PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2026-D18

PROVIDER –
South Lake Hospital

PROVIDER NO. – 10-0051

vs.

MEDICARE CONTRACTOR –
First Coast Service Options, Inc. c/o GuideWell Source (J-N)

RECORD HEARING DATE –
March 4, 2025

FISCAL YEAR END– 09/30/2014

CASE NO. – 19-2635

INDEX

ISSUE STATEMENT:

Whether the Medicare Contractor's adjustments disallowing charity care claims in their entirety due to insufficient supporting documentation was proper.[1]

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor correctly disallowed the bad debt reimbursement for certain bad debt claims because South Lake failed to adequately support their indigence determinations.

INTRODUCTION:

Orlando Health South Lake ("South Lake" or "Provider") is non-profit corporation that operates a hospital in Clermont, Florida.[2] South Lake's designated Medicare contractor[3] is First Coast Service Options, Inc. c/o GuideWell Source ("Medicare Contractor" or "MAC").

The Medicare Contractor disallowed a portion of South Lake's indigent care bad debt reimbursement for fiscal year 2014. The Provider disagrees that these claims "should be excluded due to a lack of documentation/collection effort for patients that the Provider deemed indigent."[4]

South Lake timely appealed CMS' determination to the Board and met the jurisdictional requirements for hearing. The Board approved a record hearing on March 4, 2025. South Lake was represented by L. Sue Andersen, Esq., of Hall, Render, Killian, Heath & Lyman, P.C. The Medicare Contractor was represented by Edward Lau, Esq., of Federal Specialized Services.

STATEMENT OF RELEVANT FACTS:

South Lake offers financial assistance to certain patients "who have limited or no means to pay hospital bills(s)."[5] During fiscal year 2014, South Lake incurred bad debts for Medicare patients who were deemed indigent by South Lake. The Medicare Contractor disallowed a portion of

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[1] The parties did not stipulate to an "issue statement", therefore the issue statement presented here is derived from the initial appeal request, which is a single issue. In the Provider's Preliminary Position Paper [hereinafter "Provider's PPP"] at 1-2 (May 8, 2020), the Provider incorrectly broke out the issue into two separate statements. However, no issue bifurcation was requested nor granted, and the "issue" remains one issue with a single adjudication.

[2] Joint Stipulations of the Parties [hereinafter "Stip."] at ¶ 1 (Feb. 20, 2025).

[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 term "Medicare contractor," as used herein, refers to both FIs and MACs as appropriate and relevant.

[4] Medicare Contractor's Preliminary Position Paper [hereinafter, "Medicare Contactor's PPP"] at 3 August 18, 2020). Note, the MAC filed no optional Final Position Paper and will instead rely on its Preliminary Position Paper.

[5] See Exhibit [hereinafter "Ex."] P-1 at 3 (Financial Assistance/Community Care Procedure).

South Lake's reimbursement claims "based on South Lake's alleged failure to adequately document patient indigency."[6] In the agreed-upon Stipulations, the parties further explained:

> [The Medicare Contractor] disallowed a portion of South Lake's claim for reimbursement in its NPR dated March 19, 2019. The MAC sampled 30 inpatient and 30 outpatient bad debt claims (the "NOTE" at the top of page of Exhibit P-9 indicates that the chart labeled "Test of *Inpatient* Bad Debts," derives data from an original file, WP D.14.4.2, labeled "Bad Debt Testing—*OP Indigent*.") For all of these claims, the MAC contends that the Provider did not properly determine and document patient indigency. For each of the claims sampled, the Provider contends that third party data was used to determine indigency.[7]

South Lake has argued that it "properly reviewed a patient's indigency status as required under Section 312 of CMS Publication 15-1,"[8] via the use of its Financial Assistance program ("Charity Care Program") that complied with CMS guidance and their determinations included the use of a tool, approved by the prior Medicare Contractor, First Coast Service Options, Inc.[9] Further, South Lake argued that it consistently followed its internal financial assistance policy, and while their policy requires review of a patient's income for patients who are not presumptively deemed eligible for assistance, the policy does not require consideration of a patient's assets.[10]

STATEMENT OF RELEVANT LAW:

A. Medicare Reimbursable Bad Debts

For the period pertinent to this appeal (*i.e.*, FYE 09/30/2014), 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—

[6] Stip. at ¶ 8.
[7] *Id*. at ¶ 6.
[8] *Id.* at ¶ 9.
[9] Provider's PPP at 6-7. *Also, see* Ex. P-11.
[10] Stip. at ¶¶ 13-14. *See also* Provider's PPP at 12-13.

(1) Bad debts.— Bad debts are amounts considered to be uncollectible from accounts and notes receivable which 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 other 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 rendered 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 health insurance 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.

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 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.)[11]

B. 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."[12]

[11] PRM 15-1 §§ 310 – 312.
[12] 42 C.F.R. § 405.1871(a)(3).

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."[13] 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."[14] 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."[15]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

A. Positions of the Parties

South Lake argues that its "patient indigence verification process was thorough and sufficient to identify indigent patients with no alternate payor sources who had appropriate levels of income and assets to meet the standards set forth in the Provider's Financial Assistance Policy."[16] South Lake further contends that:

> [T]he MAC adjusted the Provider's reimbursable bad debts by entirely eliminating debts attributable to patients for whom the MAC *assumed* the Provider had made insufficient determinations of indigency. (**Exhibits** [sic] **P-6** and **Exhibit P-7**). Without reviewing any underlying documentation, the MAC disallowed all claims that are attributable to Medicare patients who applied for and were determined to be qualified for the Provider's Financial Assistance program ("Charity Care Program"), which requires applications, supporting documentation, and at times, analytics run on a patient who are presumed eligible, so that Provider could make indigency determinations. (*See* **Exhibits P-1, P-8, and P-19**).[17]

As referenced above, South Lake used a third-party tool, "MEDF, which acquires information regarding sources of income, household size, and employment status"[18] in order to determine

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[13] 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).

[14] *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).

[15] 42 C.F.R. § 405.1867.

[16] Provider's PPP at 2-3.

[17] *Id*. at 6.

[18] Stip. at ¶ 12.

indigency under its Charity Care program.[19] South Lake contends that this tool was approved by the Provider's prior Medicare Contractor,[20] First Coast Service Options, Inc.[21]

South Lake also argues that they obtained sufficient documentation in making their indigency determinations, citing their application process meeting and exceeding the requirements of PRM-I § 312 and that federal courts do not require asset testing.[22] Further, patients who did not fill out an application were presumed eligible by the third-party indigency screening tool.[23] South Lake summarizes its arguments, stating:

> [T]he Provider reasonably relied on its financial assistance application, presumptive indigency screening tool, follow-up procedures to test the patients' income and assets, and otherwise met all the required criteria for determining whether the patients were indigent. Since the Provider did not simply rely on patients' declarations of their indigency, and continued utilizing its protocols, including the indigency determination tool to make determinations of presumptive indigency in accordance with its previous MAC, First Coast, it met the requirements for determining each patient's indigency.[24]

On the contrary, the Medicare Contractor argues in their Preliminary Position Paper:

> It is clear from the Provider Reimbursement Manual that the Provider is required to take all account information into consideration, which would include income verification. The Provider argues that the instructions are guidelines and not mandatory due to the use of the word "should", as opposed to the word "must". [sic] However, this interpretation takes away the intent and spirit of the instructions and would render them pointless if interpreted in this manner. It can just as easily be argued that the word "should" is a requirement. The Provider "should" take all resources into account or it risks not meeting the bad debt requirements. The MAC contends that the Provider has not complied with the instructions, as the total resources for patients deemed indigent were not taken into account.[25]

While the Medicare Contractor acknowledges the existence of judicial decisions that addressed

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[19] *See supra* n. 9.
[20] Board Note: In its PPP, South Lake calls First Coast Service Options, Inc. the "prior Medicare Contractor," however, First Coast Service Options, Inc. is still the listed Medicare Contractor.
[21] Provider's PPP at 6-7 (citing Ex. P-11). *See* Stipulations at ¶ 12.
[22] Provider's PPP at 7.
[23] *Id*. at 8.
[24] *Id*. at 13.
[25] Medicare Contractor's PPP at 5.

the "must" vs. "should" debate,[26] they point out that these decisions are not binding.[27] Further, the Medicare Contractor "contends that these cases do not justify allowing the bad debts in question in the present cases, and as previously explained, the Provider has still failed on the merits to document that it was actually following its own policy, even with its lack of independent verification of the patient financial information."[28]

Next, the Medicare Contractor contends that the third party resource utilized by South Lake in their indigence determinations, which uses credit reporting data and credit score and ranking, fails to meet CMS requirements for indigency determinations because "[t]his method does not include a patient attestation or documentation of income or family size."[29]

Finally, in regards to the Provider's bad debt policy, the Medicare Contractor maintains:

> First, the Provider has not adequately demonstrated that it was following its own indigence (charity) policies during the time period in question . . .
>
> Second, in regards to the charity policies, the MAC maintains that a bad debt is not automatically allowable even if the Provider is following its own policies. The policies must still be in accordance with the regulations and statutes.[30]

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.[31] 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.

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[26] Specifically, *Harris County Hosp. Dist. v. Shalala*, 863 F.Supp. 404 (S.D. Texas, 1994) [hereinafter "*Harris County Hospital*"] and *Baptist Healthcare System v. Sebelius*, 646 F.Supp. 2d 28 (D.D.C., 2009) [hereinafter "*Baptist Healthcare System"*].
[27] Medicare Contractor's PPP at 9.
[28] *Id*.
[29] *Id*. at 6 (citing Ex. P-9).
[30] *Id*. at 7.
[31] 42 C.F.R. § 413.89(a).

As referenced above, the PRM 15-1 § 300 addresses Medicare bad debts.[32] 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 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 patient's financial condition, the patient's debt may be deemed uncollectible without applying the reasonable collection procedures set forth in § 310.

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

As noted above, CMS requires provider to utilize their "customary method" for determining patient indigence with respect to Medicare beneficiaries under the aforementioned guidelines in § 312. CMS also uses this "customary" language in PRM 15-1 §§ 310(B) and 310.2, regarding reasonable collection efforts, in which CMS states that a "provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.[,]" and that, if, "after reasonable and *customary* attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."[33] 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."[34] As a provider's customary method for determining patient indigence is part of a provider's overall debt collection policy, a provider's indigent patient policy must also be in writing and the provider must apply its policy consistently to both Medicare and non-Medicare patients alike.[35]

1. Whether Asset Testing Is Required under PRM 15-1 § 312(B).

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

[32] 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."
[33] (Italics emphasis added.)
[34] *Momence Meadows Nursing and Rehabilitation Center, LLC v. National Gov't Servs.*, PRRB Dec. 2018-D23 at 4 (Feb. 12, 2018). *See also 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).
[35] *See Baptist Healthcare System*. *See also* Ex. P-15.

> making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence[.][36]

The Medicare Contractor maintains that "should," as used in § 312(B), connotes a mandatory requirement; otherwise, failure to comply with the instructions are of no consequence.[37] However, in *Baptist Healthcare System*, the District Court stated:

> [T]he question before the Court is 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.[38]

Further, the District Court stated "[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."[39] Ultimately, over 10 years later, in the FFY 2021 Hospital IPPS Final Rule (Sept. 18, 2020), 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 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 the requirements for a facility's determination of indigency).
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> . . .
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> We . . . proposed to amend § 413.89(e)(2) by adding new paragraph (e)(2)(ii)(A) to specify that 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

[36] (Bold and italics emphasis added.)
[37] Medicare Contractor's PPP at 5.
[38] *Baptist Healthcare System* at 33.
[39] *Baptist Healthcare System* at 35.

> 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.
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> . . .
>
> 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.[40]

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***.[41]

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 this cost reporting period at issue in this appeal, FYE 9/30/2014, predates the change.

The Board acknowledges that district court decisions are not binding, however, they may be persuasive authority on subject matters before administrative tribunals and higher courts. Moreover, prior to the District Court's decision, the Board previously ruled on this issue and, thus, continues to apply its reasoning set forth in prior Board decisions, as well as that of the District Court in *Baptist*. In its final administrative decision 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."[42] Further, the Board allowed that "some

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[40] 85 Fed. Reg. 58432, 58996-7 (Sept. 18, 2020) (bold and italics emphasis added).
[41] *Id*. at 58999 (bold and italics emphasis added).
[42] *Baptist Regional Medical Center Corbin, Kentucky* PRRB Dec. 2008-D12 at 6 (2008).

instances, [] will require an asset test while other circumstances may obviate the need for that test."[43] After this decision was overturned by the Administrator, on appeal, the District Court for the District of Columbia overturned 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 court "must" but rather court "should," it suggests an approach and does not mandate it.) Moreover, the court in *Harris County*[44] 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. [*Harris County*] 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.
>
> 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.[45]

Accordingly, the Board concurs with the District Court in *Baptist*—"*must"* connotes a mandate while "*should"* permits election. However, this finding is not dispositive of this case.

Next, the Board takes under consideration:

> Whether South Lake's charity care claims written off to Medicare bad debt meet the criteria set forth in 42 C.F.R. § 413.89 and § 312 of the Medicare Provider Reimbursement Manual.

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[43] *Id*.
[44] *Harris County Hospital*.
[45] *Baptist Healthcare System* at 35.

Previously discussed, the Board has interpreted the "reasonable and customary" language set forth in § 310 to require that a provider have a written debt collection policy to memorialize the process for its "collection efforts" required under 42 C.F.R. § 413.89(e). In the Provider's Preliminary Position Paper, it states:

> The Provider undertook the procedures outlined in the attached Financial Assistance Policy, ***but the formal Policy was not updated until 2015.*** The workpapers will show that for both 2014 and 2015, the Provider followed the Financial Assistance Policy, Application for Financial Assistance, and used the approved presumptive eligibility testing.[46]

Indeed, the Board reviewed the Financial Assistance/Community Care Procedure policy provided by South Lake and notes that the "Original Effective Date" is February 1, 2015.[47] The Board cannot accept mere argument as evidence that this policy was in place during Fiscal Year 2014. As noted *supra*,[48] providers are required to have a written debt policy and indigent patient policy. They are also required to follow said policy. Simply stated, the Board finds that South Lake has failed to prove by a preponderance of the evidence they had such a policy during FY 2014.

South Lake also cites to its "Financial Assistance Application."[49] However, the Application's footer indicates, "Rev. 7/17."[50] In accordance with standard document revision history tracking, this is a clear indication that the Application template in the record was last revised in July of 2017. This is, again, ***after*** the fiscal year in question. Additionally, Exhibit P-10 appears to be Inpatient Collection forms with information similar to that requested in the Application. However, this exhibit is not explained or interpreted anywhere in the record.[51] The mere existence of an application or collected data is not enough to determine ***how*** South Lake was making indigency determinations in FY 2014, and it is not sufficient documentary support for an application made for charity care in FY 2014. Therefore, in addition to the absence of a written policy, the Board finds that the documentation provided does not substantiate how indigency determinations were made.

Based on the foregoing, in agreement with the Medicare Contractor's determination, the Board finds that South Lake's bad debt claims were not adequately supported by sufficient documentation of patient indigency.

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[46] Provider's PPP at 7, fn. 1.
[47] Ex. P-1 at 3.
[48] *See also* n. 35 & 36.
[49] *See* Ex. P-8.
[50] *Id.* at 1.
[51] The Board also notes several discrepancies. Many (Patients A through G, T & ZD) show a "write-off date" of 9/9/9999; Patient L has a credit score of 759 and is low risk; Patients A, F, H, J, L, M have the exact same income. The Board is unable to interpret/reconcile this limited information.

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor correctly disallowed the bad debt reimbursement for the records because South Lake failed to adequately support their indigence determinations.

BOARD MEMBERS PARTICIPATING:

Kevin D. Smith, C.P.A.
Ratina Kelly, C.P.A.
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

6/4/2026

X Kevin D. Smith, CPA

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