

**PROVIDER REIMBURSEMENT REVIEW BOARD  
DECISION**

2026-D15

**PROVIDER –**  
Genesis Healthcare System

**PROVIDER NO. –** 36-0039

**vs.**

**MEDICARE CONTRACTOR –**  
CGS Administrators

**LIVE HEARING DATE –**  
December 10, 2024

**FISCAL YEAR END–** 12/31/2016 &  
12/31/2017

**CASE NO. –** 19-2664 & 20-1791

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**ISSUE STATEMENT:**

Whether Genesis Healthcare System (“Provider” or “Genesis”) is entitled to reimbursement for bad debts that were previously disallowed by the Medicare contractor<sup>1</sup> based on its interpretation that Section 312 of the Provider Reimbursement Manual (“PRM”) imposes a mandatory asset test.<sup>2</sup>

**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 Provider’s records under appeal. The Board finds that an asset test was not mandatory in indigency determinations for the time period in question. Therefore, the Board *remands* the claims to the Medicare Contractor to recalculate Genesis’ bad debt reimbursement without a mandatory asset test for these records. Further, the calculation should reflect the agreed-upon calculations for the three records in which the parties stipulated that Genesis did not follow its financial assistance policy (Records 446, 1007, and 1223).<sup>3</sup>

**INTRODUCTION:**

Genesis Healthcare System is a non-profit corporation that operates a Medicare participating acute care hospital in Ohio.<sup>4</sup> Genesis’ designated Medicare contractor is CGS Administrators (“Medicare Contractor”).

The Medicare Contractor adjusted Genesis’ reimbursement for indigent bad debts in fiscal years 2016 – 2017, “based upon its determination that Provider’s [Financial Assistance Policy (“FAP”)] did not require Provider to consider the patient’s assets in its determination of indigency, in contravention of section 312 of the PRM.”<sup>5</sup> Prior to the hearing, the parties stipulated to the facts regarding several records previously in dispute.<sup>6</sup> As a result, the issue presented to the Board is limited to whether PRM § 312 imposes a mandatory asset test.<sup>7</sup>

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<sup>1</sup> CMS’ payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries (“FIs”) and these functions are now contracted with organizations known as Medicare Administrative Contractors (“MACs”). The term Medicare contractor, as used herein, refers to both FIs and MACs as appropriate.

<sup>2</sup> Through Stipulations and based on the statements of the representatives at hearing, the parties have limited the Board’s decision to whether PRM § 312 imposes a mandatory asset test. *See* Transcript of Proceedings (hereinafter “Tr.”) at 5:9-13; 23:2-25 (Dec. 10, 2024). *See also* Revised and Supplemented Stipulations of the Parties (hereinafter “Stip.”) at ¶¶ 10, 11, 12, and 13 (Dec. 6, 2024).

<sup>3</sup> Stip. at ¶ 13.

<sup>4</sup> *Id.* at ¶ 1.

<sup>5</sup> *Id.* at ¶ 6.

<sup>6</sup> *Id.* at ¶ 10-13. Note: As delineated in Stip. ¶ 12, the only issue for the Board to decide for the records listed in Stip. ¶ 10, is whether asset verification is mandatory or optional as the parties stipulated in Stip. ¶ 10 that the Provider complied with its FAP in making determinations of indigence.

<sup>7</sup> *Id.* at ¶ 13. *See also* Tr. at 28:25 – 30:13 (in which Genesis’s Representative confirms that Stip. ¶¶ 11 and 13 are representing that Genesis did not follow its FAP for 3 specific claims and have agreed to the calculations in Stip. ¶¶ 14-16).

Genesis timely appealed CMS' determinations to the Board and met the jurisdictional requirements for hearing. The Board held a live hearing on December 10, 2024. Genesis was represented by Kevin Devaney, Esq., of Eastman & Smith, Ltd. The Medicare Contractor was represented by Joseph Bauers, Esq., of Federal Specialized Services.

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

Genesis provides financial assistance to certain low-income patients, whether they are insured or underinsured, who qualify for such help.<sup>8</sup> During fiscal years 2016 and 2017, Genesis incurred bad debts for Medicare patients who were deemed indigent by Genesis.<sup>9</sup> The method by which Genesis determined indigency for patients was documented in its FAP, which was in place for all times relevant to the appeal.<sup>10</sup>

The Medicare Contractor adjusted Genesis' reimbursable bad debts by disallowing all bad debts attributable to patients that Genesis qualified as indigent in accordance with its FAP.<sup>11</sup> The Medicare Contractor based the disallowance upon its determination that Genesis' FAP did not require Genesis to consider a patient's assets in its determination of indigency, a method which the Medicare Contractor considered to be in contravention of section 312 of the PRM.<sup>12</sup>

### **STATEMENT OF RELEVANT LAW:**

#### *A. Medicare Reimbursable Bad Debts*

For the period pertinent to this appeal (i.e., FYE 12/31/2016 and FYE 12/31/2017), Medicare addressed the costs associated with bad debt in the regulations at 42 C.F.R. § 413.89 (2015) 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

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<sup>8</sup> See Case No. 19-2664, Exhibit (hereinafter "Ex.") C-2 at C00007.

<sup>9</sup> Stip. at ¶ 6.

<sup>10</sup> *Id.* at ¶¶ 2 and 6.

<sup>11</sup> *Id.* at ¶ 6.

<sup>12</sup> *Id.*

created or acquired in providing services. “Accounts receivable” and “notes receivable” are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

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

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

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

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

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

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

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

(f) Charging of bad debts and bad debt recoveries. The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously

written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

[ . . . ]

*B. Additional Guidance*

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

310. REASONABLE COLLECTION EFFORT

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 to 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.)<sup>13</sup>

### 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.”<sup>14</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>15</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>16</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>17</sup>

## **DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:**

### A. *Positions of the Parties*

Genesis argues that the Board must find that PRM 15-1 Section 312 does not create a mandatory asset test, pointing to the District Court's reasoning in *Baptist Healthcare System v. Sebelius*,<sup>18</sup> and stating:

<sup>13</sup> PRM 15-1 §§ 310 – 312 (emphasis added).

<sup>14</sup> 42 C.F.R. § 405.1871(a)(3).

<sup>15</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>16</sup> See also *Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).

<sup>17</sup> 42 C.F.R. § 405.1867.

<sup>18</sup> 646 F. Supp. 2d 28 (D.D.C. 2009).

[T]he question before the Court was whether a reasonable determination of PRM 312 requires that the hospital perform an asset test in order to determine whether a Medicare beneficiary is indigent. ‘The Court’s determination in this case boils down to the meaning of two simple words – *must* and *should*, and contrary to the Administrator’s finding, this Court concludes that the words *must* and *should* are not synonymous neither in the context of government regulations and manuals nor in everyday usage.’<sup>19</sup>

The Court in *Baptist Healthcare* reasons that “the word must connotes an obligation” and “the word *should* [suggests] the ideal criteria a provider could use.”<sup>20</sup>

Genesis further relies on the Board’s decision in *Sentara Healthcare Bad Debt CIRP Groups vs. Palmetto GBA c/o National Government Services, Inc.* (PRRB 2020-D17) wherein “the Board rejects the Medicare Contractor’s and the Administrator’s dismissal of the D.C. district court’s holding in *Baptist* and once again finds that PRM 15-1 § 312 does not create a mandatory asset test.”<sup>21</sup>

In the parties’ Stipulations, Genesis points out that the Medicare Contractor “remains bound” by the Administrator’s decisions in *Baptist Healthcare* and *Sentara*, despite the District Courts’ subsequent holdings that “should” is permissive:

The Board has considered the language of PRM § 312 on multiple occasions, including in *Sentara Healthcare Bad Debt CIRP Groups v. Palmetto GBA*, PRRB Decision 2020-D17 (Exhibit T), as well as *Baptist Regional Medical Center vs. Blue Cross Blue Shield Association/National Government Services-Kentucky*, PRRB Decision 2008-D12). In these two decisions, the Board found that with respect to asset determinations, the word “should” was an optional provision and not mandatory. The CMS Administrator reviewed these two decisions and reversed the Board. (Exhibit U and Exhibit C-3.) However, the federal district court for the District of Columbia ultimately reversed the CMS Administrator and upheld the Board’s decisions in both of these cases. See, *Sentara Hospitals vs. Alex Azar* Case No. 20- CV\_3771 USDC, Dist. of Columbia (Exhibit V and *Baptist Healthcare Systems vs. Sebelius* 646 F. Supp.2d 28 (2009). Despite these district court holdings, the MAC remains bound by the Administrator’s determinations.<sup>22</sup>

<sup>19</sup> Case No. 19-2664, Provider’s Final Position Paper (hereinafter “Provider’s FPP”) at 3 (citing *Baptist Healthcare* at 33).

<sup>20</sup> *Baptist Healthcare* at 34.

<sup>21</sup> Case No. 19-2664, Provider’s FPP at 7 (citing *Sentara Healthcare Bad Debt CIRP Groups* at 13).

<sup>22</sup> Stip. ¶ 9.

The Medicare Contractor argues that they “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>23</sup>

Under questioning from the Board at hearing, the Medicare Contractor’s representative summarized their position:

The MAC is not disputing the outcome of the *Baptist* or *Sentara* cases either in front of the Board or in front of the courts. The MAC is bound by the Administrator’s decisions in both of those cases, and the Administrator has consistently held. The MAC makes no distinction other than, again, they’re bound the administrative decision. We understand the Board is not; we understand the Court is not; but the MAC is, and that’s why we are here today.<sup>24</sup>

### *B. Board Analysis and Decision*

The Board adopts its own prior reasoning, as well as that of the District Court in *Baptist Healthcare* - “*must*” connotes a mandate while “*should*” permits election. As the parties have limited the Board’s decision to whether PRM § 312 imposes a mandatory asset test,<sup>25</sup> the Board remands the cost report back to the Medicare Contractor to review Genesis’ 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 incorrectly disallowed the bad debt reimbursement for the Provider’s records under appeal. The Board finds that an asset test was not mandatory in indigency determinations for the time period in question. Therefore, the Board **remands** the claims to the Medicare Contractor, to recalculate Genesis’ bad debt reimbursement without a mandatory asset test for these records. Further, the calculation should reflect the agreed-upon calculations for the three (3) records in which the parties stipulated that Genesis did not follow its financial assistance policy (Records 446, 1007, and 1223).

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<sup>23</sup> *E.g.*, Case No. 19-2664, Medicare Contractor’s Final Position Paper (hereinafter “Medicare Contractor’s FPP”) at 12 (Feb. 12, 2024).

<sup>24</sup> Tr. at 35:22-36:8.

<sup>25</sup> *See supra* n. 2 and 9.

**BOARD MEMBERS PARTICIPATING:**

Kevin D. Smith, CPA  
Ratina Kelly, CPA  
Nicole E. Musgrave, Esq.  
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**FOR THE BOARD:**

5/14/2026

**X** Kevin D. Smith, CPA

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