology for

Court goes on to state that "[t]he regulations do not contain the asset test, only the manual does. The issuance of the manual was not preceded by the formal rule-making of the administrative procedure act. The rules in the manual do not have the effect of substantive law or regulation, rather they are interpretive rules." *Id.* at 409 (citations omitted).

[94] Medicare Contractor's Post Hearing Brief at 14-15.

[95] 646 F. Supp. 2d at 33.

[96] Medicare Contractor's Post Hearing Brief at 2 (emphasis added).

[97] *Id.*at 3-4.

> verifying a patient's assets, resources and income in order to self determine indigency?"[98]

The Board finds that the Medicare Contractor has improperly imposed a verification requirement on the Providers and on the Equifax data that does not appear anywhere in the regulations or § 312 of the PRM. The U.S. Court of Appeals for the Eighth Circuit has addressed this argument before, and rejected the Secretary's efforts to impose a verification requirement on any of the subsections of PRM § 312. In *Shalala v. St. Paul – Ramsey Medical Center*, [99] the provider's bad debt claims were disallowed because, according to the Secretary, the provider's "failure to independently verify the [income] information presented by the patients essentially violates section 312(A) by allowing the patient, not . . . the provider, to determine indigent status[,]" and "[w]ithout verification from an independent source . . . there was insufficient documentation for the purposes of section 312(D)."[100]

The circuit court found for the provider in the *St. Paul - Ramsey* case, holding that "the Secretary's interpretation of Section 312 of the PRM to contain an unwritten but implied independent verification requirement is 'plainly erroneous or inconsistent' with the text of section 312. . . . Here, the Secretary seeks to impose additional unstated and unwritten requirements pertaining to the nature and quality, i.e., verification, of the information used for the indigency determination – not who ultimately makes the determination."[101] The Circuit Court was clear that the Secretary's verification requirement was improper because it "adds language to the second sentence of subsection B which would modify it to read: 'In making this analysis the provider [must verify the financial information furnished by the patient and] should take into account any extenuating circumstances that would affect the determination of the patient's indigence.'"[102]

Moreover, the Eighth Circuit's decision makes clear that neither subsection A, B nor D of PRM § 312 includes a verification requirement. The court held that "[l]ikewise, section 312(D) requires documentation of the method and information used in the indigency determination. When a provider identifies its method for determining indigency and the information used to make that determination, the provider satisfies all requirements of section 312(D), express and implied."[103] In the *St. Paul-Ramsey* case, the provider "identified its method of determining indigency (an income and asset test) and the information upon which it based its determination (the patient's statement of income and assets)."[104] Under the plain language of section 312, the circuit court found that the provider had therefore satisfied all of the relevant requirements of section 312. Importantly, the Court made clear that the Secretary's arguments imposing a verification requirement in its audit regulations were equally unavailing. The Court noted that it was "reject[ing] the Secretary's arguments that [the provider] failed to comply with 42 C.F.R.

---

[98] *Id*. at 8.
[99] 50 F.3d 522 (8th Cir. 1995).
[100] *Id.* at 527.
[101] *Id.* at 528.
[102] *Id.* at 529.
[103] *Id.*
[104] *Id.*

§§ 413.20 and 413.24 for the same reasons that we reject the Secretary's arguments about section 312(D) of the PRM."[105]

Based on its analysis of the plain language of Section 312 of the PRM, and in concurrence with the analysis of this PRM section as found in *St. Paul – Ramsey*, the Board finds the Medicare Contractor improperly imposed a verification requirement on underlying Equifax data. Just as the provider in *St. Paul – Ramsey* had no obligation to delve behind and verify the data they used to determine indigency, Sentara, in this case, satisfies all its obligations under § 312 when it identifies the Equifax reports and scores as the information upon which it based its Charity by Model indigency determinations, and provided documentation of the Equifax reports and scores to the Medicare Contractor.[106]

Sentara's Incorporation of Equifax Data Complies With PRM § 312 And Auditing Regulations

The Medicare Contractor states that "[a]s the use of the Equifax process is [a]n integral part of the Providers' charity care policy, the Equifax process and work product must be scrutinized to determine if it is reliable, subject to verification, and meets CMS auditing standards."[107] However, the Medicare Contractor states that "none of [the] three [Equifax] scores [used by Sentara] are capable of proper audit, as the scores are based on a cryptic method of statistical sampling and not based on an actual analysis of the patient's income, resources and assets."[108] The Contractor claims that "[t]he formula or methodology employed by Equifax is not known" but is, rather, proprietary information and a "well-guarded" trade secret with an unknown error rate for the various predictor scores,[109] thus, the Medicare Contractor claims it is unable to perform any sort of competent audit regarding the Equifax data and not able to verify the reliability or accuracy of these predictive scores.[110] As such, the Medicare Contractor concludes that "the use of and reliance on Equifax scoring to determine indigency does not meet the

---

[105] *Id.* at n. 5.

[106] Just like the Medicare Contractor, the Concurrence/Dissent improperly imposes a requirement on Sentara that is not found in PRM § 312. The Concurrence/Dissent would uphold the Medicare Contractor's denial of Sentara's claimed bad debts because "There was no formal adoption of using Equifax as part of the Sentara indigence determination process and neither the official Sentara Charity Care Policy nor the 2010 and 2012 PCD Indigence Policies refer to Equifax." Concurrence/Dissent at 2. However, the PRM does not require that a provider's written bad debt policy identify or refer to – formally or otherwise - the identity of the individual or third party who supplies the data on which the indigency determination is made. There is no question that a provider is permitted to outsource indigency data gathering to a third party. Furthermore, there is nothing in the statute, regulations or PRM that requires a provider to identify in its bad debt policy, the particular third party with whom the provider is contracting in order to be reimbursed for its Medicare bad debts. All the evidence admitted in this case makes clear that the Medicare Contractor understood that indigency data was being furnished by Equifax, and that "the use of the Equifax process is [a]n integral part of the Providers' charity care policy..." See fn 58, infra. The Majority specifically finds that the Providers' bad debt policy, even without formal reference to Equifax, is sufficient to entitle Sentara to reimbursement for its claimed bad debts, subject to the Medicare Contractor's review on remand

[107] Medicare Contractor's Post Hearing Brief at 4.

[108] *Id*.

[109] *Id*.at 8-9; Tr. at 141.

[110] The Medicare Contractor's specific assertions with respect to the accuracy and reliability of the Equifax scores and reports are set out extensively in the Contractor's Position papers and was discussed at length during witness testimony in the Board hearing.

requirements under the [r]egulations and the PRM due to the inherent flaws and problems with the Equifax process and scoring system . . . ."[111]

As discussed above, the Board finds that the Medicare Contractor has impermissibly imposed a verification requirement on the Equifax information used by Sentara as part of its Charity Care policy determinations, and that this reason alone is sufficient to find the Medicare Contractor's disallowances to be improper. However, the Board also finds that the Medicare Contractor certainly could have performed an audit of the reliability of the Equifax scores, had it chosen to.[112] Moreover, the Board takes note that CMS's use of Equifax data belies the Medicare Contractor's concerns about its reliability. CMS uses Equifax data to verify income for individuals applying for health insurance and subsidies through the Affordable Care Act exchanges, among other uses.[113] For all these reasons, the Board finds that the Providers' use of Equifax data in its Charity by Model indigency determinations meets the requirements under both the PRM and the regulations for reimbursement of its bad debt claims.

The Board's analysis in the instant appeal does not end here, however, as the ultimate issue in this appeal is whether the Medicare Contractor properly disallowed bad debts for Medicare beneficiaries determined indigent by the provider. In order to answer that question, the Board must further examine Sentara's Charity Care Policy to determine whether it comports with the compulsory regulatory and sub-regulatory requirements and whether Sentara followed that policy for Medicare and non-Medicare patients alike.

Sentara's Charity Care Policy

As quoted *supra*, PRM 15-1 § 312 begins by stating that a provider should apply its "customary methods" for determining the indigence of patients to the case of a Medicare beneficiary under the guidelines of § 312. As the district court stated in *Baptist*, "CMS regulations and the PRM allow a provider to 'waive collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the [provider's] indigency policy. By 'indigency policy' [the Secretary] mean[s] a policy developed and utilized by the hospital to determine patients' financial ability to pay for services' as long as the policy applies to Medicare and non-Medicare patients uniformly."[114] As summarized by the court, the Agency has unequivocally stated that "a hospital may determine its own individual indigency criteria."[115] Both parties have supported this assertion in their respective position papers.

---

[111] Medicare Contractor's Post Hearing Brief at 3.
[112] The Board notes that the record includes examples where the Equifax scores obtained on individual patients wholly support the financial information provided by the patient in their Charity Care applications. *See, e.g.*, P-11 at 38 (application showed income of $23,472 per year, income predictor score of $37,000 per year).
[113] Exhibit P-15 (Press Release, Equifax, Equifax Contract with CMS Renewed, Will Continue Verification for Affordable Care Act Applicants (May 7, 2015)); Exhibit P-16 (HHS, Health Ins. Marketplace, FAQ on Remote Identity Proofing, Remote Identity Proofing Failures and Application Inconsistencies (Federally-facilitated Marketplace) (May 21, 2014)).
[114] *Baptist Healthcare System v. Sebelius*, 646 F. Supp. 2d 28, 33 (D.C. Cir. 2009) (Quoting a 2004 news release of former Secretary of HHS, Thommie Thompson).
[115] *Id.* at 34.

As explained in prior decisions, the Board has interpreted the language "reasonable and customary" with respect to Medicare bad debts to require that a provider have a written debt collection policy and that the provider follows that policy in the debt collection process.[116] As a provider's customary method for determining patient indigence is part of a provider's overall debt collection policy, a provider's indigent patient policy must also be followed by the provider for both Medicare and non-Medicare patients.

A. Comparison of Sentara's 2010 and 2012 Charity Care Policies

Sentara included two versions of its Charity Care Policy within Exhibits P-2 and P-22. The P-2 "version" appears to have been last updated in January 2010.[117] The P-22 version appears to have been last updated in February 2012.[118] A careful comparison of the two policies reveals that they are almost identical in every way. The few minor differences are found in the following paragraphs:

- Under paragraph 3, regarding Charity-by-Model patients, the 2012 Policy appears to have added language regarding categorizing a patient's status with categories denoted by 3-character designations. This categorization comports with Sentara's chart of these categories Exhibit P-47;[119]
- Under paragraph 5, the 2010 Policy states "[w]hen the processing of the application is complete by a telephone screen with a Charity model qualification or when a charity application along with the required documentation is received the account is moved to status CPA and letter PCHA is automatically sent." The 2012 Policy states "[w]hen the processing of the application is complete by a telephone screen, by a Charity model qualification, or when a charity application along with the required documentation is received the account is moved to status CPA[]";
- Under paragraph 6, the 2012 Policy added some parentheticals that appear to explain the status codes; and,
- Under paragraph 8, the sentence structure has been changed.

In reviewing these changes, the Board Majority finds that the minimal punctuation and word changes, added parentheticals and sentence structure adjustments do not amount to a material change in Sentara's Charity Care Policy from 2010-2012.[120] The changes may be attributed to

---

[116] *See supra* n.80.
[117] Exhibit P-2.
[118] Exhibit P-22.
[119] The Concurrence/Dissent dismisses Providers' Exhibit P-47 as irrelevant because it was "prepared and submitted after the hearing." Concurrence/Dissent at fn 15. When explanatory evidence is submitted to the PRRB is not the issue here. In this case, the Providers offered evidence, that was admitted as part of the record of this hearing, to further explain an algorithm that was documented in the 2012 PCD Policy (the AL4 category of accounts that may qualify for a bad debt write off). The Majority finds P-47 to be an adequate, relevant explanation of how the 2010 and 2012 PCD policies worked in practice during the cost years at issue.
[120] During the hearing, Sentara's Vice President Revenue Cycle testified for Sentara (hereinafter referred to as "Sentara's witness") that the two policies that were included as exhibits are "without material changes." Tr. at 184.

editing or general clarification, as these documents are intended for use by Sentara's pre-collections department[121] and not written in contemplation of adjudication. Therefore, the Board Majority finds that Sentara's 2010-2012 Charity Care Policies are, for the purposes of the instant decision, materially similar in substance and will hereinafter be referred to as one collective "Charity Care Policy."

B. Analysis of Sentara's Charity Care Policy under PRM 15-1 § 312

CMS permits providers to establish their own "customary methods" to determine indigent patients.[122] While providers are permitted to establish their own policies, CMS' sub-regulatory guidance, set out at PRM 15-1 § 312, outlines the "guidelines" for the providers to follow in making determinations of indigency. As discussed extensively *supra*, the "words *must* and *should* do not carry the same meaning in context of Section 312 of the PRM."[123] Thus, two of the four § 312 requirements are mandatory, while the other two requirements are "non-compulsory."[124] The two mandatory requirements are as follows:

> (A) The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence; . . .
>
> (C) The provider must determine that no other source other than the patient would be legally responsible for the patient's medical bill; e.g., Title XIX, local welfare agency and guardian[.]

As these two requirements are mandatory, the Board must assess Sentara's Charity Care Policy to determine if it incorporates these requirements into its substantive text.

1. PRM 15-1 § 312(A)

Under § 312(A), a patient's indigence must be determined by the provider. Within its Charity Care Policy, Sentara sets out three methods by which a patient may be determined indigent and have their account balances "adjusted to zero."

First, in the Charity-by-Application methodology, patients apply for charity care through written or telephone applications.[125] In these instances, these patients are referred to as "applicants." If a patient responds to Sentara's request for information through the application process or telephone screening, Sentara is able to determine qualification for charity care through the information and documentation submitted by the applicant (including self-reported information regarding income, assets, liabilities and expenses, and documents such as tax returns, bank statements, Social Security statements , W-2s, etc.).[126] With these Charity-by-Application

---

[121] *Id.* at 131,
[122] *See* PRM 15-1 § 312.
[123] *Baptist Healthcare System v. Sebelius*, 646 F. Supp. 2d 28, 35 (D.D.C. 2009).
[124] *Id.* at 34.
[125] Exhibits P-2 at ¶ 1 and P-22 at ¶ 1.
[126] Providers' Consolidated Final Position Paper at 10.

patients, Equifax scores and reports are used, to the extent they are used at all, primarily to lend support to the Applicant's self-reported information.[127] Thus, the Board Majority finds that, with respect to Sentara's Charity-by-Application policy, Sentara, not the patient, has determined an applicant's indigent status and therefore, with respect to this subset of patients, Sentara's Charity Care Policy meets the mandate of § 312(A).

Second, under the Charity-by-Model procedure, patients may still be approved for charity care even if they fail to complete a Financial Assistance or Charity Application, participate in telephone screening or respond adequately to requests for information.[128] In these circumstances, the Charity-by-Model patients are not "applicants," with the result that "[t]his [Charity-by-Model] method uses data available from other sources . . . typically furnished by Equifax . . . ."[129] Sentara "evaluates the financial data obtained through the Equifax report and any additional sources of information available[]"[130] to make a determination about a non-applicant patient's indigent status.[131]

Sentara states that the Equifax scores and reports that it uses are "designed specifically for medical providers attempting to collect for medical services."[132] Sentara uses three scores from Equifax: the income predictor score, the payment predictor score and the bankruptcy navigator index. Sentara states that "[d]ata for the scoring is drawn from the individuals' current and historical financial and credit transactions maintained in a multitude of databases that Equifax draws upon and is designed to take into account characteristics statistically associated with healthcare patients."[133] The Board Majority finds that, with respect to Sentara's Charity-by-Model policy, Sentara, through the use of Equifax scores and reports, has determined the patient's indigent status—not the patient—and therefore, with respect to this subset of patients, Sentara's Charity Care Policy meets the requirements of § 312(A).

Lastly, in Sentara's "extraordinary circumstances" policy, certain Sentara managers[134] are permitted to document approval of charity care for applications that do not meet all guidelines. By definition, this subset of patients have been reviewed and approved by Sentara for such "extraordinary circumstances" as justifying a determination of patient indigence. The Board finds that this part of Sentara's Charity Care Policy also meets the requirements of § 312(A).

2. PRM 15-1 § 312(C)

Under PRM 15-1 § 312(C), CMS requires providers to determine that no other source other than the patient would be legally responsible for the patient's medical bill; e.g., Title XIX, local welfare agency and guardian.

---

[127] *Id*. at 11.
[128] *Id*.
[129] *Id*.
[130] *Id*.
[131] *Id*.
[132] *Id*. at 7
[133] *Id*. at 8-9.
[134] Providers' Consolidated Final Position Paper at 6.

The Medicare Contractor argues that "Equifax does not determine or uncover if there are any 3rd party payors, eligibility for other governmental programs, whether the patient has a tort claim, or whether the patient is a beneficiary of a trust, life insurance, or if there is a probate estate."[135] As Sentara points out, under the terms of its Charity Care Policy, the Policy does not become pertinent unless a balance remains after all payment sources are exhausted and the remaining balance is determined to be the patient's responsibility.[136] Thus, Sentara claims that it has already eliminated additional potential payment sources, via its admission forms and use of a "CEA" representatives, *prior* to instituting its Charity Care Policy.[137] During the hearing, Sentara's witness testified that Sentara employs an agency, "CEA,'" whose on-site representative visits uninsured and Medicare in-patients to assist, if appropriate, with Medicaid approval, Medicare benefits and/or SSI.[138] The CEA representative conducts "face-to-face" assessments that Sentara may use in its indigent determinations,[139] and that the patient information obtained by CEA is "put into" Sentara's system.[140] In addition, a review of Sentara's "Financial Sheet" and "Charity Care Application" sent to the identified Prospective Charity patients demonstrates that even during the Charity Care "work-up," Sentara continues to inquire about additional payment sources.[141]

Upon review, the Board Majority concludes that Sentara's Charity Care Policy meets the requirements of § 312(C) because the Providers have systems in place (*e.g.*, admission forms, use of CEA representatives, etc.) to determine whether third party payors are available. The Providers do not rely on Equifax to perform this function under § 312(C), and therefore, the Medicare Contractor's concern in this regard is unfounded.

C. Analysis of Whether Sentara Followed its Charity Care Policy

The Medicare Contractor argues that Sentara failed to follow its own written Charity Care Policy. Specifically, the Contractor quotes the following subsections from the Policy:

> 2. Applicants for Sentara Charity Care must agree to complete the Charity Application and assist PCD by furnishing information and documentation when required to complete the Sentara Charity Care application process in a timely manner. Applicants who do not provide the requested information necessary to completely and accurately assess their financial situation will not be eligible for Sentara Charity care or Self-Pay Discount Program.
>
> . . . .

[135] Medicare Contractor's Post Hearing Brief at 12 (citing Tr. at 169-171).
[136] *See* Sentara's Opposition to MAC's Final Position Paper at 6.
[137] Sentara points out that, it "gives *every single one* of its patients a Medicare Secondary Payer form *at the time of admission*." *Id.* (emphasis in original). Although Sentara included a "Medicare Secondary Payor Questionnaire" as Exhibit P-37, the Board notes that this Questionnaire contains a "Revised Date 09/14" marking, thus the document post-dates the time period at issue in the instant appeal. Tr. at 110-111.
[138] *Id.* at 325-329.
[139] *Id.* at 327-329.
[140] *Id*, at 328-331.
[141] *See* Exhibits P-3 and P-4.

> *7.* Patients that fail to send in the required information to support the application for financial assistance within 60 days will not be considered for Charity Care. Denied or incomplete applications will be moved to status AL3 for work and letter PCHD is required to be sent.

The Medicare Contractor argues that "[i]t is clear that a patient must cooperate and complete the charity application and otherwise provide financial information and documentation in order to be considered for charity assistance."[142] The Contractor points out that Charity-by-Model patients, by definition, have not completed an application or provided financial information and thus, should not be considered for Charity Care under Sentara's written policy.[143]

During the hearing, the Board specifically asked about this part of the Charity Care Policy. Sentara's witness explained that the portion of Sentara's policy under paragraph 7 pertains to those patients who do not fall into the Charity-by-Model qualification nor have they responded to the requests for information.[144] In its Post-Hearing Brief, Sentara points out that, with respect to paragraph 2, its "written policies and procedures explain that a complete charity application will be needed from the patient 'when required[,]' [and that] a charity application is not 'required' when a patient is determined to be indigent based on Equifax data through Sentara's Charity by Model process."[145]

The Board also notes that paragraph 2 states that "*Applicants* for Sentara Charity Care must agree to complete the Charity Application and assist PCD by furnishing information and documentation when required to complete the Sentara Charity Care application process in a timely manner."[146] The term "Applicants" implies that a patient has completed at least some portion of a Charity Care "request" form. In addition, the Board notes that Sentara's Charity Care Policies not only address indigent patient determinations, but also "identify different ways that Sentara might find a patient eligible for charity[,]"[147] including Sentara's "Discount Programs." In other words, Charity-by-Model patients are not Applicants, and determinations about their qualifications for Sentara's Charity Care program are not made based on either paragraph 2 or paragraph 7 of the Charity Care policy.

Accordingly, the Board Majority finds that the Medicare Contractor's position, that Sentara's written Charity Care Policy requires *all* patients to submit an application or not be eligible for Sentara's financial assistance, is without merit.

The Medicare Contractor also argues that "the Providers[‘] charity care policy requires that the Provider consider total 'family income' or household incomes[,] [but] [i]n many of the patient summaries . . . the patient is indicated as 'married,' and yet the spouse's income is not factored into the Providers' determination."[148] Sentara argues that "Equifax financial indicators reflect

---

[142] Medicare Contractor's Post Hearing Brief at 16.
[143] *Id.*
[144] Tr. at 319-321.
[145] Providers' Post-Hearing Brief at 23.
[146] Exhibits P-2 at ¶ 2 and P-22 at ¶ 2 (emphasis added).
[147] Providers' Post-Hearing Brief at 22.
[148] Medicare Contractor's Post Hearing Brief at 16.

household assets, liabilities, and income, including household (not just individual) income, joint car loans, joint home mortgages, and open to buy bankcard scores that reflect household resources."[149]

Upon review of Sentara's written Charity Care Policy, Sentara repeatedly states that its Charity Care and Discount Policies consider "family income" when determining whether a patient is eligible for its charity care.[150] The Board Majority notes that Sentara does not specifically define "family income" in its charity care determinations. During the hearing, the Medicare Contractor argued that a "family income" review should include a review for the patient's spouse and all related adult children living in a household.[151] The Board Majority finds that, at a minimum, "family income" includes a spouse's income.

During the hearing, when asked how Equifax reports spousal income, Sentara's witness stated that "it does not—it can't bring in the spouse's information at that time."[152] When asked to clarify whether Equifax's income predictor score contains information regarding the spouse, Sentara's witness stated that it in involves "individuals."[153] In its Post Hearing Brief, Sentara includes a declaration from Sentara's Director of Revenue Management ("Director"). The Director's statements address "how a spouse's income and other financial information might be reflected in the other spouse's income predictor and payment predictor scores."[154] Specifically, the Director claims that it is his "understanding" that "couples seeking to obtain credit might need to include both individuals' incomes on personal loans, mortgages, and lease applications. . . ." The Director goes on to surmise that "[s]ince Equifax can use the reported debt obligations on an individual's credit bureau report in calculating their Income Predictor Score (IPS) it only makes sense to me that the IPS reported by Equifax for one spouse could actually include some or all of the income for the other spouse or co-debtor."[155]

The Board finds that Sentara's written Charity Care Policy requires Sentara to review "family income" in its charity care determinations. The Board also finds that, at a minimum, "family income" includes spousal income. Sentara has not been able to demonstrate, to the Board Majority's satisfaction, how a married patient's Equifax scores and reports sufficiently include a review of the spouse's income. As such, the Board Majority concludes that Sentara has not followed its written Charity Care Policy with respect to those married, Charity-by-Model patients qualified by Equifax reports and scores alone, as the Equifax scores and reports do not denote spousal income, i.e., "family income," as required by Sentara's Charity Care Policy.

[149] Providers' Post-Hearing Brief at 22 (emphasis omitted).
[150] Exhibits P-2 and P-22.
[151] Medicare Contractor's Post Hearing Brief at 16.
[152] Tr. at 288-289.
[153] *Id.* at 289-290.
[154] Exhibit P-50 at ¶ 3.
[155] *Id.* at ¶ 4.

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the "Board Majority" remands the fiscal year 2010 – 2013 cases to the Medicare Contractor to reverse the adjustments and conduct a further review[156] of Sentara's indigent bad debt determinations, for accounts less than $10,000, as follows:

1. For those patients, unmarried or married, that Sentara qualified through its Charity by Application procedure (either written or telephonic), the Medicare Contractor will review the available documentation to verify the patient's income; if family income is less than 200% of the Federal Poverty Level, the Medicare Contractor should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims;

2. For those unmarried patients that Sentara qualified through its Charity by Model procedure and, based on its Charity Care Policy, identified as ***not needing*** an asset check completed,[157] the Medicare Contractor will review the available documentation to verify the patient's income. If the sole source of documentation is an Equifax score and report, the Board finds that the Equifax score and report comport with Sentara's written Charity Care Policy regarding income verification for this subset of patients. If the unmarried patient's income is less than 200% of the Federal Poverty Level, the Medicare Contractor should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims;

3. For those unmarried patients that Sentara qualified through its Charity by Model procedure and, based on its Charity Care policy, identified as ***needing*** an asset check completed,[158] the Medicare Contractor will review the available documentation to verify a completed asset check and the patient's income. If the sole source of the documentation is the Equifax score and report, the Board finds that the Equifax score and report comport with Sentara's written Charity Care Policy regarding asset check and income verification for this subset of patients. If the unmarried patient's income is less than 200% of the Federal Poverty Level and there are insufficient assets available to pay the Sentara debt, the Medicare Contractor should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims;

4. For those married patients that Sentara qualified through its Charity by Model procedure, the Medicare Contractor will review the available documentation[159] to verify the family's

[156] The Medicare Contractor should conduct its further review under ots normal audit methodology, whether that be a sampling or a case-by-case review.
[157] Exhibits P-2 at ¶ 3 and P-22 at ¶ 3.
[158] *Id.*
[159] A non-exhaustive list of non-Equifax documentation, other than a Charity Care application, includes admission forms, Financial Information Sheet, Medicaid Eligibility, documentation that the patient qualifies as a SLMB (where individuals qualify as SLMBs if their individual or family income is 100-120% of the federal poverty level), qualifies for federal housing assistance, etc.

income; if the married patient's family income is less than 200% of the Federal Poverty Level, the Medicare Contractor should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims. However, for those married patients that Sentara qualified through its Charity by Model procedure, and the *sole source* of the documentation is the Equifax score and report, the Board finds that the Equifax score and report do ***not*** comport with Sentara's written Charity Care Policy regarding income verification for this subset of patients; and, the Board finds that, for these claims, the Medicare Contractor's denial of bad debt reimbursement was proper;

5. For those patients Sentara qualified as eligible for Charity Care due to "extraordinary circumstances,"[160] the Medicare Contractor will verify the documentation supporting the "extraordinary circumstances" and ensure that Charity Care approval was made by the Vice President - Revenue Cycle, Director - Patient Accounts, Manager - Patient Accounts, or Chief Collection Counsel, in accordance with Sentara's written Charity Care Policy. If the Medicare Contractor verifies the appropriate management employee approved the Charity Care determination based on an internal determination of extraordinary circumstances, the Medicare Contractor should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq. (Dissenting in Part)
Charlotte F. Benson CPA (Dissenting in Part)
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

8/26/2020

X Gregory H. Ziegler, C.P.A

Gregory H. Ziegler, C.P.A.
Board Member
Signed by: Gregory H. Ziegler -S

[160] Exhibits P-2 at ¶ 3 and P-22 at ¶ 3.

CLAYTON J. NIX, ESQ., CHAIR, AND CHARLOTTE F. BENSON, C.P.A., *dissenting in part and concurring in part,* in Case Nos. 16-0408GC, 16-0409GC, 16-2238GC

This consolidated, common issue related party ("CIRP") group hearing involves Sentara Healthcare ("Sentara") for fiscal years 2010 through 2013. The Medicare allowability of ***each*** of the indigence write offs at issue for 2010 through 2013 turns on the applicable ***written*** patient indigence policy that was in effect for Sentara during the time periods at issue (*i.e.*, turns on the patient indigence policy that was in effect for Sentara when Sentara wrote off the indigent patient account at issue). Unlike the Majority, we do not find that the Sentara had written policies that properly adopted and identified Equifax as part of its patient indigent determination process.

We generally concur in the Majority's description of Medicare bad debt policy. In particular, we agree with the following:

1. *Written Policy*.—The Board has historically interpreted the Program Reimbursement Manual ("PRM") 15-1, Chapter 3 entitled "Bad Debts, Charity, and Courtesy Allowances" as requiring providers to maintain written policies to memorialize their internal process for collecting and writing off bad debts, including for example their policy on patient indigence determinations. The Majority cites to three prior Board decisions to support the longstanding nature of this interpretation. While these decisions focus on reasonable collections efforts in PRM 15-1 § 310, they are no less applicable to PRM 15-1 § 312 as both sections refer to "customary" methods. In this regard, we specifically refer to the Board's 2014 decision in *St. John Health 2004-2005 Bad Debt Moratorium CIRP Group v. National Gov't Servs.*,[1] as it provides a very thorough history and explanation for the written policy requirement.

2. *Testing Assets as part of Patient Indigence Determinations*.—The guidance in PRM 15-1 § 312(B) that a provider's "customary methods" for determining patient indigence "should take into account a patient's total resources . . . ." is not mandatory as confirmed by the D.C. District Court's 2009 decision in *Baptist Healthcare Sys. v. Sebelius* ("*Baptist*").[2] More specifically, providers may choose to perform asset tests as part of the patient indigence determination process (and it is recommended that they do so) but providers are not required to perform an asset test when determining whether a Medicare beneficiary is indigent. In this regard, § 312(B) recommends but does not require that patient indigence determinations take into account all of a patient's resources.

3. *Verifying Income, Resources and Assets To Determine Eligibility for Indigence*.—There is no requirement in either 42 C.F.R. § 413.89(e) or PRM 15-1 § 312 that providers *independently* verify income, resources and assets of indigence applications as explained by the Eight Circuit Court of Appeals in *Shalala v. St. Paul-Ramsey Med. Ctr.* ("*Ramsey*").[3] In *Ramsey*, the provider collected financial information from patients on a

[1] PRRB Dec. No. 2014-D19 (Aug. 27, 2014).
[2] 646 F. Supp. 2d 28 (D.D.C. 2009).
[3] 50 F.3d 522 (8th Cir. 1995).

patient-completed form but did not verify that information.[4] In this case, Sentara made a business decision (albeit undocumented during the time at issue as explained below) to rely on Equifax to collect and present financial information on its patients (Medicare and non-Medicare) and there is no requirement that the financial information from Equifax be independently verified.[5] Rather, the Medicare Program relies on consistent application of the provider's selected patient indigence process across Medicare *and* non-Medicare patients as a means of ensuring providers are prudent in selecting their process.[6] This requirement for consistent application gives providers the incentive to be prudent since the write-off associated with patient indigence determinations for ***non***-Medicare patients is absorbed by the provider without input by the Medicare Program. As a result, we agree with the Majority that Sentara was free to contract with and rely on the third party, Equifax, to give financial information on its patients (both the three Equifax scores that Sentara used and the Equifax listing of underlying financial information upon which those scores were partially based) and there was no Medicare requirement that Sentara test or probe the exact basis for the Equifax scores or other financial information for any patient.[7] Similarly, the fact that Equifax may not take into account all of a patient's financial resources is not a fatal flaw under PRM 15-1 § 312(B) since this provision recommends but does not require such consideration.[8]

Where we depart from the Majority is in their reading and application of Sentara's written Charity Care Policy across the four years at issue: 2010 through 2013. As highlighted above, the written policy is where the rubber meets the road because the Medicare Program gives providers a lot of flexibility in designing and selecting its process for indigence determinations. As a result, the *written* policy to document those selections is critical for the Medicare Program

[4] *See id*. at 525. *See also St. Paul Ramsey Med. Ctr. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 1992-D30 (Apr. 14, 1992) (PRRB decision that was appealed and led to 8th Circuit's *Ramsey* decision).

[5] The Minority's discussion of Equifax is general in nature and is not meant to be exhaustive or definitive. Upon further review and consideration, there may be certain situations where reliance on Equifax alone may be inconsistent with Medicare guidance, in part or in whole. How Equifax is incorporated into a provider's chosen collection and write off process may also factor into this analysis, in particular, the extent to which the distinction between the bad debt collection process and the patient indigence determination process gets blurred. For example, in this case, one of the Equifax scores used is a likelihood of payment score and the Minority has some concerns that, in some instances, Equifax may have been used more for ending collection based on a more narrow finding of no likelihood to pay versus a broader finding of indigence.

[6] PRM 15-1 § 312 requires providers to apply their "customary methods for determining the indigence of patients to the case of the Medicare beneficiary." *See also Baptist*, 646 F. Supp. 2d at 34 (accepting "the premise that providers may determine their own individual indigency criteria").

[7] Again, it may be prudent for the Provider to do so (whether on a case-by-case situation or a pre-implementation basis) but that is a business decision and there is no Medicare requirement to do so. Rather, the equal treatment of Medicare and non-Medicare patients is designed to incentivize and ensure that prudence. *See* Transcript of Proceedings ("Tr.") at 106-108.

[8] Notwithstanding, the Minority notes that Sentara opted to adopt, in its indigence policies, the overarching principle that "[p]atients . . . who have ***family*** incomes not in excess of 200% of the Federal Poverty Level will be eligible to receive Sentara Charity Care." Exhibit P-2 at 1 (emphasis added); Exhibit P-22 at 1 (emphasis added). The Minority, like the Majority, has concerns whether Equifax alone can satisfy the bar Sentara set for itself.

to verify and audit compliance with the skeletal Medicare requirements, *including in particular consistency across Medicare and non-Medicare patients*.[9]

For the period at issue, 2010 through 2013, Sentara produced the following versions of the indigence policy used in the Pre-Collection Division ("PCD"):

1. PCD Policies and Procedures; Sentara Charity Care, Account balance under $10,000 effective January, 2010. Hereinafter, it will be referred to as the "2010 PDP Indigence Policy."[10]

2. PCD Policies and Procedures, Sentara Charity Care, Account balance under $10,000 effective February 2012. Hereinafter, it will be referred to as the "2012 PCD Indigence Policy."[11]

These PCD policies were governed by Sentara's Charity Care Policy as confirmed by the following statement from Sentara's witness:

> Q. Okay, and was this the official policy – the official charity care policy for the fiscal years in question?
>
> A. The – in Exhibit [P-]2?
>
> Q. Yeah, [P-]1 and [P-]2, or . . .
>
> A. Okay. Well, [P-]1 was the ***official*** charity policy. This one [*i.e.*, P-2] is a policy and procedure within the pre-collection unit.[12]

Unlike the Majority, we cannot reconcile these written policies with Sentara's alleged practice for using Equifax in its indigence determinations during 2010 through 2013 and, in particular, cannot impute the complex use of Equifax into those policies. The Majority's detailed remand order only highlights how inadequate the relevant written policies were relative to Equifax. As set forth below, it is our findings that:

1. Sentara is retrospectively attempting to shoehorn an alleged practice of using Equifax into the written policies that were in effect during 2010 through 2013.

---

[9] *See* 42 C.F.R. § 413.24(a)-(c); 42 C.F.R. § 413.20(a) ("The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program."); *Community Hosp. of the Monterey Peninsula v. Thompson*, 323 F.3d 782, 799 (9th Cir. 2003) (Agreeing with Administrator's finding that "the Providers did not maintain contemporaneous documentation in the ordinary course of business to support their claims." (quoting *California Hosps. 90-91 Outpatient Crossover Bad Debts Grp. v. Blue Cross of Cal.*, Adm'r Dec. (Oct. 31, 2000), *rev'g*, PRRB Dec. No. 2000-D80 (Sept. 6, 2000)).
[10] A copy is included at Exhibit P-2.
[11] A copy is included at Exhibit P-22.
[12] Tr. at 130-31 (emphasis added).

2. The Medicare Contractor properly disallowed the indigence write offs at issue except where: (a) either a written application was submitted by the patient or Sentara filled out a "telephone application" consistent with Paragraph 1 of the 2010 and 2012 PCD Indigence Policies; or (b) there is documentation from a State Medicaid agency establishing that the patient was below 200% of the Federal Poverty Line (*e.g.*, the patient is documented as being a qualified Medicare beneficiary, a specified low-income Medicare beneficiary, or a State-only Medicaid or state/federal SSI program where a criteria for program eligibility is being below 200% of the Federal Poverty Line). We would remand this subset of indigent write offs back to the Medicare Contractor and, in this regard, agree that the application (either written or telephone) need not be checked or probed except where Sentara itself has indicated "asset check required" in which case the Medicare Contractor should confirm that there is documentation of the asset check.

A. ***Sentara Failed to Formally Adopt and Define Its Use of Equifax in Indigence Determinations***

There was no formal adoption of using Equifax as part of the Sentara indigence determination process and neither the official Sentara Charity Care Policy nor the 2010 and 2012 PCD Indigence Policies refer to Equifax.[13] Indeed, the record does not contain ***any*** Sentara or PCD policy documents or documents adopted by Sentara or PCD from the time period at issue that describe the use of (much less even refer to) Equifax or third party credit inquires. In this regard, the record suggests that Sentara did not formally adopt and incorporate Equifax into its indigence policy until September 2015. Specifically, this September 2015 policy is identified as a Sentara policy adopted by the Sentara Board of Directors and is entitled "Financial Assistance Policy." It refers to use of third parties credit inquires as follows:

> A Hospital Facility may also utilize the income, asset, liability, expense, and other resource data from third-party credit inquiries and publicly available data sources as evidence in determining and validating an applicant's Household Income for Financial Assistance eligibility under this Policy.
>
> A presumptive determination may be made by a Hospital Facility utilizing third-party credit inquiries ***and*** publicly available data sources to determine if a patient qualifies for Financial Assistance under this policy. If ***this*** *data* suggests that such patient's Household income is at or below 200% of the then-current Federal

[13] Sentara's witness acknowledges that there was no formal adoption and attributes payment of budgetary expense for Equifax as evidence of formal adoption. *See id.* at 134-35. However, this gives no shape to the nature and extent of its adoption (*e.g.*, it could have been used solely as a bad debt collection tool and not in the patient indigence determination process). Indeed, in connection with the 2010 PCD Indigence Policy, this witness acknowledged that it does not "mention Equifax specifically, and it doesn't say that specifically it's a policy and procedure within the department, that – there is third party use of credit scoring information." *Id.* at 131. Rather, the witness stated: "I know this policy because it's internal to the department, and it requires the use of the Equifax data to perform within it." *Id*. at 131 - 132.

> Poverty Guidelines, 100% of the patient's remaining balance for Covered services may qualify to be written-off.[14]

However, these later year policy statements are not congruent with how Sentara alleges that it used Equifax during 2010 through 2013, the time period at issue. For example, Sentara has alleged that Equifax could be the sole basis for a "presumptive determination";[15] however, the above 2015 policy statement states that it must be made using "third-party inquiries *and* publically available data sources." Moreover, this is vastly different than the official Sentara Charity Policy at Exhibit P-1 that was in effect in 2010 through 2013 that simply stated, in pertinent part: "All patients with income at or below 200% of the federal poverty guideline qualify for Sentara Charity and 100% of their account balance will be written-off" and that "[t]he Sentara patient accounting department will manage this program." This statement of policy was not discussed in the "procedure" section (which only discussed certain discounts not relevant to this case).

The bottom line is Sentara's alleged practice for indigence determinations is very complex as highlighted by the detailed eight page description at Provider Exhibit P-47 that includes a description of how Equifax is used,[16] and we simply cannot shoehorn this complexity into either the 2010 or 2012 PCD Indigence Policies which were each essentially two pages long and devoid of any reference to Equifax or third party credit inquiries. We note that neither could the Majority. The Majority could only shoehorn portions of this alleged practice based on how the oblique phrases "PCD Charity Model" and "Charity model qualification" are used in the written policies.[17]

Finally, a comparison of the 2010 PCD Indigence Policy to the 2012 PCD Indigence Policy suggests that Sentara's policy was in flux between 2010 and 2012.[18] The following excerpts are from the same sections in the policy and highlight material and significant differences between the two versions and suggest that, in 2010, the written policy may have been geared towards a patient indigence program driven by written applications (referred to during the hearing as Charity by Application) where "Charity Model" played a lesser role in the overall landscape and that, in 2012, the written policy was changed to reflect the greater role of the "Charity Model":

---

[14] Exhibit I-18 at 3 (emphasis added).

[15] For example, in category AL4, Sentara may qualify a patient as indigent based solely on the Equifax report without referring to "publicly available data sources" which by its terms does not include the Equifax reports at issue since those are a commercial product and not available to the public. *See* Exhibit P-47 at 7. *See also, e.g.,* Tr. at 331-35, 497-500.

[16] We note that this summary was prepared and submitted ***after*** the hearing.

[17] *See supra* note 13 (noting that Charity Model is not a "model" but rather a "policy and procedure").

[18] It is also unclear whether the PCD adopted another intervening policy in February 2011 or whether the policy was reviewed but not revised in February 2011 since the 2012 PCD Indigence Policy lists the following dates without confirming what those dates mean: June 2, 2008; February 2009; March 2009; January 2010; February 2011; and February 2012. The development and evolution of the Charity Model is also unclear although the Providers' witness suggests that Sentara was involved with Equifax in the development of the Equifax "income predictor" scores that Sentara uses in the Charity Model policy and procedure. *See* Tr. at 264-265 (Providers' witness stating that Equifax "started developing the income predictor in the 2004/2005 time period[.]").

2010 policy	2012 policy
"3 Prospective Charity patients identified by the PCD Charity Model **and with the comment "Asset Check Required"** *in the account notes indicate that assets may be available to pay the account*. Those assets must be explored for possible payment."[19]	"3 Prospective Charity patients identified by the PCD Charity Model *will be moved to status CPM (low pay) or CIM (other).* Accounts in status AL4 **and with the comment "Asset Check Required**" in the account notes indicate that assets may be available to pay the account. Those assets must be explored for possible payment."[20]
"5 When the processing of the ***application*** is complete *by a telephone screen*[21] ***with*** *a Charity model qualification* ***or*** when a charity ***application*** along with the required documentation is received the account is moved to status CPA and letter PCHA is automatically sent. Action code 891 can be used to move the account to status CPA. The account will be assigned to desk CPA[.]"[22]	"5 When the processing of the application is complete *by a telephone screen, by a Charity model qualification,* ***or*** when a charity application along with the required documentation is received the account is moved to status CPA. Action code 891 can be used to move the account to status CPA and desk CPA."[23]

Moreover, these policies as written are confusing, particularly when so much is left out of the policy that had to be explained at the hearing and following the hearing.[24] In particular, these explanations addressed how certain paragraphs which appear to be in conflict with the *post-hoc* description of how Equifax was used in the "Charity Model" (as described in detail in Exhibit P-47) are not actually in conflict.[25] Accordingly, based on the above, we find that Sentara failed to sufficiently and contemporaneously document in the ordinary course of business how Equifax was used in its patient indigence determinations (Medicare and non-Medicare alike)[26] and that Medicare Contractor properly disallowed the indigence write offs at issue except in the limited situations described in the next section.

[19] (Emphasis added.)
[20] (Emphasis added.)
[21] During the hearing, the Provider's witness explained that that the telephone screen or application involved a Sentara employee filling out the form by telephone with the patient in lieu of a handwritten application completed by the patient. *See* Tr. at 246-248.
[22] (Emphasis added.)
[23] (Emphasis added.)
[24] For example, the 2010 and 2012 PCD Indigence Policies refer to "Charity Model" but as the Providers' witness explained it is not a "model" but a "policy and procedure within the department." Tr. at 131. The only documentation in the record that describes the Charity Model "policy and procedure" and how Equifax is used in the Charity Model "policy and procedure" is the non-contemporaneous eight page description created post-hearing and submitted as Exhibit P-47. *See also, e.g.*, Tr. at 128-33, 243-253; Provider's Post-Hearing Brief at 17-26.
[25] *See, e.g.*, Providers' Post-Hearing Brief at 17-26.
[26] *See supra* note 9 and accompanying text.

B. Applications for Patient Indigence Determinations and State Medicaid Agency Documentation of Being Below 200% of the Federal Poverty Line

We would remand these cases to the Medicare Contractor to audit the Provider files for the following subset of indigence write offs to determine if the relevant Medicare beneficiaries met the Sentara's indigence qualification standard that the applicant's "income [be] at or below 200% of the federal poverty guideline"[27] and that the Sentara policy is not intended to apply to "patients who are uninsured but who have available assets sufficient to pay for healthcare services, or whose tax-exempt or other income may not be reflected on a tax return."[28]

1. Applications for Patient Indigence

Like the Majority, we find that the 2010 and 2012 PCD Indigence Policies clearly reference and sufficiently discuss how applications (whether written or telephonic) are used in the indigence determination process. Accordingly, consistent with our finding that there is no requirement in either 42 C.F.R. § 413.89(e) or PRM 15-1 § 312 that providers *independently* verify income, resources and assets disclosed in indigence applications, we find that the Medicare Contractor should allow for reimbursement related to those patients, unmarried or married, that Sentara qualified through Charity by Application (either written or telephonic), where review of the available documentation demonstrates that the family income is less than 200% of the Federal poverty line. In this regard, if the available documentation shows that Sentara required an asset check, then the available documentation should include the results of that asset check.

2. Documentation of Being Below 200% of the Federal Poverty Line[29]

An overarching principle of both the 2010 and 2012 PCD Indigence Policies is that "[p]atients . . . who have *family* incomes not in excess of 200% of the Federal Poverty Level will be eligible to receive Sentara Charity Care."[30] We find that the Medicare Contractor improperly disallowed the bad debts at issue where there is documentation from a State Medicaid agency documenting that the patient was below 200% of the Federal Poverty Line (*e.g.*, the patient is documented as being a qualified Medicare beneficiary, a specified low-income Medicare beneficiary, or a State-only Medicaid or state/federal SSI program beneficiary where one of the criterion for program eligibility is being below 200% of the Federal Poverty Line). In this regard, the Board Minority notes that providers should be able to rely on the findings of State Medicaid agencies outside of Medicaid eligibility particularly when PRM 15-1 § 312 makes clear that Medicare beneficiaries may be deemed indigent based on a State Medicaid agency determination of Medicaid eligibility. The record is replete with examples where acceptable State Medicaid or State/Federal SSI documentation may exist. The following patient summaries from Exhibit P-11 illustrate this point:

---

[27] Exhibit P-1.
[28] Exhibit P-2 at ¶ 8; Exhibit P-22 at ¶ 8.
[29] The Majority presumably did not address this documentation issue as it would be covered and subsumed into their larger remand instructions. As the Minority disagrees with the Board, the Minority is explicitly segregating out this documentation issue.
[30] Exhibit P-2 at 1 (emphasis added); Exhibit P-22 at 1 (emphasis added).

1. Exhibit P-11 at 4—"With the hospitals [*sic*] support this patient was approved for title XIX limited Medicaid, Q1, which should pay for the patient's Medicare premiums."

2. Exhibit P-11 at 17—"The patient lives at a homeless shelter . . . ."

3. Exhibit P-11 at 35—"We met with this patient on 10/21/09 and helped him complete an application for Medicaid. Through our efforts the patient was approved for limited Medicaid coverage, Q1, to pay for the Medicare premiums, but was denied full Medicaid benefits, and was placed on a Medicaid spenddown of $2,500.23, resulting in no payment to the hospital from patient."

4. Exhibit P-11 at 37—"The account then dropped to bad debt on 1/22/09, but was soon reversed after learning that patient was a LifeNet organ donor so Medicare [*sic*[31]] had to reprocess which delayed the determination of indigency on this account."

5. Exhibit P-11 at 39—"Correspondence received from Department of Social Services 12/03/10 advising us that patient was approved for limited VMAP [the Virginia Medical Assistance Program] coverage and that they would pay Medicare premiums . . . . A patient with limited VMAP (Medicaid), title XIX, coverage would qualify for the hospital's charity program."

6. Exhibit P-11 at 48—"We contacted VMAP to see if patient had Medicaid coverage and were told that [he] did, but not eligible on that date of service and limited benefits that would pay Part B premiums only."

7. Exhibit P-11 at 49—"54 year old, married, disabled . . . . The patient also supplied a complete breakdown of the household monthly expenses totaling $1,202, received SSI statement, and 2008/2009 SSA statement for patient's husband, spouse is disabled."

In summary, we find that the Medicare Contractor properly disallowed the indigence write offs at issue except where: (a) either a written application was submitted by the patient or a Sentara employee filled out a "telephone application" consistent with Paragraph 1 of the 2010 and 2012 PCD Indigence Policies; or (b) there is documentation from a State Medicaid agency establishing that the patient was below 200% of the Federal Poverty Line (*e.g.*, the patient is documented as being a qualified Medicare beneficiary, a specified low-income Medicare beneficiary, or a State-only Medicaid or state/federal SSI program where a criteria for program eligibility is being below 200% of the Federal Poverty Line). We would remand this subset of indigent write offs back to the Medicare Contractor and, in this regard, agree that the application (either written or telephone) need not be checked or probed for verification of assets, except where Sentara itself has indicated "asset check required" in which case the Medicare Contractor should confirm that there is documentation of the asset check.

[31] It is unclear whether this is a typo or was intended to refer to Medicare as opposed to Medicaid.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA

For the Minority:

8/26/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A