PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

On the Record
2025-D47

PROVIDER –
Augusta Medical Center

Provider No.: 49-0018

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc. (J-M)

RECORD HEARING DATE –
November 29, 2023

Cost Reporting Periods Ended –
December 31, 2016, and December 31, 2017

CASE NUMBERS –
21-0710 and 22-0802

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly disallowed Augusta Medical Center's ("Augusta's" or "Provider's") Medicare Indigent bad debt claims because the Provider did not conduct asset testing.[1]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("PRRB" or "Board") finds:

The Medicare Contractor improperly disallowed all inpatient and outpatient indigent bad debt claims for the fiscal years ending ("FYE") 12/31/2016 and 12/31/2017, for which the patient received charity assistance pursuant to Augusta's Financial Assistance Policy ("FAP") without a review of the patient's assets based on the sample of 42 claims audited. Therefore, the Board ***remands*** thirty-two (32) claims (20 for FYE 12/31/2016 and 12 for FYE 12/31/2017) to the Medicare Contractor, directing that they be allowed. These claims were originally disallowed solely because there was no review of the patient's assets. The Medicare Contractor is instructed to recalculate Augusta's extrapolated allowable bad debt amounts, including these claims as allowable, based on the Board's findings.

In addition, in the case of the ten (10) Medicare indigent bad debt claims at issue for which the Medicare Contractor set forth additional rationales for disallowance, the Board finds that six (6) claims were properly disallowed as the parties have stipulated[2] or mutually agreed[3] for reasons other than Augusta's omission to conduct asset testing. These six (6) claims are FY 2016 record numbers 109, 201, 2133, and 3182, and FY 2017 record numbers 385 and 1844.

Finally, for the four (4) remaining claims under dispute, the Board finds that the Medicare Contractor's disallowance was proper, for the reasons set forth herein. These four (4) claims are FY 2016 record numbers 238 and 867, and FY 2017 record numbers 332 and 5388).

These claims were disallowed by the Medicare Contractor originally, and will remain disallowed, in accordance with the parties' stipulations/agreements.

INTRODUCTION

Augusta Medical Center is "a non-profit corporation that operates a Medicare participating acute care hospital in Virginia."[4] Augusta's assigned Medicare contractor[5] is Palmetto GBA c/o National Government Services, Inc. ("Medicare Contractor").

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[1] Provider's Consolidated Final Position Paper (hereinafter, "Provider's CFPP") at 2 (Oct. 3, 2023).
[2] *See* Stipulations at ¶ 11 (Nov. 20, 2023).
[3] Provider's response to PRRB letter Dated 5/16/2024 (May 30, 2024).
[4] Stipulations at ¶ 1.
[5] CMS's 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

During FYE 12/31/2016 and FYE 12/31/2017, Augusta claimed Medicare bad debts for its Medicare patients "who were determined to qualify as indigent ("Charity Care patients") under [Augusta's] Financial Assistance Policy ("FAP")."[6] After completing its audits, the Medicare Contractor adjusted to eliminate all of the inpatient and outpatient Medicare indigent bad debts claimed on Augusta's FYE 12/31/2016 and FYE 12/31/2017 Medicare cost reports, thus denying Augusta any reimbursement for these claims.[7]

Augusta timely appealed CMS' final determinations for the FYE 12/31/2016 and FYE 12/31/2017 and met the jurisdictional requirements for a Board hearing. The Board approved a consolidated record hearing on November 29, 2023. Augusta was represented by Daniel F. Miller, Esq. of Hall, Render, Killian, Heath & Lyman, PC. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF RELEVANT FACTS

During FYE 12/31/2016 and FYE 12/31/2017, Augusta incurred Medicare Part A and Part B bad debts for Medicare patients, which were deemed indigent by Augusta.[8] Augusta documented the method by which they determine indigence for these patients in their FAP, which was in place for all times relevant to this appeal.[9] As permitted and directed by CMS regulations and the Provider Reimbursement Manual ("PRM") guidance (see Statement of Relevant Law below), Augusta "developed and used its Charity Care program [FAP] to determine all patients' financial ability to pay for services."[10] Augusta's FAP "required that applicants submit an application [for financial assistance] and supporting documentation, particularly (a) bank statements; (b) proof of income such as recent pay stubs, unemployment insurance payment stubs or other information regarding income; (c) the applicant's most recent tax return; (d) payment history of outstanding accounts for prior hospital services; [and] (e) in some cases, information on available assets or other financial resources."[11]

As part of its audits for the fiscal years at issue, the Medicare Contractor "adjusted [Augusta's] reimbursable bad debts by disallowing all debts attributable to patients for which the [Medicare Contractor] determined that [Augusta] had not made sufficient determination of indigency."[12] The Medicare Contractor's adjustments "disallowed 100% of the sampled accounts based on a projected error rate, which resulted in the entire indigent populations being disallowed."[13] Specifically, the Medicare Contractor statistically sampled thirteen (13) inpatient and thirteen (13) outpatient indigent bad debt claims for FYE 12/31/2016,[14] and eight (8) inpatient

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Medicare administrative contractors ("MACs"). The relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" to refer to both FIs and MACs as appropriate and relevant.

[6] Provider's CFPP at 1.

[7] *Id.*

[8] *Id.*

[9] Stipulations at ¶ 2; *see also* Exhibit P-6.

[10] Provider's CFPP at 8.

[11] Stipulations at ¶ 3.

[12] *Id.* at ¶ 6.

[13] Medicare Contractor's Final Position Paper (hereinafter, "Medicare Contractor's FPP") (Case No. 21-0710) at 4. *See also*, Medicare Contractor's FPP (Case No. 22-0802) at 4.

[14] *See* Exhibit (hereinafter, "Ex.") P-5a at 3 and 5.

and eight (8) outpatient indigent bad debt claims for FYE 12/31/2017,[15] totaling forty-two (42) claims under review.

For all forty-two (42) indigent bad debt claims under review, the Medicare Contractor determined that Augusta did not consider "total resources" in its indigence determinations in accordance with PRM 15-1, Section 312(B).[16] In its cost report adjustment explanations for FYE 12/31/2017, the Medicare Contractor found that Augusta lacked "support for the assets, liabilities or expenses" for each indigent bad debt claim.[17] The Medicare Contractor's submitted audit workpaper for FYE 12/31/2017 stated that the "Provider did not submit proper documentation to show how the patients qualified for financial indigency."[18] In preparation for the record hearing, the Parties stipulated that three (3) claims identified "were improper and should be disallowed. These claims are identified as record numbers 201, 2133, and 3182."[19] Furthermore, Augusta later acknowledged that the MAC properly disallowed three (3) claims for record numbers 109, 385, and 1844.[20] Thus, in total, six (6) claims were identified as properly disallowed.

For the four (4) claims that remain under dispute for reasons other than the lack of asset testing, the Medicare Contractor has set forth the following rationales for disallowance of the bad debt claims:[21]

- Part A Bad Debt Sample #238 for FY16 – "Patient applied for financial assistance after the date of first bill (i.e., in September). The patient's application was not approved until December 2016. As a result, during the interim, the Provider billed the patient in accordance with its normal collection practices, which included referring the account to its first collection agency (PMS). A few weeks after referral to PMS, the account was approved for indigence and written off. However, PMS did not return the account to the hospital until more than 2 years later. The account cannot be claimed as a bad debt until all collection efforts have ceased and the account is returned from the applicable collection agency."[22]

- Part B Bad Debt Sample #867 for FY16 – "No documentation was supplied to support 4th child's social security income. In addition, the bank statements indicate that the family has alternate bank accounts, as money is being transferred between accounts on a regular basis. Therefore, [the Medicare Contractor] cannot confirm that patient is indigent in accordance with the Provider's [FAP] and CMS regulations."[23]

- Part A Bad Debt Sample #332 for FY17 – "The [Medicare Contractor] notes that the patient account history indicates that the patient has a part time job. No documentation

[15] *See* Ex. P-5b at 5 and 8.
[16] Medicare Contractor's FPP (Case No. 21-0710) at 4 (*citing* PRM 15-1, Section 312(B)). *See also* Medicare Contractor's FPP (Case No. 22-0802) at 4.
[17] *See, e.g.,* Ex. C-1 (Case No. 21-0710) at C-0020 and C-0021.
[18] Ex. C-2 (Case No. 22-0802) at (C-0036) and (C-0037).
[19] Stipulations at ¶ 11.
[20] Provider's Response to PRRB Letter Dated 5/16/2024. (May 30, 2024)
[21] *See* Medicare Contractor's Exhibits C-8 and C-9 in Case No. 21-0710 and Case No. 22-0802, as applicable.
[22] Ex. C-8 (Case No. 21-0710) at (C-0089).
[23] Ex. C-9 (Case No. 21-0710) at (C-0091).

was supplied to support the income from that part time job and therefore, it was not included in the indigence application/determination. In addition, the Provider imputed the patient's 2017 Social Security income based on the patient's 2015 Social Security benefit statement and the published cost of living increase percentages. The Provider's indigence policy does not allow this. Per the Provider's indigence policy, 'To apply for financial assistance, patients must submit a complete application (including supporting documents)', which includes proof of income. The [Medicare Contractor] contends that submitting obsolete and incomplete income documentation makes the indigence application incomplete and inaccurate. The [Medicare Contractor] cannot verify the patient's indigence at the time of application and the Provider did not follow its own policy."[24]

- Part B Bad Debt Sample #5388 for FY17 – "This patient was deemed presumptively eligible for indigence. However, no documentation or financial assistance application was initially supplied to support how this presumption was made. On 12/1/2022, the Provider Rep submitted additional documentation supporting the patient's PARO (Predictive Modeling for Healthcare) score, an estimated FPL and a determination regarding homeownership. However, no supporting documentation was received to support how the PARO score was calculated (even though the submitted PARO Validation Results Training Guide states that this information is available to auditors), what income and assets went into the FPL determination or what basis/source was used for identifying the patient's homeowner status. In addition, the Provider's indigence policy requires the completion of a financial assistance application and states that external sources can be used to verify patient information when documentation is not available. It does not state that the external resource can be used in lieu of a patient application. This patient received 4 bills before being written off to presumptive eligibility. However, there's no explanations [sic] for why this patient's unresponsiveness to those 4 bills is any more or less unresponsive than a traditional bad debt account and in turn why that unresponsiveness triggered a presumptive indigence determination. The [Medicare Contractor] contends that the indigence determination is not within the scope of the Provider's indigence policy and no documentation was supplied to support the indigence determination."[25]

STATEMENT OF RELEVANT LAW

For the period pertinent to this appeal (i.e., FYE 12/31/2016 and FYE 12/31/2017), Medicare addressed the costs associated with bad debt in the regulations at 42 C.F.R. § 413.89 as follows:

> (a) Principle. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost. However, subject to the limitations described under paragraph (h) of this section and the exception for services described under paragraph (i) of this section, bad debts attributable

[24] Ex. C-8 (Case No. 22-0802) at (C-0108).
[25] Ex. C-9 (Case No. 22-0802) at (C-0110).

to the deductibles and coinsurance amounts are reimbursable under the program.

(b) Definitions—

(1) Bad debts. Bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

(c) Normal accounting treatment: Reduction in revenue. Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services furnished does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

(d) Requirements for Medicare. Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not allowable costs.

(e) Criteria for allowable bad debt. A bad debt must meet the following criteria to be allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

(2) The provider must be able to establish that reasonable collection efforts were made.

(3) The debt was actually uncollectible when claimed as worthless.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

(f) Charging of bad debts and bad debt recoveries. The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

(g) Charity allowances. Charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs. These charity allowances include the costs of uncompensated services furnished under a Hill–Burton obligation. (Note: In accordance with section 106(b) of Pub.L. 97–248 (enacted September 3, 1982), this sentence is effective with respect to any costs incurred under Medicare except that it does not apply to costs which have been allowed prior to September 3, 1982, pursuant to a final court order affirmed by a United States Court of Appeals.) The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

(h) Limitations on bad debts—

(1) Hospitals. In determining reasonable costs for hospitals, the amount of allowable bad debt (as defined in paragraph (e) of this section) is reduced:

(i) For cost reporting periods beginning during fiscal year 1998, by 25 percent;

(ii) For cost reporting periods beginning during fiscal year 1999, by 40 percent;

(iii) For cost reporting periods beginning during fiscal year 2000, by 45 percent; and

(iv) For cost reporting periods beginning during fiscal years 2001 through 2012, by 30 percent.

(v) For cost reporting periods beginning during a subsequent fiscal year, by 35 percent.

[. . .]

> (i) Exceptions applicable to bad debt reimbursement.
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> > (1) Bad debts arising from covered services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program.
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> > (2) For end-stage renal dialysis services furnished on or after January 1, 2011 and paid for under the end-stage renal dialysis prospective payment system described in § 413.215, bad debts arising from covered items or services that, prior to January 1, 2011 were paid under a reasonable charge-based methodology or a fee schedule, including but not limited to drugs, laboratory tests, and supplies are not reimbursable under the program.

The Centers for Medicare & Medicaid Services ("CMS") provides additional guidance on its bad debt policy in the Provider Reimbursement Manual ("PRM"), CMS Pub. No. 15-1 ("PRM 15-1"):

> 310. REASONABLE COLLECTION EFFORT
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> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See §312 for indigent or medically indigent patients.)
>
> A. Collection Agencies.--A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient,

Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

B. Documentation Required.--The 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.

310.1 Collection Fees.--Where a provider utilizes the services of a collection agency and the reasonable collection effort described in §310 is applied, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.

When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs. For example, where an agency collects $40 from the beneficiary, and its fee is 50 percent, the agency keeps $20 as its fee for the collection services and remits $20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency ($40) in the patient's account receivable and records the collection fee ($20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service, and, therefore, is not treated as a bad debt.

310.2 Presumption of Noncollectibility.--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.

312. INDIGENT OR MEDICALLY INDIGENT PATIENTS

In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:

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 indigency;
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> 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;
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> 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
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> 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.
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> Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures. (See §322 for bad debts under State Welfare Programs.)[26]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Indigency Determinations

Augusta states that the disallowance of its "claimed bad debts related to unpaid Medicare coinsurance and deductible amounts for the Provider's qualified Charity Care patients was based on the Medicare Contractor's determination that Augusta did not submit "[a]n analysis and necessary documentation needed to verify proof of patients' assets and expenses." The Medicare Contractor faulted Augusta for making an indigency determination "based on income only."[27]

Augusta contends that it "properly made patient indigency determinations according to its Charity Care Program's Financial Assistance Policy."[28] Augusta "required applications and supporting documentation" in making its indigency determinations.[29] Documents supporting such indigency determinations included information about household income, Social Security Numbers and benefit letters, employment status, pay stubs, and tax returns.[30]

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[26] PRM 15-1 §§ 310 – 312, *also available a*t Ex. P-9.
[27] Provider's CFPP at 4.
[28] *Id.* at 7.
[29] *Id.* at 7, 10.
[30] *Id.* at 10-11.

Augusta explains that "[s]ome of the Charity Care applicants did not file tax returns" due to low income; instead, the FAP allowed for alternative documentation, such as pay stubs, income tax returns, bank statements, or Social Security award letters, to verify income.[31] Augusta argues this type of alternative documentation was deemed acceptable for verifying income and resources in the case of *Faxton-St. Luke's Healthcare v. National Government Services, Inc.*, PRRB Dec. No. 2015-D25.[32] In *Faxton-St. Luke's Healthcare*, the Board found "that Faxton – St. Luke's indigency policy complie[d] with PRM-I § 312 . . . [and] that Faxton – St. Luke's exercised due and sufficient diligence in determining indigency by consistently obtaining and reviewing substantive and pertinent documents including Social Security benefit information, the State Medicaid medical assistance determinations, and a questionnaire of expenses."[33]

Augusta supports its position by explaining that bank statements are reasonable because they show income sources and withdrawals.[34] Augusta was able to identify regular Social Security deposits and other income sources, considering it a reasonable verification method for those without tax returns.[35] Further, Augusta contends verifying a patient's indigency with evidence of SSI payments is reasonable because the Social Security Administration does not allow for benefits unless an individual meets the program's income and asset criteria.[36]

The Medicare Contractor maintains that Augusta should have also reviewed a patient's *assets*.[37] The Medicare Contractor argues that if Augusta does not ask for asset information (e.g., through its FAP, application, or an interview process) some patients may not list assets like pensions and retirement accounts "since they are not a steady or regular stream of cash" (i.e., may not be considered income).[38] The Medicare Contractor also argues that Augusta provided no evidence or documentation to show that Augusta cross-verified SSI or verified "income and assets with 'recent bank statements.'"[39]

The Medicare Contractor also argues that Augusta should have reviewed "at least the same substantive financial resources that a State would use to determine Medicaid eligibility."[40] The Medicare Contractor refers to the financial testing that the Commonwealth of Virginia – where Augusta is located – would have required, such as "countable resources of not more than $2,000 for one person or $3,000 for a couple. Resources are things such as bank accounts (checking, savings, certificates of deposit, Christmas club, etc.), stocks, bonds, the cash value of some life insurance policies, property that does not adjoin your home, etc."[41]

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[31] *Id.* at 11.
[32] *Id.* at 13, *See also* Ex. P-15.
[33] Ex. P-15B at (AMCFPP0898) (PRRB Decision 2015-D25 (Sept. 22, 2015)).
[34] Provider's CFPP at 11.
[35] *Id*.
[36] *Id.* at 12.
[37] Medicare Contractor's FPP at 11. (The Medicare Contractor's Final Position Papers for Case Numbers 21-0710 and 22-0802 are substantially the same; therefore, the Board cites to the Medicare Contractor's Final Position Paper for Case No. 21-0710 unless differentiation is warranted.)
[38] *Id.* at 15.
[39] *Id.* at 16.
[40] *Id.* at 10.
[41] *Id.* at 9, *citing* Commonwealth of Virginia Department of Medical Assistance Services Medical Assistance Handbook (effective 6/1/2019), available at https://coverva.dmas.virginia.gov/media/1152/medical-assistance-handbook_2019_-12142021-rev-final.pdf (last accessed Sept. 4, 2025).

The Medicare Contractor disallowed all sampled indigent bad debt accounts based on a projected error rate, resulting in the entire indigent population being disallowed. This was because total resources were not used for Augusta's indigence determinations, as the Medicare Contractor claims is required by PRM 15-1, Section 312(B)[42], which states:

> 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;[43]

Specifically, the Medicare Contractor "disallowed bad debts attributable to individuals that had applied for and received assistance pursuant to [Augusta's FAP] because the [FAP] did not require a review of the patient's/applicant's assets."[44]

Augusta states that the Medicare Contractor's "imposition of a mandatory asset testing protocol has been consistently rejected by the Board and the federal courts that have considered the issue."[45] To that end, Augusta points to the district court's decision in *Baptist Healthcare System v. Sebelius*.[46] In *Baptist*, the court concluded "that the words must and should are not synonymous neither in the context of government regulations and manuals nor in everyday usage" and therefore, an asset test was not necessary to find that a Medicare beneficiary is indigent.[47] August notes that "[t]he Board applied the holding in the *Baptist* decision again in its decision in *University of Wisconsin Hospitals and Clinics Authority v. National Government Services*, PRRB Dec. No. 2019-D36" wherein the Board rejected the "contention that Section 312 of the PRM creates mandatory requirements for asset and total resource testing as a part of an indigency determination."[48]

Augusta further refutes the Medicare Contractor's argument by pointing out that "CMS imposed a mandatory asset testing protocol through rulemaking in 2020, but it does not apply to the fiscal years in question."[49] Augusta notes that in 2020 CMS did publish a proposed rule, which stated:

> Over the past several years, the criteria set forth in PRM section 312 regarding the determination of indigence have been the subject of litigation as questions have been raised as to whether the criteria are mandatory. In this proposed rule, we are proposing to clarify and codify our longstanding policy and criteria set forth in PRM

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[42] *Id.* at 4.
[43] PRM 15-1 § 312(B) (emphasis added).
[44] Stipulations at ¶ 7.
[45] Provider's CFPP at 12.
[46] *Baptist Healthcare Sys. v. Sebelius*, 646 F. Supp. 2d 28 (D.D.C. 2009).
[47] *Id.* at 33.
[48] Provider's CFPP at 15; *see also* Ex. P-16.
[49] Provider's CFPP at 15.

> section 312 A. through D. (setting for the requirements for a facility's determination of indigency.
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> * * *
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> We are also proposing to amend §413.89(e)(2) by adding new paragraph (e)(2)(ii)(A) to specify that to determine a beneficiary to be an indigent non-dual eligible beneficiary, the provider must apply its customary methods for determining whether the beneficiary is indigent under the following requirements: (1) The beneficiary's indigence must be determined by the provider, not by the beneficiary; that is, a beneficiary's signed declaration of their inability to pay their medical bills and/or deductibles and coinsurance amounts cannot be considered proof of indigence; (2) the provider *must take into account* a beneficiary's total resources which includes, but is not limited to, *an analysis of assets* (only those convertible to cash and unnecessary for the beneficiary's daily living), liabilities, and income and expenses. While a provider must take into account a beneficiary's total resources in determining indigence, any extenuating circumstances that would affect the determination of the beneficiary's indigence must also be considered; and (3) the provider must determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill; for example, a legal guardian.
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> * * *
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> In this proposed rule, we are proposing that these revisions would be effective for cost reporting periods beginning before, on and after the effective date of this rule because they are clarifications and codifications of longstanding Medicare policies.[50]

When CMS initially proposed these regulatory changes, they were to be applied *retroactively, as stated in the proposal*.[51] However, in the final rule CMS determined that the changes amending 42 C.F.R. § 413.89(e)(2) to include a requirement that providers utilize a mandatory income and asset testing process would be applied *prospectively* to cost reports beginning on or after October 1, 2020. [52] Thus, Augusta maintains the FY 2021 Final Rule does not apply to the instant cases.[53]

The Medicare Contractor, however, argues that it "followed the interpretation of the Secretary for this issue based on PRM 15-1, Section 312(B), which requires total resources to be analyzed

[50] *See* 85 Fed. Reg. 32460 at 32871-72 (May 29, 2020) (emphasis added).
[51] *See* 85 Fed. Reg. 32872.
[52] *See* 85 Fed. Reg. 58432, 58989-99 (Sep. 18, 2020).
[53] Provider's CFPP at 15-16.

to determine indigence."[54] Indeed, Medicare contractors have taken this position in other cases before the Board.[55]

The Board reviewed the statute, regulations, PRM, and case law and rejects the Medicare Contractor's argument that PRM 15-1 § 312.B and 312.D *required* Augusta to apply asset tests when making indigency determinations. While the Board acknowledges that the CMS Administrator has interpreted PRM § 312 to "create a mandatory asset test,"[56] that interpretation was rejected by the District Court for the District of Columbia in *Baptist Healthcare System v. Sebelius ("Baptist")*. [57] In the *Baptist* decision, the court found "[t]he Administrator's conclusions stand in stark contrast to the Agency's unequivocal statement that, a hospital may determine its own individual indigency criteria" and that PRM § 312 paragraphs B and D "are best construed as strong, but ***non****compulsory* recommendations."[58] The Board concurs with the District Court's holding in *Baptist* on this issue, and finds that it was improper for the Medicare Contractor to interpret PRM § 312 paragraphs B and D as mandatory requirements for Augusta to evaluate a patient's assets as part of its determination of indigence. Consistent with its prior decisions, the Board finds that the Medicare Contractor improperly imposed a mandatory asset testing protocol in evaluating Augusta's FAP.

Augusta makes an argument for patients whose income is too low to file an income tax return stating that it could obtain bank statements. The bank statements would document repeated deposits from the Social Security Administration as well as other income sources and withdrawals for patients' expenses that were reported on their FAP applications.[59] The Medicare Contractor notes Augusta's argument that its FAP "could require the submission of pay stubs or the most recent income tax return for some patients and that the income tax return would substantiate income from all sources, dividends earned from stocks, interest earned from savings accounts and/or other assets."[60] In this regard, the Medicare Contractor points out that for FYE 12/31/2016, for the twenty-six sampled bad debt claims, "a tax return was only submitted for one patient and a bank statement was only submitted for two patients,"[61] while, for FYE 12/31/17, neither a tax return nor a bank statement was submitted for any of the sixteen sampled bad debt claims.[62] The Medicare Contractor faults Augusta for not spelling out in its FAP when tax return and bank statement verification is "warranted" and who warrants it.[63]

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[54] Medicare Contractor's FPP at 17-18.
[55] *See, e.g.*, *Faxton-St. Luke's Healthcare v. National Government Services, Inc.*, PRRB Dec. No. 2015-D25; *University of Wisconsin Hospitals and Clinics Authority v. National Government Services*, PRRB Decision 2019-D36; *Baptist Healthcare System v. Sebelius*, 646 F.Supp.2d 28 (D.D.C. 2009); *Harris County Hosp. Dist. v. Shalala*, 863 F.Supp. 404 (S.D.Tex.1994); *Sentara Hospitals, et al. v. Azar*, 2022 WL 910514 (D.D.C.3/29/2022).
[56] *See Baptist Regional Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec., 7 (Feb. 8, 2008), *reversing*, PRRB Dec. No. 2008-D12 (Dec. 10, 2007).
[57] *Baptist*, 646 F. Supp. 2d 28 at 34 (D.D.C. 2009).
[58] *Id*. (emphasis added).
[59] Provider's CFPP at 11.
[60] Medicare Contractor's FPP at 14.
[61] Medicare Contractor's FPP (Case No. 21-0710) at 15.
[62] Medicare Contractor's FPP (Case No. 22-0802) at 15.
[63] Medicare Contractor's FPP (Case Nos.21-0710 and 22-0802) at 14-15 (Emphasis included).

The Board reviewed the four (4) claims that were disallowed for reasons other than asset testing and are still in dispute[64] and finds that the Medicare Contractor's adjustment was proper.

For claim #238 in FYE 12/31/2016, the regulation at 42 C.F.R. § 413.89(e)(3) and (4) (2015) requires that "[t]he debt was actually uncollectible when claimed as worthless. . . . [and] [s]ound business judgment established that there was no likelihood of recovery at any time in the future." The Medicare Contractor's audit work indicates that Augusta claimed this account as indigent while it was still with the collection agency.[65] In response, Augusta only argues that the "patient was screened for Medicaid, but was over the limit."[66] No mention is made as to why the claim remained at the collection agency for over 2 years. The bad debt account would properly have been deemed worthless when it was transferred from the collection agency[67] back to Augusta on 4/11/2019, not on the date when the patient financial assistance application was approved in December of 2016.[68] As such, it was not an allowable bad debt in FYE 12/31/2016.

Claim #867 in FYE 12/31/2016 is an example of the Medicare Contractor's argument that the indigent determination was not properly documented.[69] The bank statements submitted as evidence show deposit transfers from other accounts on a regular basis, while the income reported on the FAP application is not reconcilable to the data in the supporting documents.[70] The supporting evidence provided shows evidence of 3 separate payments from Social Security (two disability and one not), plus separate payments from Social Security of smaller additional monthly amounts. One pay summary from an employer shows an average monthly income of just over $700. However, the household consists of 5 individuals, per the FAP, the patient and 3 sons and 1 daughter. There is only income data for 4 individuals, and the amounts give do not reconcile to the amount reported for 2015 on the FAP.[71] The documentation is not sufficient to support the conclusions of the Provider.

Similarly, claim #332 in FYE 12/31/2017 shows notes in the patient account details that the patient had part-time work in FYE 12/31/2017 but there is no evidence that this was verified with documents such as paystubs. Ultimately, the patient's FYE 12/31/2017 income was imputed exclusively based on the patient's 2015 Social Security benefit statement and an assumed cost of living increase of 0.003%.[72] The 2015 statement used for these calculations indicates a 1.7% increase from 2014 to 2015 for cost of living.[73] Yet, no increase has been accounted for in 2016, and the amount used for 2017 is less than 20% of the amount of increase from 2014 to 2015. This application violates the Provider's FAP which states:

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[64] Note, the parties agreed/stipulated that 6 of the 10 claims disallowed by the MAC for reasons other than assets testing was proper.
[65] Ex. C-8 at (C-0089) (Case No. 21-0710).
[66] Provider's Response to PRRB Letter Dated 5/16/2024 at 1 (May 30, 2024).
[67] The collection agency was denoted as "PMS."
[68] Ex. P-7A at AMCFPP0377-0379. See also Ex. C-8 at (C-0089).
[69] Medicare Contractor's FPP (Case No. 22-0710) at 15.
[70] Ex. P-7A at AMCFPP 0229-00240 and Ex. C-9 at (C-0091).
[71] Ex. P-7A at AMCFPP0229-0240.
[72] Ex. P-7B at AMCFPP 0579-0588.
[73] *Id.* at AMCFPP0588.

> [i]n addition to completing an application, individuals should be prepared to supply the following documentation:
> - bank statements
> - proof of income for applicant (and spouse if applicable), such as recent pay stubs (3 months' worth), unemployment insurance payment stubs, or sufficient information on how patients are currently supporting themselves.[74]

Lastly, there is discussion, but no evidence in the record, as to whether Augusta followed its FAP to assist in qualifying the patient for "other means of payment (e.g., Medicaid, other local funding programs) BEFORE approval for financial assistance."[75] Patient account notes indicate that the patient was "[R]ej[ected] over income, did discuss if stops working part time job, can do SLMB program. Patient will get back in touch with me."[76] No mention is made of further pursuing the Medicaid SLMB program in the patient account.

For claim #5388 in FYE 12/31/2017, the Medicare Contractor's audit notes indicate that presumptive eligibility for indigence was used, including a predictive score from Predictive Modeling for Healthcare (PARO) technology, but that no documentation was provided to support the calculation of that score, nor was a completed financial assistance application provided.[77] Further, the Medicare Contractor notes that the Review of Validation Results for 2017 provided by PARO, for Augusta Health, indicates that an "important consideration" is that "PARO Presumptive scoring **does not replace traditional FAP application** processes; it is used to supplement these efforts."[78] This document also indicates that the FAP requires specific language, including, "[t]he patient's eligible through this process will not be assigned to bad debt."[79] However, Augusta's Financial Assistance Policy[80] does not incorporate this language. In fact, Augusta's FAP only states that "[e]xternal, public sources like credit scores may also be used to verify eligibility as well."[81] It does not say that this will replace an application. Augusta's position is that the "use of PARO scores is consistent with Provider's FAP" because the "FAP states that external and public sources, including credit scores may also be used to verify eligibility." Specifically, these scores are used "when a patient is not responsive to [Augusta's] efforts to establish indigency."[82] Augusta also cites to a previous Board decision and the related D.C. District Court case, *Sentara Hospitals, et al. v. Azar*.[83] In its decision, the Board found that the Equifax income predictor and payment scores "comport with Sentara's written Charity Care Policy regarding income verification for [unmarried patients]."[84] In Augusta's case, its FAP is not the same as Sentara's. Further, these scores were only deemed

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[74] Ex. P-6 at (AMCFPP0119).
[75] *Id.* at (AMCFPP0115) (capitalization in original).
[76] Ex. P-7B at AMCFPP0579.
[77] Ex. C-9 (Case No. 22-0802) at (C-0110). *See also* Medicare Contractor's FPP (Case No. 22-0802) at 17.
[78] Ex. P-7B at AMCFPP0710 (emphasis in original).
[79] *Id*.
[80] Ex. P-6.
[81] *Id*. at AMCFPP0119.
[82] Provider's Responsive Brief at 8.
[83] No. 20-CV-3771 (CRC), 2022 WL 910514 (D.D.C. Mar. 29, 2022). *See also* PRRB Decision 2020-D17 (Aug. 26, 2020).
[84] PRRB Decision 2020-D17 at 2 (Aug. 26, 2020).

appropriate for unmarried patients, as these credit scores do not address household income, and therefore the Medicare contractor's bad debt disallowances for married patients who solely used such scores were upheld by the Board in that same decision.[85] The supporting documentation provided by Augusta for this claim does not address the marital status of the patient, nor whether anyone else is in the household.[86] More importantly, Augusta's policy clearly states the following:

> Determinations for eligibility for free care will *require* patients to submit a complete financial assistance application (including all documentation required by the application) and may require appointments or discussion with hospital financial counselors. . . . Additionally, Augusta Health may refer to or rely on external sources and/or other program enrollment resources *if uninsured patients lack documentation that supports eligibility.* For example, Augusta Health may provide free care when:
> - Patient is homeless
> - Patient is eligible for other state or local assistance programs that are unfunded
> - Patient is eligible for food stamps or subsidized school lunch program
> - Patient is eligible for a state-funded prescription medication program
> - Patient's valid address is considered low-income or subsidized housing
> - Patient receives free care from a community clinic and is referred to hospital for further treatment.[87]

This does not indicate that no application will be completed, just that the external sources may be used or relied upon if the patient lacks documentation to support eligibility. There is no application provided in this record. Thus, Augusta did not follow its policy which requires patients "to submit a complete financial assistance application."[88]

DECISION AND ORDER

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board finds:

The Medicare Contractor improperly disallowed all inpatient and outpatient indigent bad debt claims for the fiscal years ending 12/31/2016 and 12/31/2017, for which the patient received charity assistance pursuant to Augusta's Financial Assistance Policy without a review of the patient's assets based on the sample of 42 claims audited.

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[85] *Id.* at 3.
[86] Ex. P-7B at AMCFPP0698-0706.
[87] Ex. P-6 at (AMCFPP0117) (italics emphasis added).
[88] *Id.*

Therefore, the Board ***remands*** thirty-two (32) claims (20 for FYE 12/31/2016 and 12 for FYE 12/31/2017) to the Medicare Contractor, directing that they be allowed. These claims were disallowed solely because there was no review of the patient's assets. The Medicare Contractor is instructed to recalculate Augusta's extrapolated allowable bad debt amounts, including these claims as allowable, based on the Board's findings.

In addition, in the case of the ten (10) Medicare indigent bad debt claims at issue for which the Medicare Contractor set forth additional rationales for disallowance, the Board finds that six (6) claims were properly disallowed as aforementioned and stipulated[89] or mutually agreed[90] for reasons other than Augusta's omission to conduct asset testing. These six (6) claims are FY record numbers 109, 201, 2133, and 3182, and FY 2017 record numbers 385 and 1844.

Finally, for the four (4) remaining claims under dispute, the Board finds that the Medicare Contractor's disallowance was proper, for the reasons set forth herein. These four (4) claims are FY 2016 record numbers 238 and 867, and FY 2017 record numbers 332 and 5388).

BOARD MEMBERS PARTICIPATING

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FOR THE BOARD:

9/25/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A

[89] Stipulations at ¶ 11.
[90] Provider's Response to PRRB Letter Dated 5/16/2024 at 1 (May 30, 2024).