PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2026-D14

PROVIDER –
Reid Health

PROVIDER NO. – 15-0048

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING DATE –
October 23, 2024

FISCAL YEAR END– 12/31/2015

CASE NO. – 19-1379

INDEX

ISSUE STATEMENT:

Whether the Medicare Contractor's disallowance of Reid Health's indigent bad debt claims was proper.[1]

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor incorrectly disallowed the bad debt reimbursement for the indigent bad debt claims because the Medicare Contractor improperly interpreted that an asset test was mandatory in indigency determinations. The Medicare Contractor is directed to reconsider Reid Health's bad debt reimbursement allowance without a mandatory asset test.

INTRODUCTION AND PROCEDURAL HISTORY:

Reid Health ("Reid Health" or "Provider") is a non-profit corporation that operates a hospital located in Richmond, Indiana.[2] Reid Health's designated Medicare contractor[3] is WPS Government Health Administrators ("Medicare Contractor").

On September 13, 2018, Reid Health was issued a Notice of Program Reimbursement ("NPR") for its Fiscal Year Ending ("FYE") December 31, 2015.[4] Reid Health claimed $516,159 in reimbursement for indigent Medicare bad debts on its 2015 cost report.[5] The Medicare Contractor denied Reid Health's claim for the indigent bad debt, finding that Reid Health failed to review patients' assets before making indigency determinations.[6]

On March 12, 2019, Reid Health timely appealed the NPR, citing its sole issue as "Bad Debt" and stated that the Medicare Contractor "disallowed the Provider's Bad Debts related to indigence/charity care in their entirety alleging insufficient supporting documentation and that Provider did not verify patient assets as part of its determination of indigence/charity care."[7]

The Board approved a record hearing on October 23, 2024. Reid Health was represented by Heather Mogden of Hall, Render, Killian, Heath & Lyman, P.C. The Medicare Contractor was represented by Scott Berends, Esq., of Federal Specialized Services.

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[1] *See* Provider's Preliminary Position Paper at 2 (Nov. 7, 2019); *see also* MAC's Preliminary Position Paper at 4 (March 2, 2020).
[2] Executed Joint Stipulations of Fact (hereinafter "Stip.") at ¶ 1 (Oct. 14, 2024).
[3] 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 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.
[4] Exhibit (hereinafter, "Ex.") P-3.
[5] Stip. at ¶¶ 2-3.
[6] Stip. at ¶¶ 7, 9.
[7] Issue Statement at 1

STATEMENT OF RELEVANT FACTS:

Reid Health provides financial assistance to certain low-income patients, including Medicare patients, who meet stated eligibility requirements.[8] Reid Health's Financial Assistance Program Policy – also referred to in the parties' position papers, and thus, herein, as the "Charity Care Policy" – provides a discount schedule based on the patient's income as a percentage of Federal Poverty Level ("FPL"):

Percentage of Federal Poverty Level	Reduction Percentage[9]
0% to 100%	100%
101% to 200%	75%
201% to 250%	50%
251% to 300%	25%

In addition to setting forth the discounts based on FPL, Reid Health's Financial Assistance Program Policy provides, in pertinent part:

> **Financial Assistance**
>
> A patient qualifying for financial assistance is a person who is uninsured or underinsured, receives care and unable to pay their bill.
>
> To be eligible for assistance under the *financial* assistance guidelines, a person's income shall be at or below a percentage of the Federal Poverty Level (FPL) as determined by Federal Poverty Guidelines. Household size and income determines the % of FPL. Reid Hospital & Health Care Services, or its designee, may consider other financial assets and liabilities of the person when determining eligibility.
>
> Reid Hospital & Health Care Services will use the most current poverty income guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for financial assistance. The poverty income guidelines are published annually in the *Federal Register* and for the purposes of this policy will become effective the first day of the month following the month of publication.
>
> To qualify under the Financial Assistance portion of this policy, a completed Financial Assistance application must be submitted and

[8] *See* Ex. C-2 (Reid Health's Financial Assistance Program Policy (Eff. 1/1/2015)) at C-0013.
[9] Ex. C-2 at C-0020.

> proof of income, proof of no income and proof of lack of financial assets must accompany the application.[10]

As provided for in the Financial Assistance Program Policy, to qualify, a complete Financial Assistance application must be submitted:

> **Application for Assistance**
>
> The patient's eligibility for Financial Assistance will be determined through an application process. The Reid Hospital & Health Care Services Financial Assistance Application form is the valid application form for the application process. Reid Hospital & Health Care Services' Financial Assistance Policy and application will be made available to all patients.
>
> A signature is required on the application (the patient, guarantor or legal representative). It is the responsibility of the patient/guarantor to complete an assistance application.
>
> The application requires the patient to provide their name, current address and valid contact information and the names and ages of persons in their household.
>
> The application requires the patient to list all income amounts and their sources.
>
> Documentation of all information provided on the application is required to complete the assistance application. Reid Hospital & Health Care Services, or its designee, may use other sources to verify or validate the information that is provided. A written statement from the individual(s) that are supporting the applicant may also be requested if current income or lack thereof is not sufficient to meet their daily living expenses.
>
> Patient advocates are available to help anyone wanting to apply for assistance and are available during business hours at the hospital and Patient Financial Services office. Verification of requested income and a complete list of all countable household members may be required.
>
> A FA Policy application may be used for covered services that are provided up to 6 months after the date the FA Policy application was received.

[10] Ex. C-2 at C-0015 – C-0016 (underline and italic emphasis in original). Reid Health was formerly known as Reid Hospital & Health Care Services, which is the entity named in the Financial Assistance Program Policy.

> All FA Policy applications will be retained for a minimum of 7 years.
>
> Any exceptions to this policy in the awarding of financial assistance must be approved by the FA Policy Executive Committee.
>
> The patient may appeal the decision of denied financial assistance by writing:
>
> Director of Revenue Cycle, 1100 Reld Parkway, Richmond, IN 47374.
>
> **Application and Notification Period**
>
> An indication of an inability to pay for services will be treated as a request for assistance. This request may be made by or on behalf of the individual seeking services. A request for assistance may be made at any time but should be made no later than 30 days after service/discharge, or final bill.
>
> Requests for assistance are not required to be in writing. However, once a request has been made, an application for assistance must be completed and signed by the person making the request or their guarantor or guardian, and can be completed with the help of a Patient Advocate.[11]

Reid Health's Financial Assistance Program Policy also describes the factors to be considered for financial assistance:

> **Household Size and Income**
>
> The following factors may be considered in determining the eligibility of the patient for assistance and must be provided by all income earning residents in the countable household unit unless they are not dependents based on IRS guidelines for determining whether a household member can be considered a dependent.
>
> - Adjusted Gross Income if self-employed (include schedule C from tax return; line 37 from 1040) or if taxes are not filed a completed income and expense report.
> - Indiana workforce wage report for last 2 quarters (unemployment income)

[11] *Id*. at C-0014.

- At least one pay stub or a letter or printout from employer(s) providing verification of gross income if currently employed. This documentation should not be more than 30 days old from date of issue and include year-to-date information.
- Social Security award or entitlement letter or other proof of gross monthly award.
- Retirement income.
- Investment income.
- Statement from person(s) that are providing direct support
- Number of dependents.
- Other financial obligations.
- The amount and frequency of hospital/medical bills.
- Other financial resources that produce income.

Financial Capacity

Individuals with the financial capacity to purchase health insurance coverage through the Health Insurance Marketplace may be required to purchase and will be provided access to meet with an Indiana Certified Navigator as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

Individuals have been found they are ineligible for Medicaid or other affordable health care coverage must provide proof of denial. Food Stamps or Supplemental Nutrition Assistance Program (SNAP) will not be counted as income.
Cosmetic services are not eligible for any kind of assistance and cannot be included in the amount of hospital/medical bills owed.[12]

Reid Health's Financial Assistance Program Policy states that "[i]t may not be possible to verify a claim of little or no income. A credit inquiry may be performed in these cases and an approval of assistance given if the inquiry supports the claim of no or little income."[13]

Reid Health's Financial Assistance Program Policy also describes when a patient *will not* be considered for financial assistance, and in some instances, exceptions to those rules:

Reasons for not being eligible for FA Policy assistance

Household income exceeds the maximum of the FPL However, the patient may be eligible for an adjustment of charges discount or catastrophic discount.

[12] *Id.* at C-0016 – C-0017.
[13] *Id.* at C-0019.

> If a patient is eligible for Medicaid, the Health Insurance Marketplace, (Healthcare.gov) or other state or federal programs and the patient fails to cooperate in the application, re-application, or appeal process, or the patient does not pay the required monthly premium, thereby making the patient ineligible for the State program.
>
> If the patient is eligible and enrolled in a Healthcare Marketplace plan and does not pay the required monthly premium, thereby causing the health plan to discontinue coverage.
>
> Patient is in the custody of a unit of Government, which is responsible for coverage of the medical needs of the patient.
>
> Services are not medically necessary or excluded from the program.[14]

Reid Health's Financial Assistance Program Policy additionally describes situations in which no assistance application is necessary:

> **Presumptive Eligibility**
>
> A patient in any of the following circumstances will be automatically deemed eligible for financial or economic assistance (presumptively eligible). No assistance application is necessary if patient is deemed presumptively eligible for assistance. Documentation validating these circumstances may be required.
>
> - Patient and/or the responsible guarantor reside(s) at Salvation Army, Women's Shelter or any similar shelter; is currently incarcerated but services were provided prior to incarceration or homeless and they are ineligible for Medicaid or other health coverage programs.
>
> - Patient /guarantor is on a fixed income at or below FPL but is considered over resource limits for any Medicaid program.
>
> - Patients who are currently enrolled in any state Medicaid program that have exhausted their benefits for the month are considered automatically qualified under this financial assistance policy. Accounts for any patient who qualifies for Medicaid but whose coverage does not include services within the past ninety (90) days will be presumptively eligible for a

[14] *Id.* at C-0017.

> charity adjustment. There must be a denial of coverage from Medicaid prior to the balance being adjusted to charity.[15]

Finally, Reid Health's Financial Assistance Program Policy provides the following guidance regarding lack of financial information:

> **Failure to Provide Appropriate Information**
>
> Failure to provide information necessary to complete a financial assessment may result in a negative determination, but the account must be reconsidered upon receipt of the required information. The account may also be submitted for approval if Reid Hospital & Health Care Services has been able to verify information from a reliable third party, i.e. Social Security, Medicaid, credit reporting bureau, etc. A determination of eligibility for financial or catastrophic assistance may be made without a completed assessment form if the patient or information is not reasonably available and eligibility is warranted under the circumstances.
>
> Patients who fail to provide required documentation or information will be provided notification.
>
> A determination of eligibility for financial assistance may be made without a completed eligibility form if the patient or information is not reasonably available and eligibility is warranted under the circumstances.
>
> No patient may be denied assistance due to their failure to provide information or documentation not specified in the [Financial Assistance] Policy or application.[16]

In September 2018, the Medicare Contractor conducted a limited desk review of Reid Health's FYE 2015 cost report.[17] After reviewing the above-referenced Financial Assistance Program Policy and the indigent bad debts claimed on the cost report, the Medicare Contractor denied reimbursement for Medicare indigent bad debt claims because it found that the Provider "did not document that the patients' total resources were considered for the 20 patients tested."[18]

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[15] *Id.* at C-0017 – C-0018.
[16] *Id*. at C-0018.
[17] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 3 (Apr. 20, 2023).
[18] *Id.* at 6.

STATEMENT OF RELEVANT LAW:

A. Medicare Reimbursable Bad Debts

For the period pertinent to this appeal (i.e., FYE 12/31/2015), 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 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 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.
>
> 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.)[19]

C. 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."[20] 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."[21] 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."[22] 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."[23]

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[19] PRM 15-1 §§ 310 – 312 (emphasis added); *also available at* Ex. P-14.
[20] 42 C.F.R. § 405.1871(a)(3).
[21] 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).
[22] *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).
[23] 42 C.F.R. § 405.1867.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

A. Positions of the Parties

The Medicare Contractor disallowed Reid Health's claim for indigent bad debt reimbursement "based on Reid Health's failure to review a patient's assets prior to making an indigency determination."[24] Relying on the Administrator's decision in *Baptist Regional Medical Center vs. BCBSA* (February 8, 2008), the Medicare Contractor supports its disallowance determination based on a failure to conduct asset testing, as referenced in CMS Pub. 15-1 § 312(B), stating, "CMS maintains that in the context of this Manual provision, the use of the word should does not relieve providers from performing asset tests."[25] Further, the Medicare Contractor argues that "even if an asset review is not required by CMS's Medicare Bad Debt policy, Reid Health's internal charity care policy required the consideration of a patient's assets prior to making an indigency determination. Specifically, [Reid Health's] charity care policy provides 'a patient's eligibility for Financial Assistance will be determined through an application process' and 'the application requires the patient to list all income amounts and their sources.'"[26]

At the conclusion of its limited desk review of Reid Health's indigent bad debt claims, the Medicare Contractor found that Reid Health "only compared the patients' income to the Federal Poverty Level (FPL)" and ignored "bank account information [that] was attached to the [Financial Assistance] forms."[27] Further, the Medicare Contractor found that "[t]he Financial Assistance Form included a space for reporting liquid assets, but it was never completed for any of the patients that were tested."[28] As a result, the Medicare Contractor "decided to disallow all indigent care claims because [Reid Health] was not following Medicare policy and *their own Financial Assistance Program Policy*."[29] To that end, the Medicare Contractor contends that even if a provider's written policy meets CMS Bad Debt policy requirements, "if a provider lacks internal controls to help ensure the policy is followed, the policy is of no value and is only for show, which is clearly the case with respect to the Provider."[30]

The Medicare Contractor goes on to provide examples of Reid Health's alleged failures to follow its own written policy, pointing to the income ratios for the 20 sampled claims, and posits that based on the patients' income levels in comparison to the Federal Poverty Level, many of these patients should be eligible for Medicaid, and Reid Health should have assisted with this to screen for "all available resources," in accordance with its Financial Assistance Program Policy.[31]

The Medicare Contractor also argues that Reid Health is required to determine that for each patient there is "no source other than the patient [who] is legally liable for the patient's medical

[24] Stip. at ¶ 9.
[25] Medicare Contractor's FPP at 14.
[26] Stip. at ¶ 11.
[27] Medicare Contractor's FPP at 6.
[28] *Id.*
[29] *Id.* (italic emphasis in original).
[30] *Id*. at 13.
[31] *Id*. at 13-14 (citing Ex. C-2 at C-0009).

bills."[32] The Medicare Contractor says they received no evidence of this from Reid Health.[33]

Finally, the Medicare Contractor argues that the burden of proof is upon Reid Health, that this was not met, and the MAC's determination was not arbitrary nor capricious and adhered to Medicare regulations and CMS policy.[34]

To refute the Medicare Contractor's disallowance of its bad debt claims, Reid health argues that prior Board and District Court decisions have favored Medicare providers on similar bad debt issues and held that "providers have substantial leeway in creating their own charity care policies, and those policies are not required to include asset testing."[35] Reid Health argues that PRM 15-1 § 312 does not create a mandatory asset test requirement.[36] Citing the District Court decision in *Baptist Healthcare System v. Sebelius*,[37] Reid Health 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 has not done so for the fiscal year in question.[38]

Further, Reid Health points out exceptions set forth in its Financial Assistance Program Policy "which do not require an application for charity care."[39] These patients are presumptively deemed eligible. Reid Health then contends that, for those patients ***not*** presumptively deemed eligible, although a review of the patient's income is required by the policy, "the policy *does not require* consideration of a patient's assets, rather, assets *may* be considered in determinations of financial need."[40] Reid Health also notes that their policy permits eligibility for charity care if Reid Health "has been able to verify the information from a reliable third party, i.e., Social Security, Medicaid, credit reporting bureau, etc."[41] Reid Health suggests that this is consistent with § 312 of CMS Pub. 15-1, subsection B "which requires only that a provider *should* take into account a patient's total resources, not that it *must* take resources into account[.]"[42]

Reid Health goes on to argue that their patient indigency determinations are within Medicare guidelines and its Charity Care Policy, and that the Medicare Contractor's review of Reid Health's Financial Assistance Program Policy was selective and limited.[43] After examining several examples, Reid Health concludes:

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[32] *Id.* at 13.
[33] *Id*.
[34] *Id*. at 16.
[35] Provider's Final Position Paper (hereinafter, "Provider's FPP") at 5-6 (Apr. 12, 2023) (citing *Sentara Hosps. v. Azar*, No. 20-cv-3771, 2022 WL 910514 (D.D.C. Mar. 29, 2022)).
[36] *Id*. at 6.
[37] *Baptist Healthcare,* 646 F. Supp. 2d 28 (D.D.C. 2009).
[38] Provider's FPP at 7 (citing 646 F. Supp. 2d 28, 35 (D.D.C. 2009)). 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 (Sept. 18, 2020) (included as Ex. C-4).
[39] Stip. at ¶ 12.
[40] Stip. at ¶ 13. *See also* Ex. C-2 at C-0015 (Italics emphasis included).
[41] Stip. at ¶ 16.
[42] Provider's FPP at 8.
[43] *Id*. at 9.

> Here, the evidence demonstrates that the Provider has developed and consistently applied its customary methods for determining indigency by requiring patients to disclose their income sources and sign an attestation statement to their veracity, and by testing that data using supporting documentation and/or an analytical tool. In all cases, the Charity Care Policy, application, and identified supporting documentation reasonably enabled the Provider to make indigency determinations on a case-by-case basis. The Provider's Charity Care Policy meets the standards set in CMS's regulations, the guidance outlined at PRM-I § 312, and the requirement under 42 C.F.R. § 413.89. Since the Provider did not simply rely on patients' declarations of their indigency, and since the Provider consistently searched for all available options to bill its patients, it met the requirements for determining each patient's indigency. Because the Provider properly relied on the financial assistance application and supporting documentation to determine patients' indigency, the MAC's decision to disallow the Provider's indigency bad debt must be reversed.[44]

B. Board Analysis and Decision

The Board'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.[45]

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.

As referenced above, PRM 15-1 § 300 addresses Medicare bad debts.[46] 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 "[o]therwise, the

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[44] *Id*. at 13.
[45] 42 C.F.R. § 413.89(a).
[46] For instance, 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. *See* pertinent sections reproduced *infra* at "Relevant Law."

provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary"[47] 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 set forth in § 310.[48]

As noted above, CMS requires provider to utilize their "customary method" for determining patient indigence with respect to Medicare beneficiaries under aforementioned guidelines in § 312. CMS also uses this "customary" language in § 310 where 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.[,]"[49] 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 bills is mailed to the beneficiary, the debt may be deemed uncollectible."[50] As thoroughly explained in prior decisions on the issue of the reasonable 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.[51]

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

PRM 15-1 § 312(B) 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[.][52]

In its position papers, the Medicare Contractor argues that CMS' indigent patient determination criteria set out at PRM 15-1 § 312, specifically at § 312(B), create a "require[d] review of assets"[53], or, a mandatory asset test that must be included in a provider's indigent patient policy. It further argues that the Reid Health's own policy "requires a review of assets." [54] The Medicare Contractor points specifically to the CMS Administrator's decision in *Baptist Regional Medical*

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[47] PRM 15-1 § 312.
[48] *Id.*
[49] PRM 15-1 § 310(B).
[50] PRM 15-1 § 310.2 (emphasis added).
[51] *See, for example, 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).
[52] (Italics emphasis added).
[53] Medicare Contractor's Preliminary Position Paper at 14 (Mar. 2, 2020). *See also* Medicare Contractor's FPP at 14.
[54] Medicare Contractor's FPP at 14.

Center.[55] 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."[56] The Administrator goes on to declare that "Section 312 of the PRM does create a mandatory asset test."[57] In addition, the Administrator noted that "within the context of the regulation and the PRM, 'should' is synonymous with 'must.'"[58] Accordingly, the Medicare Contractor argues that Reid Health's reliance on the usage of "should" in PRM 15-1, § 312(B) as it relates to patient asset testing, as well as in § 312(D) regarding indigence determination documentation, is misplaced.[59]

Reid Health counters, stating:

> In sum, Medicare requires that provider, and not the patients themselves, determine the patient's indigence, and that provider determine that no other payor source would be legally responsible for the patient's medical bills. PRM-I § 312. Medicare recommends that providers ***should*** take into account a patient's total resources (assets, liabilities, income and expenses), and ***should*** place in patients' files documentation of the method by which indigence was determined and all information substantiating the determination.[60]

Reid Health argues that this standard is well-established, citing Board and District Court decisions, including *Univ. Wis. Hosps. & Clinics Auth. V. Nat'l Gov. Servs.*, PRRB Dec. 2019-D36,[61] *Sentara Healthcare Bad Debt CIRP Groups v. Palmetto GBA*, PRRB Dec. No. 2020-D17,[62] *aff'd*, *Sentara Hosps. v. Azar*, No. 20-cv-3771, 2022 WL 910514 (D.D.C. Mar. 29, 2022).[63] Further, Reid Health cites back to the District Court's decision in *Baptist Healthcare System*, asserting that "[t]he Secretary has the discretion to change the language of the PRM so that each paragraph uses the auxiliary verb *must*, but for some reason she has chosen not to. In order to preclude courts from reaching the same conclusion in future decisions, the Secretary should amend Section 312 of the PRM."[64] To that end, Reid Health ***correctly*** points out[65] that in the September 18, 2020 Hospital IPPS Final Rule, the Secretary did just that stating:

> Over the past several years, the criteria set forth in PRM § 312 regarding the determination of indigence have been the subject of litigation as questions have been raised as to whether the criteria

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[55] Medicare Contractor's FPP at 14-15 (citing *Baptist Regional Medical Center v. BlueCross BlueShield Ass'n/National Government Servs*. Adm'r Dec. 2008-D12 (Feb. 8, 2008)).
[56] Adm'r Dec. at 7.
[57] *Id*.
[58] *Id*. at 8 n.3.
[59] Medicare Contractor FPP at 14-16.
[60] Provider's FPP at 8.
[61] *Id.* at 5 (*see* Ex. P-21).
[62] *Id*. (*see* Ex. P-20).
[63] *Id*. (*see* Ex. P-22).
[64] Provider's FPP at 7, citing 646 F. Supp. 2d at 35.
[65] *Id*. at 8.

> are mandatory. In the proposed rule, we proposed to clarify and codify our longstanding policy and criteria set forth in PRM § 312 A. through D. (setting for the requirements for a facility's determination of indigency).
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> . . .
>
> We . . . proposed 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 include, but are 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 (for example, a legal guardian) would be legally responsible for the beneficiary's medical bill.
>
> . . .
>
> We proposed 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.[66]

However, after feedback from commenters, the rule was applied only prospectively:

> In the proposed rule, we proposed that our proposals would be effective for cost reporting periods beginning before, on and after the effective date of this rule because our proposals were clarifications and codifications of longstanding Medicare policies. However, because of the changes to the policies we are finalizing after consideration of public comments, we are finalizing these policies with an effective date for cost reporting periods ***beginning on or after October 1, 2020***.[67]

[66] 85 Fed. Reg. 58432, 58996-7 (Sept. 18, 2020).
[67] *Id*. at 58999 (emphasis added).

In effect, this serves as an acknowledgement by the Secretary of the ambiguity of the prior language, the resulting litigation history, and a prospective clarification for cost reporting periods on or after October 1, 2020. The Board will not, as the Secretary did not, retroactively revise the language of the prior rule – as the cost reporting period at issue in this appeal, FYE December 31, 2015, predates the change.

Thus, the Board continues to apply its reasoning set forth in prior Board decisions, as well as that of the District Court's decision in *Baptist*. In *Baptist*, the Board found that § 312(B) "does not create a mandatory asset test. Rather, each determination of indigence must take into consideration each patient's circumstances."[68] Further, the Board allowed that some instances "will require an asset test while other circumstances may obviate the need for that test."[69] After this decision was overturned by the Administrator, it was appealed by Baptist and the District Court for the District of Columbia overturned the Administrator's Decision, agreeing 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 court "must" but rather court "should," it suggests an approach and does not mandate it.) Moreover, the court in *Harris County*[70] 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.

[68] Provider Reimbursement Review Board Dec. 2008-D12 at 6.
[69] *Id*.
[70] *Harris County Hosp. Dist. v. Shalala*, 863 F. Supp. 404 (S.D. Tex. 1994).

> 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.[71]]

Accordingly, the Board concurs with the District Court in *Baptist*—"*must"* connotes a mandate while "*should"* permits election. As the Medicare Contractor's disallowance of bad debts reimbursement was "based on Reid Health's failure to review a patient's assets prior to making an indigency determination,"[72] the Board remands the cost report back to the Medicare Contractor to review Reid Health's indigency determinations and claims for bad debt reimbursement consistent with the holding herein and in *Baptist*—without the requirement of mandatory asset test in accordance with the permissive language in PRM 15-1, § 312(B).

The parties agree that Reid Health's "Financial Assistance Program Policy (Charity Care Policy) ***complied with CMS policy*** because it included provisions for assessing a patient's available income and available assets[,]"[73] However, the limited desk review performed by the Medicare Contractor did not address the issue of whether the Provider followed its Financial Assistance Program Policy in its indigence determinations as the determination that it had failed to do any asset testing ended the review of these claims. The Board finds that the proper course of action is to remand the determination back to the Medicare Contractor. The Medicare Contractor is directed to review the indigent bad debt claims for compliance with Reid Health's policy and without any presumption of a required asset test.

DECISION AND ORDER:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor incorrectly disallowed the bad debt reimbursement for the indigent bad debt claims because the Medicare Contractor improperly interpreted that an asset test was mandatory in indigency determinations. The Medicare Contractor is directed to reconsider Reid Health's bad debt reimbursement allowance without a mandatory asset test.

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FOR THE BOARD:

4/28/2026

X Kevin D. Smith, CPA

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

[71] 646 F. Supp 2d at 35. *See also* Ex. P-15.
[72] Stip. at ¶ 9.
[73] Medicare Contractor FPP at 13 (emphasis added).