CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Sentara Healthcare Bad Debt CIRP Groups	**Determination for Cost Reporting Periods Ending: 2010-2011, 2012, 2013**
Providers	
vs.	**Case Nos. 16-0408GC, 16-0409GC, 16-2238GC**
Medicare Contractor - Palmetto GBA c/o National Government Services	**Review of: PRRB Dec. No. 2020-D17 Dated: August 26, 2020**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The Medicare Administrative Contractor (MAC)[1] commented, requesting Administrator's review. The parties were notified of the Administrator's intention to review the Board's decision. The Providers submitted comments requesting that the Administrator affirm the Board's decision, in part, and reverse the portion of the Board decision, in part. The Chronic Care Policy Group (CCPG), Center for Medicare, commented disagreeing with the Board's decision to reverse the MAC's disallowance of the bad debts. Accordingly, the case is now before the Administrator for final administrative decision.

BACKGROUND

The Providers in these group appeals consist of Medicare-certified acute care hospitals located in the Commonwealth of Virginia, each of which are under the common ownership or control of Sentara Health care. The MAC denied Medicare reimbursement for all of the Providers' Medicare

[1] 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" refers to both FIs and MACs as appropriate.

indigent patient bad debts, pursuant to the methodology utilized by the Providers for making the indigency determination. The MAC contended that its disallowance was proper because the Providers failed to follow the prescribed criteria for verifying indigency in accordance with CMS regulations and to document that verification. More specifically, the MAC disallowed the bad debts at issue due to the Providers' lack of due diligence in establishing patient indigence by not performing an asset analysis as instructed by Provider Reimbursement Manual (PRM) 15-1, § 312. The Providers argued that hospitals are free to develop their own customary methods for determining and documenting a beneficiary's indigence, and that the plain language of the controlling rules allow Medicare bad debt reimbursement with respect to Medicare patients who are determined to be indigent under the hospital's customary methods. In addition, the Providers claim that the credit reports and scores that are used in the indigence determinations provided a reliable and accurate means of assessing income, assets, expenses and liabilities.

ISSUE AND BOARD'S DECISION

The issue, set forth by the Board, was whether the MAC properly adjusted Medicare bad debt accounts considered indigent by the Providers and claimed as Medicare bad debt. The Board focused its decision-making on whether the asset-test guideline at §312(B) of the PRM must be applied to determine a Medicare beneficiary's indigence. The Board majority found that the MAC improperly adjusted the Providers' Medicare bad debt claims for indigent patients and remanded the fiscal years 2010 – 2013 to the Medicare Contractor to reverse the adjustments in part and conduct a further review of the Providers indigent bad debt determinations, for accounts less than $10,000, as follows:

1. For those patients, unmarried or married, that Sentara qualified through its Charity by Application procedure (either written or telephonic), the MAC will review the available documentation to verify the patient's income; if family income is less than 200% of the Federal Poverty Level, the MAC should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims;

2. For those unmarried patients that Sentara qualified through its Charity by Model procedure and, based on its Charity Care Policy, identified as not needing an asset check completed, the MAC will review the available documentation to verify the patient's income. If the sole source of documentation is an Equifax score and report, the Board finds that the Equifax score and report comport with Sentara's written Charity Care Policy regarding income verification for this subset of patients. If the unmarried patient's income is less than 200% of the Federal Poverty Level, the MAC should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims;

3. For those unmarried patients that Sentara qualified through its Charity by Model procedure and, based on its Charity Care policy, identified as needing an asset check completed, the MAC will review the available documentation to verify a completed

asset check and the patient's income. If the sole source of the documentation is the Equifax score and report, the Board finds that the Equifax score and report comport with Sentara's written Charity Care Policy regarding asset check and income verification for this subset of patients. If the unmarried patient's income is less than 200% of the Federal Poverty Level and there are insufficient assets available to pay the Sentara debt, the MAC should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims;

4. For those married patients that Sentara qualified through its Charity by Model procedure, the MAC will review the available documentation to verify the family's income; if the married patient's family income is less than 200% of the Federal Poverty Level, the MAC should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims. However, for those married patients that Sentara qualified through its Charity by Model procedure, and the sole source of the documentation is the Equifax score and report, the Board finds that the Equifax score and report do not comport with Sentara's written Charity Care Policy regarding income verification for this subset of patients; and, the Board finds that, for these claims, the MAC's denial of bad debt reimbursement was proper;

5. For those patients Sentara qualified as eligible for Charity Care due to "extraordinary circumstances," the MAC will verify the documentation supporting the "extraordinary circumstances" and ensure that Charity Care approval was made by the Vice President - Revenue Cycle, Director - Patient Accounts, Manager - Patient Accounts, or Chief Collection Counsel, in accordance with Sentara's written Charity Care Policy. If the MAC verifies the appropriate management employee approved the Charity Care determination based on an internal determination of extraordinary circumstances, the MAC should determine the appropriate amount of bad debt reimbursement due under the Medicare program for this subset of claims.[2]

Two Board Members concurred with the majority's description of Medicare bad debt policy that an asset analysis was not required and that a third party source, like Equifax, may be used by providers. However, the two Board members pointed out that the Medicare allowance of the indigent bad debts turns on the applicable of a written patient indigence policy that was in effect for the Providers during the time periods at issue. Unlike the majority, they did not find that the Providers had written policies that properly adopted and identified Equifax as part of its patient indigent determination process. The dissenters found that the MAC properly disallowed the indigence write offs at issue except 1) where either a written application was submitted by the patient or a Sentara employee filled out a telephone application; or 2) there was documentation

[2] *See*, PRRB Decision 2020-D17, at pp. 23-24.

from a State Medicaid agency establishing that the patient was below 200% of the Federal Poverty Line.[3]

SUMMARY OF COMMENTS

The MAC submitted comments, requesting reversal of the Board's decision. The MAC argued that §312 of PRM provides specific instructions for determining indigence including the use of an asset analysis. The asset analysis or test is defined as an accounting of a patient's total resources, including, but not limited to, an analysis of assets, liabilities, and income and expenses. Providers are required to follow the prescribed criteria for verifying indigency in accordance with the PRM and the regulations at 42 C.F.R. §413.89, and they are also required to document that verification for audit. The MAC noted that the cost reimbursement regulation at 42 C.F.R. § 413.24(a) states that providers receiving Medicare payment on the basis of reimbursable cost must provide adequate cost data based on the providers' financial and statistical records which must be capable of verification by auditors. The MAC noted that as the indigence claims were primarily determined by using Equifax scores and reports, the Equifax process and work product must be audited.

The MAC argued that, however convenient and cost effective, the Equifax scores are not capable of proper audit, as the scores are based on a cryptic method of statistical sampling and not based on an actual analysis of the patient's income, resources and assets. The formula or methodology employed by Equifax is mostly unknown, proprietary and a well-guarded trade secret with an unknown error rate for the various predictor scores. The source data is not known, and no human review or input is involved. Thus, the MAC argued that it was unable to perform any sort of competent audit regarding the Equifax data and is not able to verify the reliability or accuracy of these predictive scores.

Moreover, the MAC noted that the Providers failed to follow its own written Charity Care Policy. The policy states that in order to be eligible for Sentara charity care, patients must agree to complete the Charity Application, furnish information and documentation when required, and complete the application process. The MAC pointed out that patients identified by the Charity-by-Model process have not cooperated with the application process, nor provided financial information and documentation as the policy requires, and thus, these patients should not be eligible for Sentara charity care. Moreover, the Equifax data does not identify whether another party is responsible for the patient's medical bills, a requirement of the PRM. The MAC argued that Sentara's Charity Care Policy requires the Providers to consider "family income" when making its indigent patient determinations, but the Equifax scores and reports only consider individual patient resources. Equifax also does not uncover if there are any third party payors, eligibility for other governmental programs, whether the patient has a tort claim, or whether the patient is a beneficiary of a trust, life insurance, or if there is a probate estate, etc. The MAC argued that these factors are critical since Medicare is the payor of last resort.

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[3] *See* PRRB Dissent for Decision 2020-D17, at pp. 4-8.

The MAC also contested the Board's conclusion that the Secretary's use of the words "must" and "should" within PRM § 312 do not carry the same meaning in the context of § 312 of the PRM, and that ultimately the hospital was not required to perform an asset test when determining indigency. The MAC stated the Board's findings were directly contrary to CMS' longstanding position that the PRM does mandate an asset analysis to determine indigency. Moreover, the MAC argued there was no way to obtain the underlying source data that Equifax uses to generate the predictor scores, as the reports merely provided a numeric score to predict whether the patient was likely to pay the hospital. The MAC also argued there is nothing in the record to explain how and why the reports were reliable, accurate, or how the scores were generated. The MAC further noted that the Board incorrectly determined that the reports are admissible in a legal proceeding to prove the assertion being made without any foundation. It further argued that no court has accepted such evidence without a long standing and established foundation of reliability and accuracy. Thus, the MAC stated that it believed the Board erred in proclaiming that the Equifax reports were sufficient to determine a patient's indigency as a matter of law. Moreover, the MAC argued that the burden is on the Providers to establish indigency and not the MAC. The MAC argued that the Board's decision should be reversed, accordingly.

The Providers commented, requesting affirmation of the portions of the Board Majority ruling for the Providers, and reversal of the portion of the Board Majority decision ruling against the Providers and incorporated by reference the arguments set forth in briefs. These included some of the following arguments. The Providers noted that in §312 of the PRM, CMS declares that a provider should apply its customary methods for determining the indigence of patients. The Providers argued that, during the fiscal years at issue, its indigent determinations for both Medicare and non-Medicare patients were completed using its "customary methods" as documented within its Charity Care Policy. Under Sentara's Charity Care Policy, patients may be identified as "Prospective Charity" through written applications, telephone applications, telephone screening or "Charity Model" (i.e., Charity-by-Model) qualification. The Charity-by-Model qualification relies heavily, if not exclusively, on Equifax credit scores and reports. Once a patient has been identified as Prospective Charity, a Financial Assistance or Charity Application is sent to the patient. Sentara's Charity Care Policy states that "[a]pplicants who do not provide the requested information necessary to completely and accurately assess their financial situation will not be eligible for Sentara Charity Care."[4]

If a Prospective Charity patient responds to Sentara's request for information through the application process or telephone screening, Sentara is able to determine qualification for charity care through the information and documentation submitted by the patient (including self-reported information regarding income, assets, liabilities and expenses, and documents such as tax returns, bank statements, Social Security statements, W-2s, etc.). With these Charity by Application

[4] Providers' Consolidated Final Position Paper, Exhibits P-2 and P-22.

patients, Equifax scores and reports are used primarily to verify the patient's self- reported information.[5]

Prospective Charity patients identified by Sentara's Charity-by-Model qualification involve patients with Equifax "scores" that fall within certain parameters. Under the Charity-by-Model method, patients may still be approved for charity care even if those patients fail to complete a Financial Assistance or Charity Application, participate in telephone screening or respond to requests for information. The Providers argued that this method uses data available from other sources, typically furnished by Equifax, where it evaluates the financial data obtained to verify a patient's indigent status. The Provider also stated that the Equifax scores and reports that it uses are specifically designed for medical providers attempting to collect for medical services. It utilizes three scores from Equifax: the income predictor score, the payment predictor score and the bankruptcy navigator index. The Provider argued that data for the scoring is drawn from the individuals' current and historical financial and credit transactions maintained in a multitude of databases that Equifax draws upon and is designed to take into account characteristics statistically associated with healthcare patients. Thus, the Provider argued that, when making its patient indigence determination, the use of these Equifax scores is as accurate and complete, if not more so, than the information self-reported by patients.[6]

In denying the Provider's indigent patient bad debt, the MAC claimed that §312 of the PRM creates a mandatory asset test that Sentara failed to perform during its indigent patient determinations. The Provider argued that within the plain language of §312 of the PRM, CMS suggests, but does not mandate, that providers perform an asset test when conducting its indigent patient determinations. The Provider also claimed that, even if CMS mandates an asset test be performed in such situations, Equifax's reports and scores provide a reliable and accurate means of assessing income, assets, expenses and liabilities.[7]

The Chronic Care Policy Group (CCPG) commented disagreeing with the Board's decision to reverse the MAC's disallowance of the bad debts. CCPG argued that the Providers failed to evaluate the beneficiaries' indigence for Medicare bad debt under the requirements set forth in the regulations under 42 CFR § 413.9 and the Provider Reimbursement Manual (PRM) (CMS Pub. 15-1), Chapter 3, §312. CCPG noted that, of importance in this case, under § 413.89(g), charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs. Thus, under PRM, Chapter 3, §328, charity, courtesy, and third party payer allowances are not reimbursable Medicare costs. The CCPG emphasized that it is very important to recognize the difference between determining indigence for charity care purposes and determining indigence for Medicare bad debt purposes. CCPG noted that because charity care costs are not reimbursable Medicare costs, Medicare only requires a provider to have a verifiable charity care policy in place.[8] The CCPG explained that this does not mean that a provider's charity care policies have to be the

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[5] *Id.* at 11.
[6] Providers' Consolidated Final Position Paper, pages 7-11.
[7] Providers' Consolidated Final Position Paper at 14.
[8] *See* 75 Fed. Reg, 44314 at 44456.

same as those policies used to determine indigence for Medicare bad debt payment. The CCPG commented that PRM §312, in fact, requires a provider to perform a more intensive analysis to determine a Medicare beneficiary's indigence for bad debt purposes than that used for charity care determinations in the instance case. It is this more intensive analysis for bad debt purposes that ensures that the most appropriate and auditable process is in place to protect the Medicare Trust Fund.

The CCPG also disagreed with the Board's assertions and mischaracterizations that PRM §312.B does not mandate an evaluation of a beneficiary's assets. The CCPG supported Medicare's longstanding bad debt policy regarding indigence determinations that includes the requirement that a provider evaluate a patient's total resources, including assets. The CCPG also disagreed with the Board's finding that the MAC improperly imposed verification requirements of the underlying Equifax data supplied by the Providers. CCPG concluded that the Equifax data and work product do not meet CMS auditing and verification standards under the regulations set forth § 413.20 and 413.24. The Equifax data does not verify the Providers' declarations of indigence for the beneficiaries at issue. CCPG stated that providers are required to maintain sufficient financial records for the proper determination of costs payable under the Program, and furnish such information to the contractor as may be necessary to receive Medicare payments and to assure that the payment is appropriate Thus, the CCPG disagreed with the Board's decision to remand the FYE 2010-2013 bad debt determinations to the Contractor to reverse the adjustments and conduct further review of the Providers' indigent bad debt determinations for accounts less than $10,000.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments were received timely and are included in the record and have been considered.

The Medicare program provides, among other things, medical benefits to eligible persons over the age of 65. Medicare Part A provides reimbursement for inpatient hospital and related post-hospital, home health and hospice care.

Section 1815 of the Act requires a provider to support its claim for costs with verifiable, auditable documentation and states:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate ... from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to

> any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

Under §1861(v)(1)(a) of the Act, provider of services are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. That section defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included...." The section does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters. One of the underlying principles set forth in §1861(v)(1)(A) of the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs.

This principle is reflected at 42 C.F.R. §413.9(c), which provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries. However, if the provider's costs include amounts not reimbursable under the program, those costs will not be allowed. Further, paragraph (c) (1) states that "[i]t is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients."

Consistent with these principles, 42 C.F.R. §413.89[9] provides that bad debts, which are deductions in a provider's revenue, are generally not included as "allowable costs" under Medicare. The regulation at 42 CFR 413.89 defines "bad debts" as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services." "Accounts receivable" and "notes receivable" are defined as designations for claims arising from the furnishing of services, and are collectable in money in the relatively near future. The regulation at 42 C.F.R. §413.89 recognizes that that the cost of Medicare services are not to be borne by others. Therefore, for such services reimbursed by the program based on reasonable cost, or paid under a cost based prospective payment system, the costs attributable to the Medicare deductible and coinsurance amounts which remain unpaid are added to the Medicare share of allowable costs if certain criteria are met.[10] The circumstances under which providers may be reimbursed for the bad

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[9] The regulation at 42 CFR 413.80 et. seq. has been redesignated to 42 CFR 413.89 et. seq. See 69 Fed. Reg. 49254 (Aug. 11, 2004).

[10] The following amounts are not included as allowable bad debts under Medicare: "Unpaid Medicare deductible and coinsurance amounts associated with furnishing non-covered services and services furnished to non-Medicare patients; Unpaid Medicare premiums and Medicare copayments 510 associated with any covered service; Unpaid Medicare deductible and coinsurance amounts associated with any covered services paid by the program under a fee schedule or under a reasonable charge-based methodology including Program fee schedule payments made to physicians (and payments to providers on behalf of provider-based physicians)

debts derived from uncollectible deductibles and coinsurance amounts are set forth at paragraph (e). The regulation at 42 C.F.R. §413.80(e) states that to be allowable, a bad debt must meet the following criteria:

> 1) The debt must be related to covered services and derived from deductible and coinsurance amounts
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> 2) The provider must be able to establish that reasonable collection efforts were made.
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> 3) The debt was actually uncollectible when claimed as worthless.
>
> 4) Sound business judgment established there was no likelihood of recovery at any time in the future.

In addition, under §413.89(g), charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs.[11] Notably, unpaid Medicare deductible and coinsurance amounts written off to charity care are not allowable. Accordingly, standards used by providers for charity care determinations do not rely upon the requirements of 42 CFR 413.89 as Medicare funds paid under 413.89 are not at risk or implicated.

To comply with 42 C.F.R. §413.89(e)(2), the Provider Reimbursement Manual (PRM) provides further guidance with respect to the payment of bad debts. Section 302 of the PRM sets forth the applicable definition, stating:

> 302.1 Bad Debts.--Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

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for professional services and fee schedule payments made to other practitioners; Unpaid Medicare deductible and coinsurance amounts associated with covered services paid for under a contractual capitated rate-based plan, such as but not limited to, a Medicare Advantage plan; *Unpaid Medicare deductible and coinsurance amounts written off to charity care*; Unpaid Medicare deducible and coinsurance amounts written off to a contractual allowance account." 84 Fed. Reg. 58989.

[11] 42 C.F.R. §413.89(g), Charity allowances, states: "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."

> 302.2 Allowable Bad Debts.--Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in § 308. Allowable bad debts must relate to specific deductibles and coinsurance amounts.
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> 302.3 Charity Allowances.--Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.
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> ….
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> 302.5 Deductible and Coinsurance Amounts.--Deductible and coinsurance amounts are amounts payable by beneficiaries for covered services received from providers of services, excluding medical and surgical services rendered by physicians and surgeons. These deductibles and coinsurance amounts, including the blood deductible, must relate to inpatient hospital services, post-hospital extended care services, home health services, outpatient services, and medical and other health services furnished by a provider of services.

Section 310 of the PRM provides the criteria for meeting reasonable collection efforts. Section 310 of the PRM pertaining to a reasonable collection effort, states in part:

> 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 section 312 for indigent or medically indigent patients.) (Emphasis added.)

Moreover, §310.B states that the provider's collection effort should be documented "in the patients file by copies of the bill(s)...." Section 312 of the PRM explains that individuals who are Medicaid eligible as either categorically or medically needy may be automatically deemed indigent. Section 312 of the PRM, “Indigent or Medically Indigent Patients,” states:

> 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:
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> 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;
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> B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;
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> C. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; and
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> D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.
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> E. 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.

Consistent with the documentation requirements of 42 C.F.R. §412.20 and §413.24, the Secretary has consistently interpreted the manual provisions as requiring providers to comply with all terms in order to receive reimbursement for Medicare bad debt and has issued subsequent interpretive materials consistent with this position. Sections 310 and 312 of the PRM set forth procedures that must be followed and criteria that must be met in order to comply with the regulations. In addition, consistent with 42 C.F.R. §413.89(e) under PRM, chapter 3, § 328, Charity, Courtesy, and Third-Party Payer Allowances—Cost Treatment, charity, courtesy, and third-party payer allowances are distinguished from foregoing Medicare bad debts relating to unpaid coinsurance and deductibles and are not reimbursable Medicare costs.[12]

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[12] Section 328 of the PRM, states: "Charity, courtesy, and third-party payer allowances are not reimbursable Medicare costs. Charges related to services subject to these allowances should be recorded at the full amount charged to all patients, and the allowances should be appropriately shown in a revenue reduction account. The amount reflecting full charges must then be used as applicable to apportion costs and in determining customary charges for application of the lower of costs or charges provision. Example - The provider entered into an agreement with a third-party payer to render services at 25 percent below charges. Accordingly, for an X-ray service with a charge of $40, the provider billed the third party payer $30. The charge of $40 would be used to

In the instant case, the indigent patient bad debts at issue does not concern Medicare beneficiaries determined eligible for Medicaid. The Providers sought Medicare bad debt reimbursement related to accounts associated with beneficiaries the Providers had declared to be indigent, using for the most part a third party Equifax evaluation tool. The Provider had various charity care policy models that required it to review patients' income or income and assets only, depending on which charity care policy the patient falls.

Sentara Healthcare provides financial assistance to certain low-income patients who qualify for assistance. The Providers' written Charity Care Policy are set forth in Provider Exhibits P-2 and P-22. The written Charity Care Policy provides full charity care write-off of account balances less than $10,000 for patients whose household income is 200% or less of the Federal Poverty Level and, not involved in this case, also offers a sliding scale discounts for those uninsured patients whose household income is above 200% of the FPL.

The Providers' written charity care describes three methods for granting charity care: (1) Sentara's Charity-by-Application procedure, in which a prospective charity care patient applies for charity care by either submitting an application or completing an application by phone; (2) Sentara's Charity-by-Model procedure in which prospective charity care patients who are identified through other means, including Equifax credit reporting and scores; and, (3) Sentara's "extraordinary circumstances" policy in which certain Sentara managers are permitted to document approval of charity care for applications that do not meet all guidelines.

Under Sentara's Charity Care Policy, patients may be identified as "Prospective Charity" through written applications, telephone applications, telephone screening or may be identified as "Prospective Charity" through the "Charity Model" (i.e., Charity-by-Model) qualification, which relies heavily on Equifax credit scores and reports. Once a patient has been identified as Prospective Charity, a Financial Assistance or Charity Application is sent to the patient, and completion is required to be eligible for Sentara Charity Care. If a Prospective Charity patient responds to Sentara's request for information through the application process or telephone screening, Sentara is able to determine qualification for charity care through the information and documentation submitted by the patient (including self-reported information regarding income, assets, liabilities and expenses and Equifax scores and reports are used primarily to verify the patient's self-reported information. Prospective Charity patients identified by Sentara's Charity-by-Model qualification involve patients with Equifax scores that fall within certain parameters

Under the Charity-by-Model method, the Provider stated that patients may still be approved for charity care, even if those patients fail to complete a Financial Assistance or Charity Application, participate in telephone screening or respond to requests for information. This method uses data available from other sources typically furnished by Equifax. Sentara evaluates the financial data

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apportion costs and the $10 allowance would be recorded in a revenue reduction account."(Transmittal 332, dated 01-83).

obtained through the Equifax report and any additional sources of information available to verify a patient's indigent status.

Sentara stated that the Equifax scores and reports that it uses are designed specifically for medical providers attempting to collect for medical services and uses three scores from Equifax: the income predictor score, the payment predictor score and the bankruptcy navigator index. The data drawn upon by Equifax is designed to take into account characteristics statistically associated with healthcare patients.[13] The MAC disallowed the Providers' FY 2010-2013 Medicare bad debt claims because the Providers did not furnish the Contractor with the documentation necessary to substantiate their indigence determination. The Providers failed to perform an analysis of beneficiaries' total resources, including an analysis of beneficiaries; assets, income, liabilities and expenses, as required to establish indigence under PRM §312.

First, the Administrator finds that §312 of the PRM requires providers to take into account all necessary information and resources to properly deem any patient indigent and, thus, meet the regulatory requirements that a reasonable collection effort was made and that the debt was uncollectible when claimed as worthless. Pursuant to the regulation and manual instructions cited above, except in cases where a patient has been determined eligible for Medicaid, providers are required to follow certain procedures in making indigency determinations. Those procedures include: not relying on patient declarations of inability to pay as proof of indigency; the application of an asset test- taking into account patient assets, as well as liabilities, income expenses, to determine indigency; and ensuring after an initial determination that a patient is indigent, that the beneficiary's financial condition has not improved. Medicare beneficiary may have assets that are convertible to cash, unnecessary for the beneficiary's daily living expenses, and which can be used for the beneficiary's care, including medical cost-sharing expenses. Evaluating a beneficiary's income and assets yields a more appropriate assessment of indigence for Medicare bad debt purposes.

Section 312 of the PRM compels providers to follow the above-cited procedures to determine indigence to ensure compliance with the requirements of 42 C.F.R. §413.89(e). The required provider compliance with these procedures in order to receive Medicare payment, flows from the plain, mandatory language of PRM §312, providing *inter alia*: "indigence must be determined by the provider… a patient's signed declaration… cannot be considered proof of indigency", "[t]he provider should take into account a patient's total resources"; "[t]he provider must determine that no other source other than the patient would be legally responsible"; "[t]he patent's file should contain documentation"; and "the provider concludes that there has been no improvement in the beneficiary's financial condition." (Emphasis Added).[14] A review of PRM bad debt Manual

[1313] Provider Exhibit P-5 and P-6.

[14] The Administrator notes that the introduction and paragraphs B and D of § 312 of the PRM uses "should" whereas paragraphs A and C use "must." The Administrator finds that within the context of the regulation and the PRM, "should" is synonymous with "must." *The Random House Dictionary of the English Language*, p. 1771 (2d ed. 1987); *Rogets International Thesaurus*,

provisions shows the consistent interchangeable use of the terms "must" and "should".[15] For example, in §328 of the PRM, "should" is used where clearly no other action is an option.[16] In contrast, when guidance is optional, the PRM manual uses the word "may" such as when the PRM states that a provider's collection effort *may* include using or threatening to use court action to obtain payment or *may* include the use of a collection agency.[17] The Board's own five point order in this case shows the fluid and interchangeable use of the terms "will" and "should" when the Board instructs the MAC as to the ruling's implementation using the term will in one sentence

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§637.10 (3d ed 1962). The Administrator also notes that the district court in *Harris County Hospital v. Shalala*, 863 F. Supp. 404 (S.D. Texas, 1994); affirmed by *Harris County Hospital District v. Shalala*, 64 F.3d 20, disagreed with the Administrator's interpretation that "should" means "must" within the context of § 312 of the PRM. The District Court in *Harris County*, found, much like the Board in the instant case, that the use of the word "should" is precatory language and only suggests, but does not mandate, the use of an asset test. However, the Administrator also notes that the District Court's decision was affirmed by the Eleventh Circuit Court of Appeals' decision in *Harris County* on grounds other than the definition of "should" and "must." The Administrator also notes that the district court in *Baptist Healthcare System v. Seblius*, 646 F. Supp. 2d 28 (D.D.C., 2009), disagreed with the Administrator's interpretation that "should" means "must" within the context of § 312 of the PRM. The Board rejected the MAC's argument that the District Court decision is distinguished from the instant case, in that (1) all of the patients in *Baptist* submitted applications, whereas the Charity-by-Model patients at issue here have no applications; (2) *Baptist* did not involve the use of Equifax scoring; and (3) in *Baptist*, the Provider's charity care policy was not at issue, while in the instant appeal, the MAC is asserting that the Providers have not followed their own written charity care policies. The Board found these distinctions were not relevant as the issue in both cases involved criteria the Providers "must' meet and those the Provider "should" meet. However, these facts underscore that, even under the Baptist ruling, the Providers are not in the same factual situation as the Baptist providers. Moreover, CMS has since codified the mandatory requirements under review since this ruling.

[15] The Board's own order shows the fluid interchangeable use of the terms of "will" and "should" when instructing the MAC as to its implementation .It is unlikely the MAC would interpret the Board's use of the term "should " as an optional discretionary action to be undertaken by the MAC, but rather interpret it to align consistent with the term "will" in the prior sentence.

[16] *See e.g*. Section 328 of the PRM, which states: "Charges related to services subject to these allowances *should* be recorded at the full amount charged to all patients, and the allowances *should* be appropriately shown in a revenue reduction account." In using the term "should, the Medicare program is not offering this instruction as permissive guidance.

[17] *See e.g.*, Section 312 of the PRM. ("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,…"); section 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.")

and should in the next sentence, where clearly both are not discretionary actions to be undertaken by the MAC.

The criteria set forth in PRM §312 regarding the determination of indigence has been the subject of litigation as to whether the criteria are mandatory. The final rule published on September 18, 2020 at 85 Fed. Reg. 58432, 58988, clarifies and codifies this longstanding policy and criteria set forth in PRM §312 - A through D.[18] The rule also amended 42 C.F.R. §413.89(e)(2) by adding new paragraph (e)(2)(ii) to define an indigent non-dual eligible beneficiary as a Medicare beneficiary who is determined to be indigent by the provider and not eligible for Medicaid as categorically or medically needy. CMS also amended §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 conditions:

(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;
(3) May consider extenuating circumstances that would affect the determination of the beneficiary's indigence or medical indigence which may include an analysis of both the beneficiary's liabilities and expenses, if indigence is unable to be determined under (ii)(A)(2).
(4) 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.
(5) Must maintain and, upon request, furnish its Medicare contractor with the provider's indigence determination policy describing the method by which indigence or medical indigence is determined and all the verifiable beneficiary specific documentation which supports the provider's determination of each beneficiary's indigence or medical

The rule amended §413.89(e)(2) by adding new paragraph (e)(2)(ii)(B) to specify that once indigence is determined the bad debt may be deemed uncollectible without applying a collection effort under paragraph (e)(2)(i)(A) or (B) of this section. These rules are effective for cost reporting

[18] 85 Fed. Reg. 58432 (September 18, 2020).

periods beginning before, on and after the effective date of this rule because they are clarifications and codifications of longstanding Medicare policies.

In addition, CMS specifically responded to the use of "presumptive eligibility tools" and stated:

> Commenters' suggested to allow providers to determine Medicare beneficiaries to be indigent by using presumptive eligibility tools for Medicare bad debt purposes, which could also serve to reduce burden to providers when evaluating indigence. Commenters suggested that many presumptive eligibility tools utilize various factors to evaluate a patient's ability to pay for medical services, including but not limited to, a patient's demographics, zip code, credit score, or income, and could also be used to determine a Medicare beneficiary to be indigent for bad debt purposes. Although presumptive eligibility tools may reduce a provider's burden when evaluating indigence, we disagree that presumptive eligibility tools should be used to determine a Medicare beneficiary's indigence status for Medicare bad debt purposes. Many of the presumptive eligibility tools cursorily review a patient's financial status, based either on the patient's declaration or demographic presumptions, or income and presume one to be indigent.[19]

In addition, as emphasized by CMS, the costs at issue here are not charity care costs, but costs providers claimed for payment by the Medicare Trust fund. Accordingly, while a provider may apply less stringent documentation standards for its hospital charity care program or other governmental charity care programs, Medicare rules have specific criteria for documenting the indigent for Medicare bad debt purposes. CMS recognized that other Federal, State or local indigent programs may have criteria different from the Medicare bad debt indigence policy, for various reasons or program incentives, and permit providers to use presumptive eligibility tools, to qualify patients for other indigent program. CMS observed that, in contrast to these indigence programs:

> The Medicare bad debt policy is not an indigence program; it is a Medicare policy to pay providers for a beneficiary's unreimbursed deductible and coinsurance amounts after the provider has met certain criteria. The criteria for other indigence programs, such as charity care, may have different program or policy requirements than Medicare bad debt. Medicare does not pay providers directly for charity care, whereas Medicare bad debt amounts may be allowable, and directly paid to various provider types, without the providers performing a reasonable collection effort if the beneficiary qualifies for indigence.[20]

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[19] 85 Fed. Reg. 58998.

[20] 84 Fed. Reg. 58998.

Accordingly, providers may adopt charity care criteria that are different from those required by Medicare and rely upon evaluation tools, but Medicare rules requires a more intensive case by case analysis to determine indigence for allowable Medicare bad debt purposes and verifiable documentation.

In the instant case, the Provider used Equifax scoring, (a tool and methodology not reflected in their policy, but used it their practice), to determine whether beneficiaries were indigent and also declared that the use of Equifax scoring complied with Medicare bad debt policy because the indigence determination was not made by the patient.[21]
Section 312 of the PRM does require, among other things, an asset test and a review of total resources. Equifax in contrast is a predictive analytic modeling method, that is proprietary, not auditable, and that does not rely upon patient specific information on the patient's total resources, nor reveal other payors. Medicare rules also do not allow for self- verification of indigence of the individual. To use such evaluation tools in allowing Medicare bad debt payments, would replace Medicare bad debt and documentation rules established by the agency tasked with the legal authority to administer the Medicare program, with the proprietary protected "rules"[22] for determining charity care developed by a private entity with no such legal or contractual responsibilities to the program.

Even aside from the requirement that a provider consider all resources including assets, including the beneficiary's income, assets, expenses and liabilities in making an indigence determination, it is, more centrally an element that the provider itself must determine the indigence of a patient. In these cases, the indigence determinations were not made by the Providers, but rather, they were made by Equifax based on an unauditable and proprietary method using predictive analytic modeling and not based on an actual analysis of the patient's resources, much less the patient's total liquid resources. Such reliance on a credit scoring company replaces Medicare indigence

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[21] The Board's dissenting opinion also noted that the Providers' used Equifax data to determine patients eligible for charity care, however the Providers' did not have written policies adopting the use of Equifax data as part of their patient indigence determination procedures. The Board also found that the Providers' Charity by Model patients by definition do not submit applications and hence the Providers followed their own policy procedures for this group of patients, in qualifying them using the Equifax without an application. However, certainly without an application, the authority and sufficient information needed to accurately access a patient's credit report maybe problematic. *See e.g.*, Tr. 124-126. Rubenstein, Sarah, "Why Hospitals Want Your Credit Report" *Wall Street Journal* (March 18, 2008) https://www.wsj.com/articles/SB120580305267343947 ("It's unclear how much latitude hospitals have to legally check a patient's financial information…") Those nonresponsive patients who did not submit an application and who did not have an Equifax report produced were handled "the old fashion way" through billing and not the use of "predictive analytics." Tr. 125.

[22] *See e.g.*, Provider Exhibits P-5, P-6, P-47; Provider's witness, Tr at 124" ([W]e don't know all of the routines and things that Equifax has that are proprietary.")

determination rules with a credit company's unauditable algorithms. An Equifax credit score is not based on a review of the specific beneficiary's resources. Moreover, Equifax data methodology cannot account for spousal support and income otherwise available to the beneficiary, nor determine if other payors are available.[23] Accordingly, even if the Providers' had incorporated the use of the Equifax data methodology into their written indigence policy, relying on Equifax data is an inadequate and improper methodology to determine indigence for Medicare beneficiaries under PRM§312.

The Administrator also does not find persuasive the Board's reliance on CMS' use of evaluation tools in other areas for the validation of their use by the Providers for the payment of Medicare bad debt claims here. The Board found that CMS uses Equifax data to verify income for individuals applying for health insurance and subsidies through the Affordable Care Act exchanges, among other uses.[24] However, with respect to the premium tax credit health insurance subsidy, the amount of subsidy the government actually paid the health insurance company is compared to the amount it should have paid based on the income for the year reported on the Federal income tax. If those two amounts are different, there will be a "reconciliation" when the Federal tax forms are filed. Further, qualification for subsidies is not based on total applicant resources. In addition, certain programs require a remote identity proofing (RIDP) process before submitting an application online. RIDP is not an eligibility requirement but rather a way to ensure that online applicants are who they say they are by having them answer a series of personal questions (drawn from their credit files and other sources) that only the actual person could likely answer correctly. RIDP is intended to protect consumers from unauthorized access to their personal information. These uses do not support the use for Medicare bad debt. There is no reconciliation process in the use of the Equifax in the indigence determinations and the evaluation tool is not being used as a RIDP. Finally, in both instances, there is a contractual and legal relationship between CMS and the evaluation tool entity that would outline the scope of work and legal responsibilities to align with the CMS' authorities and the program's legal responsibilities.

In sum, the Providers failed to evaluate the respective patients' total resources and did not properly evaluate the indigency status of its patients and, thus, the MAC properly disallowed the Provider's claimed bad debts. In addition, the Providers further failed to provide adequate documentation as

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[23] Under the legal theory Doctrine of Necessaries, a person is liable for medical debts of their spouse. Thus, if for example, a spouse incurs medical debts during the marriage, the other spouse is liable for the debt even if the bills only come in the name of your spouse and were not guaranteed. In some States, spouses have liability for the necessary support of each other, but this rule is not the law in all or many States. If the Doctrine of Necessaries applies, creditors have the right to collect a debt from a parent or spouse.

[24] Exhibit P-15 (Press Release, Equifax, Equifax Contract with CMS Renewed, Will Continue Verification for Affordable Care Act Applicants (May 7, 2015)); Exhibit P-16 (HHS, Health Ins. Marketplace, FAQ on Remote Identity Proofing, Remote Identity Proofing Failures and Application Inconsistencies (Federally-facilitated Marketplace) (May 21, 2014)).

required under §413.20, to support their determination of beneficiaries' indigence for bad debts under PRM§312.

In light of the foregoing, the Administrator finds that the Board's decision is incorrect as the bad debts claimed by the Provider were not worthless when written off as Medicare bad debts. In light of the guaranteed payment by the Medicare program of uncollectable beneficiaries coinsurance and deductibles, a provider must meet the indigence criteria set forth in §312 of the PRM and take into account all necessary information needed to properly deem any patient indigent. The provider must meet the regulatory requirements that a reasonable collection effort was made and that the debt was uncollectible when claimed as worthless. Thus, the Administrator finds that the Board improperly reversed the MAC's disallowances.

Thus, the Administrator finds that the MAC properly adjusted the Providers' bad debt claims for indigent patients in fiscal year 2010 – 2013 cases, for accounts less than $10,000.

1. For those patients, unmarried or married, that Sentara qualified through its Charity by Application procedure (either written or telephonic), the Medicare Contractor properly disallowed the amount of bad debt reimbursement due under the Medicare program for this subset of claims;

2. For those unmarried patients that Sentara qualified through its Charity by Model procedure and, based on its Charity Care Policy, identified as not needing an asset check completed, where the sole source of documentation is an Equifax score and report, the Medicare Contractor properly disallowed the amount of bad debt reimbursement due under the Medicare program for this subset of claims;

3. For those unmarried patients that Sentara qualified through its Charity by Model procedure and, based on its Charity Care policy, identified as needing an asset check completed, where the sole source of the documentation is the Equifax score and report, the Medicare Contractor properly disallowed the bad debt reimbursement due under the Medicare program for this subset of claims;

4. For those married patients that Sentara qualified through its Charity by Model procedure, the MAC properly denied the bad debt reimbursement due under the Medicare program for this subset of claims;

5. For those patients Sentara qualified as eligible for Charity Care due to "extraordinary circumstances," the Medicare Contractor properly disallowed the bad debt reimbursement due under the Medicare program for this subset of claims.

DECISION

In accordance with the foregoing opinion, the decision of the Board is reversed as to the patients described in paragraphs 1-3 and paragraph 5, and is modified with respect to the patients described in paragraph 4.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 10/22/2020

/s/
Demetrios L. Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services

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