

**PROVIDER REIMBURSEMENT REVIEW BOARD  
DECISION**

2026-D12

**PROVIDER –**  
Norton Hospital

**RECORD HEARING DATE –**  
May 17, 2024

**PROVIDER NO. –** 18-0088

**FISCAL YEAR END–** 12/31/2014,  
12/31/2015, 12/31/2016

**vs.**

**MEDICARE CONTRACTOR –**  
CGS Administrators

**CASE NO. –** 17-1597, 19-0027, 19-0618

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**ISSUE STATEMENT:**

Whether the MAC's adjustments disallowing bad debt claims with respect to indigent patients were proper, in view of the Provider's Financial Assistance Policy ("FAP"), and the criteria set forth in 42 C.F.R. § 413.89 and the Medicare Provider Reimbursement Manual ("PRM 15-I") at Section 312.<sup>1</sup>

**DECISION:**

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly disallowed the bad debt reimbursement for Record #325 and Record #2029. For the remaining records, the Board finds that the Medicare Contractor incorrectly disallowed the bad debt reimbursement for these records based upon an improper interpretation that an asset test was mandatory in making indigency determinations. The Medicare Contractor is directed to reconsider Norton Hospital's bad debt reimbursement without a mandatory asset test for these records.

**INTRODUCTION AND PROCEDURAL HISTORY:**

Norton Hospitals, Inc. ("Norton Hospital" or the "Provider") is a non-profit corporation that operates Medicare-participating acute care hospitals in Kentucky.<sup>2</sup> Norton Hospital's designated Medicare administrative contractor<sup>3</sup> is CGS Administrators ("Medicare Contractor" or "MAC").

On December 7, 2016, Norton Hospital's Notice of Program Reimbursement ("NPR") for Fiscal Year Ending ("FYE") December 31, 2014 was issued by the Medicare Contractor.<sup>4</sup> Subsequently on May 31, 2017, the Board received Norton's individual appeal request.<sup>5</sup> On June 5, 2017, the Board responded with the issuance of an Acknowledgement and Critical Due Dates Letter.<sup>6</sup> Before the hearing, and based on the parties' respective position papers, a Partial Administrative Resolution was reached on July 2, 2019, resolving the "Bad Debts – Must Bill" portion of the appeal. However, the parties were unable to reach an agreement on the issue of "Bad Debts – Indigence Determination" which focused upon differing interpretations by the parties of 42 C.F.R. § 413.89 and the Provider Reimbursement Manual ("PRM") 15-1, Section 312, relating to the verification of assets.<sup>7</sup>

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<sup>1</sup> Provider's Consolidated Final Position Paper (hereinafter, "Provider's Cons. FPP") at 2 (Dec. 4, 2023); *see also* Medicare Contractor's Final Position Paper (hereinafter, "Medicare Contractor's FPP") at 6 (Jan. 4, 2024)

<sup>2</sup> Stipulations in Support of Joint Request for Record Hearing (hereinafter "Stip.") at ¶ 1 (Apr. 2, 2024).

<sup>3</sup> 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 Medicare administrative contractors ("MACs"). The relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.

<sup>4</sup> Exhibit (hereinafter, "Ex.") P-1.

<sup>5</sup> Ex. P-2.

<sup>6</sup> Ex. P-3.

<sup>7</sup> Ex. P-4.

On April 25, 2018, Norton Hospital's NPR for FYE December 31, 2015 was issued by the Medicare Contractor.<sup>8</sup> The Board received Norton's individual appeal request on October 10, 2018.<sup>9</sup> The Board issued an Acknowledgement and Critical Due Dates Letter on November 5, 2018.<sup>10</sup> Before the hearing, "the parties reached a partial administrative resolution that was processed as a reopening."<sup>11</sup> On August 20, 2020, a Notification of Pending Reopening was issued which included the Medicare Administrative Contractor's Supporting Analysis.<sup>12</sup>

On July 18, 2018, Norton Hospital's NPR for FYE December 31, 2016 was issued by the Medicare Contractor.<sup>13</sup> Subsequently, on January 10, 2019, Norton submitted its individual appeal request for that final determination.<sup>14</sup> On February 4, 2019, the Board issued an Acknowledgement and Critical Due Dates Letter.<sup>15</sup> On July 2, 2019, the parties reached a Partial Administrative Resolution, resolving the "Bad Debts – Refund" portion of the appeal, and resolving one outpatient bad debt record, but were unable to reach an agreement on issue of "Bad Debts – Indigence Determination" which focused upon differing interpretations by the parties of 42 C.F.R. § 413.89 and the Provider Reimbursement Manual ("PRM") 15-1, Section 312, relating to the verification of assets.<sup>16</sup>

Following these administrative resolutions, Norton Hospital continued to pursue its appeal for the disallowance of indigent care bad debt reimbursement for FYEs 2014, 2015, and 2016.

The Board issued hearing notices for FYE 2014 (Case No. 17-1597) and FYE 2015 (Case No. 19-0027) on June 21, 2023 and June 23, 2023 respectively.<sup>17</sup> The hearings for FYE 2014 and 2015 were later combined with FYE 2016 (Case No. 19-0618) as part of Norton Hospital's request for a consolidated hearings which was filed on June 29, 2023, and which the Board approved on July 6, 2023.<sup>18</sup> On April 2, 2024, the parties requested a record hearing, which the Board granted on May 17, 2024.<sup>19</sup>

As part of the parties' stipulations for the record hearing, and prior to the Board's approval of the record hearing, the parties resolved many of the indigent care bad debt records previously in dispute through a partial administrative resolution.<sup>20</sup> For the remaining disputed records, the parties stipulated to certain issues and facts.<sup>21</sup> Specifically, the parties have limited the issues presented to the Board as:

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<sup>8</sup> Ex. P-9.

<sup>9</sup> Ex. P-10.

<sup>10</sup> Ex. P-11.

<sup>11</sup> Provider's Cons. FPP at 3.

<sup>12</sup> Ex. P-12.

<sup>13</sup> Ex. P-17.

<sup>14</sup> Ex. P-18.

<sup>15</sup> Ex. P-19.

<sup>16</sup> Ex. P-20.

<sup>17</sup> See Ex. P-24, P-25.

<sup>18</sup> See Ex. P-26, P-27.

<sup>19</sup> See Request for Record Hearing Pursuant to Provider Reimbursement Review Board Rule 32.4, which includes the parties' Stipulations in Support of Joint Request for Record Hearing (Apr. 2, 2024).

<sup>20</sup> Stip. at ¶¶ 11-13. See also Partial Administrative Resolution, filed in OH CDMS (Jun. 6, 2024).

<sup>21</sup> *Id.* at ¶ 14 and ¶ 15.

(1) whether asset testing is mandatory or optional;<sup>22</sup> and

(2) with respect to the Specified Low Income Medicare Beneficiaries (“SLMB”) in Records 325 and 2029, did Norton Hospital follow its financial assistance policy (“FAP”) and “whether the Kentucky Medicaid program’s determinations that the patients qualify as SLMBs are sufficient to meet the presumption of indigence provision set forth in PRM Sec. 312.”<sup>23</sup>

Norton Hospital was represented by Daniel Miller of Hall, Render, Killian, Heath & Lyman, P.C. The Medicare Contractor was represented by Joseph Bauers of Federal Specialized Services.

### **STATEMENT OF RELEVANT FACTS:**

The Medicare Contractor adjusted Norton Hospital’s indigent care bad debt reimbursement for fiscal years 2014 through 2016 “based upon its determination that Provider’s FAP did not require [Norton Hospital] to consider the patient’s assets in its determination of indigency, in contravention of section 312 of the PRM.”<sup>24</sup>

Norton Hospital provides financial assistance to certain low-income patients, including Medicare patients, who meet eligibility requirements.<sup>25</sup> Norton Hospital’s applicable written Financial Assistance Policy (for all fiscal years at issue) describes the qualifications/requirements for the program.<sup>26</sup> Norton Hospital’s financial assistance policy required applicants to submit an application with documentation based on their individual circumstances.<sup>27</sup>

The Financial Assistance Policy also describes circumstances not requiring an application such as Presumptive Medicaid recipients, Qualified Medicare Beneficiary (“QMB”) Medicaid recipients, Out of State Medicaid recipients, and patients who are Medicaid eligible in the month immediately prior to or following the date of services.<sup>28</sup> The Financial Assistance Policy in effect for FYs 2014 and 2015 also allowed for management approval of financial assistance without an application for “a Medicaid patient receiving services that are medically necessary but not covered by Medicaid (speech therapy, self administered drug charges for Medicare and Medicaid eligible patients), patients that are approved directly by Kosair Charity Administration, and those patients that have a valid U of L Class Card dependent on the category classification level.”<sup>29</sup> While the Financial Assistance Policies in effect for FY 2016 do not include these additional categories, they do include “[p]atients who have been determined to be FAP-eligible within the preceding six (6) months.”<sup>30</sup>

<sup>22</sup> *Id.* at ¶ 17.

<sup>23</sup> *Id.* at ¶ 14.

<sup>24</sup> *Id.* at ¶ 6. *See also* Provider’s FPP at 1.

<sup>25</sup> *See* Ex. P-7A (Provider’s Financial Assistance Policy for FYs 2014 and 2015) and P-7B (Provider’s Financial Assistance Policies for FY 2016).

<sup>26</sup> *Id.*

<sup>27</sup> *See* Stip. at ¶ 3; *see also* Ex. P-7A at NHFPP0185 and Ex. P-7B at NHFPP0192 (reflecting policy number 3549.2 effective Jan. 1, 2016) and NHFPP0202-203 (reflecting policy number 3549.6 effective Nov. 10, 2016).

<sup>28</sup> *See* Ex. P-7A at NHFPP0186 and Ex. P-7B at NHFPP0192 and NHFPP0203.

<sup>29</sup> Ex. P-7A at NHFPP0186.

<sup>30</sup> Ex. P-7B at NHFPP0192 and NHFPP0203.

In addition, the factors considered to qualify patients for financial assistance are outlined in the 2014/2015 policy, as follows:

In order to qualify for Norton charity, a patient's household income and resource/asset limits must meet Norton's guidelines, which state that a "household" is composed of people who share the same residence and expenses. Individuals living alone may also be considered a household. "Income" is the total money received by all household members from all sources during the previous 12 months. If the patient is currently unemployed, but was working the previous 11 months, those months will be included in this calculation. Future inpatient or outpatient services are not guaranteed for Norton Charity. The resource determination will be made based on liquid and non-liquid assets. Exclusions to the resource determination are made for a portion of equity for automobiles, 401K/403B/IRA accounts, some real-estate, and certain burial arrangements/plans. Certificate of Deposits/CDs, will be considered in the total of resources/assets. The specific exclusions and limits are outlined on the Charity Matrix attached.<sup>31</sup>

Norton Hospital's Financial Assistance Policy, effective November 10, 2016, requires that, to be eligible for financial assistance, "[t]he patient's family unit resources / assets are equal to or less than 200% of the DSH guidelines"<sup>32</sup> where "A family unit's resources/assets include both liquid (cash, bank accounts, certificates, of deposit, etc.) and non-liquid assets although certain exclusions exist..."<sup>33</sup>

Further, as highlighted by the Medicare Contractor, Norton Hospital's Internal Operational Worksheet for Financial Assistance, effective April 1, 2014, states that "the liquid and non-liquid assets are both counted in the resources guidelines, Cash on hand, checking/saving and money market accounts, CD's, stocks/bonds."<sup>34</sup>

The evidence indicates that Norton Hospital submitted patients' tax returns to substantiate its verification of total resources for certain sampled records.<sup>35</sup> In addition, Norton Hospital submitted Medicaid eligibility documentation for certain other patients.<sup>36</sup> Norton Hospital also submitted various exhibits for specific sampled records as evidence of patient indigency and/or income.<sup>37</sup>

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<sup>31</sup> Ex. P-7A at NHFPP0185.

<sup>32</sup> Ex. C-9 at C00103; *see also* Medicare Contractor's FPP at 44.

<sup>33</sup> Ex. C-9 at C00104; *see also* Medicare Contractor's FPP at 44.

<sup>34</sup> Medicare Contractor's FPP at 43, citing Ex. C-8 at C00101.

<sup>35</sup> *See* Medicare Contractor's FPP at 45.

<sup>36</sup> *See* Provider's Responsive Position Paper at 8, citing Ex. P-15.

<sup>37</sup> *See* Provider's Responsive Position Paper at 9 – 10.

**STATEMENT OF RELEVANT LAW:***A. 42 C.F.R. § 413.89 Bad Debts, charity, and courtesy allowances.*

For the period pertinent to this appeal (*i.e.*, FYEs 12/31/2014, 12/31/2015, and 12/31/2016), Medicare addressed the costs associated with bad debt in the regulations at 42 C.F.R. § 413.89 (2013) 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 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.

(2) Charity allowances. Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill–Burton obligation are considered as charity allowances.

(3) Courtesy allowances. Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(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:

[ . . . ]

(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.

(1) Bad debts arising from covered services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program.

*B. Provider Reimbursement Manual Guidance*

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

**310. REASONABLE COLLECTION EFFORT**

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.

\* \* \*

310.2 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;

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.

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.)<sup>38</sup>

#### *A. Standard of Review and Burden of Proof*

A Board decision must include findings of fact and conclusions of law that "the provider carried its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."<sup>39</sup> Additionally, "[a] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the [Medicare contractor] and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole."<sup>40</sup> In *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 230 (1938), the U.S. Supreme Court held, "[s]ubstantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."<sup>41</sup> Accordingly, in an appeal before the Board, a provider must prove by a preponderance of substantial, relevant evidence that it is entitled to the relief sought. Further, the "Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS."<sup>42</sup>

<sup>38</sup> PRM 15-1 §§ 310 – 312, *also available at* Ex. P-29.

<sup>39</sup> 42 C.F.R. § 405.1871(a)(3).

<sup>40</sup> 42 U.S.C. § 1395oo(d). This statutory provision further confirms that: "[t]he Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination."

*See also* 42 C.F.R. § 405.1869(a).

<sup>41</sup> *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).

<sup>42</sup> 42 C.F.R. § 405.1867.

**DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:*****A. Positions of the Parties***

Norton Hospital argues that PRM 15-1 § 312 “alternates between the use of *must* and *should* to distinguish what is mandatory and what is strongly recommended.”<sup>43</sup> Norton goes on to argue that “[c]ourts have been addressing whether the PRM-I §§ 312(B) and 312(D) are mandatory over several decades, and they have been held consistently that the PRM does not require an asset test.”<sup>44</sup> Citing the District Court decision in *Baptist Healthcare System v. Sebelius*,<sup>45</sup> Norton Hospital argues that if the PRM requirements were intended to be mandatory the Secretary has the power to change the language of the PRM from “should” to “must”, but the Secretary had not done so for the fiscal years in question.<sup>46</sup>

Norton explains that its financial assistance policy “required applications and supporting documentation . . . [in order to] make informed indigency determination in accord with its FAP . . . [which] complied in all material respects with Medicare program guidance on reimbursable bad debts . . . .”<sup>47</sup> In addition, Norton Hospital maintains that its financial assistance policy “reasonably verified the existence of income as well as other assets and resources from the patients’ Income Tax returns.”<sup>48</sup>

Finally, Norton Hospital stated that it:

[a]dopted (and subsequently revised it) the FAP and then conducted its own analysis and testing of the information the patients supplied with respect to income and assets. The MAC’s apparent objection to this arrangement is that in verifying the patients’ income, Provider did not require specific supporting documentation for the patient’s total resources, assets, liabilities and expenses, but it is settled law that the Provider is not required to do so under PRM-I § 312. Contrary to the MAC’s analysis, the Provider obtained sufficient documentation to support its determination of Indigent Care claims in accord with its FAP. Further, despite the MAC’s contention, federal courts have consistently concluded that there is no mandatory total resources or asset testing required under PRM-I § 312.<sup>49</sup>

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<sup>43</sup> Provider’s Cons. FPP at 17 (*citing* Faxton-St. Luke’s Healthcare v. National Government Services, Inc., PRRB Dec. No. 2015-D25 and *Baptist Healthcare System v. Sebelius*, 646 F.Supp. 2d 28 (D.D.C. 2009)); *see also* Ex. P-35 and Ex. P-1 at 34, respectively.

<sup>44</sup> Provider’s Cons. FPP at 19.

<sup>45</sup> *Baptist Healthcare System v. Sebelius*, 646 F.Supp. 2d 28 (D.D.C. 2009).

<sup>46</sup> *Id.* The Board notes that CMS eventually imposed a mandatory asset testing protocol to be applied prospectively to cost reports beginning on or after October 1, 2020. *See* 85 Fed. Reg. 58989 through 58999 (September 18, 2020) (included as Ex. P-30).

<sup>47</sup> *Id.* at 8.

<sup>48</sup> *Id.* at 11.

<sup>49</sup> *Id.* at 16.

For the disputed Record #325 (2015 Inpatient), the Medicare Contractor argues that “[n]o asset support was submitted to determine indigence and the charity application has no date on it. The MAC is unable to verify when the patient requested charity assistance.”<sup>50</sup> Similarly, for disputed Record #2029 (2015 Outpatient), the Medicare Contractor argues that “[t]he patient was noted as having buy-in Medicaid coverage. No support was received to verify Medicaid was billed.”<sup>51</sup>

Additionally, in their Stipulations, the parties presented a summary of these records in dispute before the Board:

With regard to Records 325 and 2029, the parties stipulate that both were determined to qualify as a Specified Low Income Medicare Beneficiary (SLMB) by the Kentucky Medicaid program, and Provider relied upon that fact and invoked the presumption of indigence set forth in Sec. 312 of the PRM as support for its indigence determination. The MAC contends that Provider did not follow its FAP and cannot rely on the presumption of indigence provision of Sec. 312 but must make an independent indigence determination with respect to these patients, as a patient with SLMB does not have Medicaid coverage. For SLMB patients, Kentucky Medicaid pays a “buy-in” premium for SLMB members to have Medicare but offer no claims coverage. As to these claims, the parties stipulate that the issue for the Board to decide is whether the Provider followed their FAP and whether the Kentucky Medicaid program’s determinations that the patients qualify as SLMBs are sufficient to meet the presumption of indigence provision set forth in PRM Sec. 312.<sup>52</sup>

Regarding the larger issue in dispute, the Medicare Contractor’s “only basis for objection with respect to the remaining claims is its contention that PRM section 312 imposes a mandatory asset testing requirement.”<sup>53</sup> The Medicare Contractor argues that it followed “the longstanding policies and interpretation of the Secretary based on PRM 15-1, Section 312(B), which requires assets to be verified to determine indigence for the cost reports appealed.”<sup>54</sup>

### **Board’s Analysis**

In general, per regulation, CMS considers bad debts, charity and courtesy allowances as deductions from revenue that are 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.”<sup>55</sup> 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

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<sup>50</sup> Medicare Contractor’s FPP at 33.

<sup>51</sup> Medicare Contractor’s FPP at 35.

<sup>52</sup> Stip. at ¶ 14.

<sup>53</sup> *Id.* at ¶ 15.

<sup>54</sup> Medicare Contractor’s FPP at 15.

<sup>55</sup> 42 C.F.R. § 413.89(d). *See also* 42 C.F.R. § 413.89(a).

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 PRM 15-1 contains interpretive guidelines regarding certain Medicare regulations,<sup>56</sup> including the bad debt regulations relevant to the instant appeal. Specifically, bad debt is covered in § 300 of PRM 15-1. PRM 15-1 § 308 “mirrors” the criteria set out at 42 C.F.R. § 413.89(e), § 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 Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid.” PRM 15-1 § 312 goes on to state that, “[o]therwise, the provider should apply its 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 beneficiary’s financial condition, the debt may be deemed uncollectible without applying the reasonable collection procedures” set out in § 310.

As noted above, CMS requires a provider to utilize their “customary methods” for determining patient indigence with respect to Medicare beneficiaries under the aforementioned § 312 guidelines. CMS also uses this “customary” language in § 310, stating: “[t]he 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, “[i]f 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.”<sup>57</sup> 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.<sup>58</sup>

*Board’s Analysis of Whether, with respect to the SLMBs in Record 325 and Record 2029, Norton Hospital Followed its Financial Assistance Policy*

The Board conducted a review of Norton Hospital’s Financial Assistance Policy that was used in its indigence determinations pertaining to SLMBs in Record 325 and 2029.

After review, the Board finds that Record #325 (found at Ex. P-46) should be disallowed. The application includes many contradictions. For example, it is unclear how many people reside in the household as the applicant gave conflicting information on pages NHFPP1504 (no answers are given for “Number in Household” or “Number of Dependents,” however, a note indicates the

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<sup>56</sup> See *Battle Creek Health Sys. v. Leavitt*, 498 F. 3d 401, 404 (6th Cir. 2007).

<sup>57</sup> (Italics emphasis added).

<sup>58</sup> See, e.g., *Marian Health Center v. Blue Cross & Blue Shield*, PRRB Dec. 85-D110 (Sept. 23, 1985), *declined review*, CMS Adm’r (Oct. 29, 2014). See also *St. John Health 2004-2005 Bad Debt Moratorium CIRP Group v. National Gov’t Servs.*, PRRB Dec. 2014-D19 (Aug. 27, 2014), *rev’d on other grounds*, CMS Adm’r (Oct. 23, 2014); *Momence Meadows Nursing and Rehabilitation Center, LLC v. National Gov’t Servs.*, PRRB Dec. 2018-D23 (Feb. 12, 2018), *declined review*, CMS Adm’r. (Apr. 6, 2018).

patient “lives alone”) and NHFPP1513 (“Number in Household” is answered “2”, and “Number of Dependents” is answered “0”).<sup>59</sup> As another example, the patient represents on the first page of their application for financial assistance that they did not file taxes in 2012 (at NHFPP1504). However, pages NHFPP1506-1507, show a 2012 IRS Form 1040 signed by a paid preparer. The Board finds the information provided is inconsistent and deficient to make an indigency determination.

The Board also attempted to review Record #2029 but was unable to identify this record because many of the documents submitted as exhibits did not include record numbers on each page, making it impossible to determine with any certainty, which was intended to support Record #2029.<sup>60</sup> Since the submitted exhibits for review were inconclusive,<sup>61</sup> Record #2029 should also be disallowed.

In conclusion, the Board finds that Norton Hospital did not provide sufficient evidence to support its indigency determination as required by its Financial Assistance Policy.

*Board’s Analysis of Whether the Kentucky Medicaid Program’s Determinations that the Patients Qualify as SLMBs Are Sufficient to Meet the Presumption of Indigence Provision Set Forth in PRM Sec. 312*

As an alternative argument, the Board was asked to consider whether there is a presumption of indigence, as set forth in PRM Sec. 312, for the SLMBs, as the parties stipulated that both patients in records #325 or #2029 are SLMBs.<sup>62</sup> The Board notes that the provision at PRM 15-1, Sec. 312 states, “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.”<sup>63</sup> However, SLMB-only patients are not Medicaid-eligible but rather have their Medicare Part B premium paid by Medicaid; no Medicaid claims coverage is provided.<sup>64</sup> Accordingly, the Board concludes that SLMB only patients do not qualify, as the “presumption of indigence” is limited to patients who are Medicaid-eligible.<sup>65</sup> Finally, Norton’s financial assistance policy applicable to 2014-2015

<sup>59</sup> See Ex. P-46 at NHFPP1504 and NHFPP1513. The Board notes that there are also two records labeled #325 – one is for date of service (“DOS”) 06/13/2025 and one for DOS 06/02/2014. See Ex. P-46 at NHFPP1512 and NHFPP1500, respectively. However, see also P-15 at NHFPP0402 and NHFPP0403. Record #325 is the only record number that appears twice in these spreadsheets. Stip. at ¶ 14 shows that 2015 *Inpatient* Record #325 is disputed. Stip. at ¶ 15 shows that for 2015 *Outpatient* Record #325, the Medicare Contractor’s only objection is its contention that PRM § 312 imposes a mandatory asset testing requirement. Thus, based on Norton Hospital’s references to Ex. P-46 in its position papers, the Board believes P-46 to represent two different dates of service for same inpatient rather than one inpatient record and one outpatient record.

<sup>60</sup> See Ex. P-15.

<sup>61</sup> Ex. P-15 (Redacted Documents Related to MAC’s Selected Sample of Provider’s FAP Applications for Patients Qualified as Indigent for FY 2015) shows this record on the spreadsheet listing patients but there is no information related to the application. By contrast, the records in Ex. P-23 are clearly numbered.

<sup>62</sup> Stip. at ¶ 14.

<sup>63</sup> (Italics emphasis added.)

<sup>64</sup> See Stip. at ¶ 14. See also <https://www.medicare.gov/basics/costs/help/medicare-savings-programs> (last visited Mar. 31, 2026), which states “Specified Low-Income Medicare Beneficiary (SLMB) Program Helps pay for: Part B premiums.”

<sup>65</sup> PRM 15-1, § 312.

specifically refers to “QMB Medicaid recipients” deemed as “presumptive indigence”, but makes no mention of SLMBs.<sup>66</sup> No mention is made of QMBs or SLMBs in the 2016 FAP.<sup>67</sup>

*Board’s Analysis of Whether Asset Testing is Mandatory or Optional*

Regarding the “Asset Test” for Indigent Patient Determinations as set forth in PRM 15-1 § 312(B), the Board adopts its prior reasoning and refers to the District Court’s decision in *Baptist*. In its decision for *Baptist*, the Board found that “CMS Pub. 15-1, § 312 “does not create a mandatory asset test[,] [r]ather, each determination of indigence must take into consideration each patient’s circumstances.”<sup>68</sup> Further, the Board determined that “some instances, [] will require an asset test while other circumstances may obviate the need for that test.”<sup>69</sup> After this decision was overturned by the Administrator,<sup>70</sup> the District Court for the District of Columbia received the case on appeal from the Administrator’s Decision, and agreed with the Board’s interpretation of the language/policy distinction:

The case law is clear and, [s]everal Courts of Appeals discussing the word should repudiate the notion that it is synonymous with must. *See Marshall v. Anaconda Co.*, 596 F.2d 370, 375 (9th Cir. 1979) (stating that the words “should . . . unless” are more advisory than the words “shall . . . unless”); *United States v. Maria*, 186 F.3d 65, 70 (2nd Cir. 1999) (stating that the common meaning of “should” suggests or recommends a course of action, while the ordinary understanding of “shall” describes a course of action that is mandatory.); *United States v. Harris*, 13 F.3d 555, 559 (2nd Cir. 1994) (opining that because the regulation does not say that the court “must” but rather the court “should,” it suggests an approach and does not mandate it.) Moreover, the court in *Harris County* squarely dealt with this issue in sum and substance, and here, just as in *Harris County*, the [Administrator] “goes to heroic efforts to assert that should means must,” but offers nothing to refute the plain meaning of the two words, and thus her argument must fail. [*Id.*] at 410. And while the Secretary beseeches this Court that her interpretation of the PRM’s language is entitled to substantial deference, the Court finds this interpretation arbitrary because it disregards the purposeful word choice undertaken when drafting regulations and guidelines that have far reaching legal implications. This is especially the case when drafters of such documents toggle between words within a particular provision.

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<sup>66</sup> See Ex. P-7A at NHFPP0186.

<sup>67</sup> See Ex. P-7B.

<sup>68</sup> PRRB Dec. 2008-D12 (Dec. 10, 2007) (included as Ex. P-31C at NHFPP1300).

<sup>69</sup> *Id.*

<sup>70</sup> *Baptist Regional Medical Center v. BlueCross BlueShield Association National Government Services*, Decision of the Administrator (Dec. 10, 2008) (included as Ex. P-31B at NHFPP1296),

Thus, for the reasons cited above, the Court believes that words *must* and *should* do not carry the same meaning in the context of Section 312 of the PRM.<sup>71</sup>

The Board concurs with the District Court in *Baptist*. “*Must*” connotes a mandate; “*should*” permits election. As the parties have stipulated “that the only issue for the Board to decide with respect to the claims in paragraph 15 is whether asset testing is mandatory or optional[,]”<sup>72</sup> the Board remand the cost reports back to the Medicare Contractor to review Norton Hospital’s indigency determinations and bad debt reimbursement without a mandatory asset test.

**DECISION:**

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly disallowed the bad debt reimbursement for Record #325 and Record #2029. For the remaining records, the Board finds that the Medicare Contractor incorrectly disallowed the bad debt reimbursement for these records based upon an improper interpretation that an asset test was mandatory in indigency determinations. The Medicare Contractor is directed to reconsider Norton Hospital’s bad debt reimbursement without a mandatory asset test for these records.

**BOARD MEMBERS PARTICIPATING:**

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 Ratina Kelly, CPA  
 Nicole E. Musgrave, Esq.  
 Shakeba DuBose, Esq.

**FOR THE BOARD:**

4/6/2026

**X** Kevin D. Smith, CPA

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

<sup>71</sup> *Baptist Healthcare System d/b/a/ Baptist Regional Medical Center v. Sebelius*, 646 F.Supp. 2d, 28, 35 (Aug. 18, 2009) (included as Ex. P-31A at NHFPP1290-91) (citing *Harris County Hospital District. v. Shalala*, 863 F.Supp.404 (S.D. Tex. 1994)).

<sup>72</sup> Stip. at ¶ 17.