Medicare Bad Debt Checklist and Recent Clarifications

August 20, 2019

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Holly provides Medicare and Medicaid cost report preparation and consulting services in support of hospitals, skilled nursing facilities, hospices, and home health agencies. She has more than a decade of experience in the healthcare industry and previously worked as a field cost report auditor for a Medicare Administrative Contractor (MAC), where she developed extensive knowledge in the areas of disproportionate share (DSH), Medicare bad debt, and Medicare wage index. She also has experience compiling Medicare bad debt listings for cost report amendments, performing mock audits, assisting with MAC audits and desk reviews, updating square footage for proper cost allocations, and providing various Medicare benchmarking, educational, and analytical services. Prior to working in the healthcare industry, Holly gained two years of governmental accounting and auditing experience with the Auditor of State's office in Cambridge, Ohio.

Objectives and Takeaways

- Review key facts and expectations
- Discuss the progression of Medicare bad debt policy
- Implement best practices for defending bad debt listings
- Clarify recent changes – audit and desk reviews
- Utilize a bad debt checklist
- Address common pitfalls
- Benchmarking - performance measurement

Medicare Bad Debt Basics

- Medicare bad debt is claimed on a provider's Medicare cost report and submitted to an assigned Medicare Administrative Contractor (MAC) annually.
- CMS administers the Medicare program and relies on a network of MACs to serve as the primary operational contact between the Medicare program and the healthcare providers enrolled in the program.
- Medicare currently reimburses providers 65% of unpaid and uncollectible Medicare beneficiary cost-sharing amounts (deductible and coinsurance).
- Medicare bad debt basic criteria:
  - Debt must be related to covered services and derived from deductible and coinsurance amounts;
  - Provider must be able to establish that reasonable collection efforts were made;
  - Debt was actually uncollectible when claimed as worthless and;
  - Sound business judgment established that there was no likelihood of recovery at any time in the future.

Regulations: PRM, Part I, Chapter 3 & CFR, Title 42, Section 413.89.

Three Types of Medicare Bad Debt

- **1. Traditional Medicare bad debt (a.k.a. Regular, Non-indigent)**
  - Beneficiary is not Medicaid eligible and does not qualify for charity.
  - Reasonable collection efforts are required.
    - Collection effort must be similar to effort put forth to collect comparable amounts from non-Medicare patients. All collection effort must cease prior to write-off;
    - A bill must be issued on or shorty after discharge or death;
    - Must be written off at least 120 days after the date of first bill to patient.
- **2. Dual-Eligible bad debt (a.k.a. Crossover)**
  - Beneficiary is Eligible for both Medicare and Medicaid. Medicare is primary payor, but providers bill the applicable state Medicaid program for coinsurance and deductibles.
  - CMS “Must-bill” policy stipulates Medicaid must be properly billed and a valid Medicaid remit must be on file.
  - No patient liability
  - **3. Indigent bad debt (a.k.a. “Charity”)**
  - Beneficiary is not eligible for Medicaid. Patient is liable.
  - Provider should determine indigency by taking into account a patient’s total resources (income/expense/asset/liability verification) in accordance with their unique charity policy.

Exclusions

- Medicare Advantage bad debt cannot be claimed on the cost report.
  - Providers have contractual arrangements with Medicare Advantage payers (not CMS).
  - Providers must deal with the individual MA payers to negotiate payments towards uncollectible deductible and coinsurance amounts.
  - Some MA payers reimburse providers a percentage of unpaid and uncollectible deductible and coinsurance amounts but you often have to REQUEST IT!
- Exclude non-covered service items
- Exclude coinsurance and deductible amounts related to Physician Services (PPS- professional review codes billed on UB) and amounts for services paid on a fee schedule (DME, Ambulance, laboratory & therapy services)
- Non-Medicare recipients, self pay and non-Medicare contracted providers (non-certified sub-providers)
- Presumptive Charity (use of a sliding scale)

*Note: Original Medicare beneficiaries with a Medi**CAID** HMO (crossovers) are eligible for inclusion on the Medicare bad debt listing, provided a valid Medicaid remittance advice is on file.*

QMB and SLMB

- Be cautious of patients who participate in Medicare Savings Programs (MSPs – QMB, SLMB, QI & QDWI) :
  - Note that many eligible beneficiaries do not participate
  - QMB – Qualified Medicare Beneficiary (largest program)
    - Assistance with paying Medicare Part A/B premiums, deductibles, coinsurance & copayments
    - Medicaid program that exempts patients from Medicare cost sharing (patient responsibility)
    - Patient can not be billed for Medicare deductibles, coinsurance or copayments (sanction risk- per OBRA of 1989 and Balanced Budget Act of 1997)
  - SLMB – Specified Low-Income Medicare Beneficiary (OBRA 90)
    - Assistance with Part B premiums
    - Possibility of billing patient for Medicare cost sharing amounts

QMB (MSP)

- Under the Omnibus Budget Reconciliation Act (OBRA) of 1986, Medicaid coverage of Medicare costs was expanded by way of the QMB program. Became mandatory in 1988 through the Medicare Catastrophic Coverage Act.
- Requires states to cover Medicare Part B premiums, as well as Medicare Part A/B deductibles and coinsurance for Medicare beneficiaries with incomes up to 100% of the federal poverty level and with limited assets.
  - Provider need not be enrolled in the state Medicaid program in order to receive payments
  - States not obligated to pay full amount of Medicare cost sharing if the provider payment would exceed the state's Medicaid rate for the same service

QMB (MSP)

- QMB status available on Medicare RA or through verification using automated Medicaid eligibility-verification systems in the State in which the person is a resident (or beneficiary Medicaid ID card).
- Individual State Medicaid policy dictates providers ability to include QMB beneficiaries on their Medicare crossover bad debt listings:
  - States obligated to pay full Medicare cost-sharing amounts (exclude)
  - States that limit Medicare cost-sharing payments (potential to include uncollectible amounts – bill Medicaid and maintain a valid Medicaid remittance advice)

Related Statistics

- A TransUnion Healthcare study revealed total Medicare bad debt increased from $3.14 billion (program) in 2012 to $3.69 billion in 2016 (17% boost) and is likely to continue rising as out-of-pocket costs increase.
- 21% of provider organizations do not have an in-house process or third-party vendor for hospital bad debt recovery and 18% do not re-check insurance eligibility (survey by Sage Growth Partners).
- Despite rising healthcare costs and hefty deductibles, only 46% of Americans budget $50 or more per month for healthcare-related expenses (based on an Amino poll)
- Three quarters of Americans say their healthcare costs have gone up in the past few years.

Related Statistics

- 59% of Sage's survey participants said that high patient co-pays, **greater deductibles**, and other health insurance reforms are the largest drivers of hospital bad debt.
- *The rate of increase in Medicare enrollment will accelerate until 2030 as more members of the baby-boom generation become eligible, at which point it will continue to increase (but more slowly) after the entire baby-boom generation has become eligible.
- *The total number of people enrolled in the Medicare program will increase from about 58.4 million in 2017 to about 84.5 million in 2035.

**Source: The 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds*

Additional Considerations:

- Medicare enrollment expected to grow rapidly in next twenty years
- Expected increase in seniors trending toward Medicare HMO plans, particularly in urban areas
- Estimated one-third of Americans cannot afford an unexpected medical bill over $100, but PBAI keeps growing
- In some cases, patient accounting staff may not be versed on Medicare bad debt.

Progression of Medicare Bad Debt

TABLE 9—SUMMARY OF MEDICARE BAD DEBT REIMBURSEMENT BY PROVIDER TYPES FOR COST REPORTING PERIODS THAT BEGIN DURING FY 2013, 2014, 2015 AND SUBSEQUENT YEARS [4]

Provider type	*Allowable bad debt amount during FY 2012* (percent)	*Allowable bad debt amount during FY 2013* (percent)	*Allowable bad debt amount during FY 2014* (percent)	*Allowable bad debt amount during FY 2015 & subsequent FYs* (percent)
Hospitals	70	65	65	65
SNFs: Non-Full Dual Eligibles	70	65	65	65
Swing Bed Hospitals: Non-Full Dual Eligibles	100	65	65	65
SNFs: Full Dual Eligibles	100	88	76	65
Hospital Swing Beds: Full Dual Eligibles	100	88	76	65
CAHs	100	88	76	65
ESRD Facilities	100	88	76	65
CMHCs	100	88	76	65
FQHCs	100	88	76	65
RHCs	100	88	76	65
Cost Based HMOs	100	88	76	65
Health Care Pre-Payment Plans	100	88	76	65
Competitive Medical Health Plans	100	88	76	65

Congressional Budget Office (CBO) Proposals

- CBO periodically issues a compendium of policy options covering a broad range of issues, including Medicare bad debt.
- Some Recent Budget Proposals – Change in Outlay:
  - Reduce percentage of allowable bad debt to 45%
  - Reduce percentage of allowable bad debt to 25%
  - Eliminate the coverage of allowable bad debt
- Excluded from final rule thus far.

Congressional Budget Office (CBO) Proposals

- Arguments **FOR** reduction or elimination:
  - Medicare currently reimburses facilities but does not reimburse doctors or other noninstitutional providers.
  - Reimbursement of bad debt was originally intended to reduce the incentive for cost shifting, but the evidence of cost shifting is mixed.
  - Private payers often do not reimburse hospitals for unpaid patient cost-sharing.
  - Deficit reduction.
- Arguments **AGAINST** reduction or elimination:
  - Facilities may have difficulty collecting additional payments from enrollees or other sources.
  - Would lead to an effective cut in Medicare's payments to institutional providers.

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CBO Budget Proposals - Argument Against

- Providers may try to mitigate the impact of this change by limiting their treatment of dual-eligible Medicare beneficiaries.
- Hardship on facilities that treat a disproportionate share of low-income Medicare beneficiaries, potentially reducing access to care.
- Medicaid frequently underpays beneficiaries' Medicare cost-sharing obligations.
- The Medicare program already pays less than the cost of providing care to Medicare beneficiaries.
- Medicare reimbursement has declined significantly over the years.
- The government determines both the amount Medicare pays and the amount of the cost-sharing responsibility of the patient. Private insurers and hospitals, however, establish payment rates through negotiation.

Sources: www.cbo.gov and www.aha.org

Best Practices for Compiling a Bad Debt Listing

- Submit in CMS Exhibit format.
- Remove outpatient services paid on a fee screen.
- Separate the listing by type:
  - Three types of Medicare bad debt
  - Inpatient vs. outpatient vs. subunit
  - Recoveries (payments received on previously claimed bad debt)
- Consider any updates to internal bad debt and collection policies/procedures and/or CMS guidelines.
- Perform basic log testing procedures prior to MAC submission.

Formatting a Bad Debt Listing - CMS Exhibit

04-06 EXHIBIT 5)

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER_____ PREPARED BY _____

NUMBER_____ DATE PREPARED _____

FYE _____ INPATIENT _____OUTPATIENT _____

(1) PATIENT NAME	(2) HIC NO.	(3) DATES OF SERVICE		(4) INDIGENCY & WEL. RECIP. (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFICIARY	(6) WRITE-OFF DATE	(7) REMITTANCE ADVICE DATES	(8)* DEDUCT	(9)* COINSURANCE	(10) TOTAL
		FROM	TO	YES /NO	MEDICAID NUMBER						

* THESE AMOUNTS MUST NOT BE CLAIMED UNLESS THE PROVIDER BILLS FOR THESE SERVICES WITH THE INTENTION OF PAYMENT. SEE INSTRUCTIONS FOR COLUMN 4 - INDIGENCY/WELFARE RECIPIENT, FOR POSSIBLE EXCEPTION

Rev. 6 11-37

Note: Patient Account Number should be added to CMS Exhibit shown above. Exclude any additional data from final listings.

Basic Log Testing Procedures - Checklist

- Perform a search for duplicates. Include accounts from prior year submission.
- Ensure all write-off dates fall within the current cost reporting period.
- Calculate to verify bad debt does not exceed total deductible + coinsurance.
- Foot the bad debt listing (include summary).
- Confirm all CMS required information is included.
- Perform the following calculations on the Traditional bad debt listings:
  - Timely Billing: Patients should be billed on or shortly after discharge. Most MACs use a 90-day threshold for this determination.
  - 120 Day Rule: Accounts should not be written off until at least 120 days after the patient's first bill date. Note than any payment resets the 120-day rule clock.

Recent CMS Clarification

- Providers will be required to write-off Medicare crossover bad debt to a bad debt **expense account** (contractual not allowed), **effective October 1, 2019**.
- Chronology of related events
  - **2018 –** Palmetto GBA (MAC) has been denying reimbursement in cases where Medicare bad debt has been written off to a contractual account in the financial records.
  - **9/6/2018** - Four hospital associations sent a letter to CMS officials raising concerns about increased focus and scrutiny of Medicare bad debt by Palmetto GBA, requesting CMS reconsider the determinations and reverse the audit adjustments.
  - **1/21/2019** – The four hospital associations (and others), met directly with CMS staff to discuss Palmetto's policy. As a result, CMS communicated that it would direct Palmetto to **reverse any denials** it has made for crossover bad debt in past cost reporting periods on the basis of the accounting classification rule. CMS also indicated that Palmetto should reconsider reopening requests that were denied for this reason.

Recent CMS Clarification

- **3/29/2019** – Palmetto GBA published an update to a previous article specifically instructing hospitals to charge crossover bad debts to an **expense account** for uncollectible accounts.
- **4/4/2019** – CMS provided clarification in their *MLN Matters* article titled "*Medicare-Medicaid Crossover Bad Debt Accounting Classification*" instructing providers to "*correctly classify unpaid deductible and coinsurance amounts for Medicare-Medicaid crossover claims*" in their accounting records. The article instructs providers to charge these amounts to an **expense account** for uncollectible accounts**,** effective October 1, 2019.

Recent CMS Clarification

- CMS' announcement states providers must comply with this "*longstanding*" rule to claim reimbursement for crossover bad debts effective October 1, 2019. Providers will be denied reimbursement for these claims unless the underlying balances are logged to a **bad debt expense account** in their financial records.
  - Section 320.1 of the PRM provides indistinct guidance for properly classifying unpaid deductible/coinsurance in accounting records, but includes the following language:

    …*"**amounts deemed to be uncollectible are charged to an expense account for uncollectible accounts**. The amounts charged to the expense account for bad debts should be adequately identified as to those which represent deductible and coinsurance amounts applicable to beneficiaries and those which are applicable to other than beneficiaries or which are for other than covered services…"*
- **ISSUE:** It has been common practice for providers to log crossover balances to **contractual allowance** accounts, and many now consider this practice mandatory due to recent changes to the GAAP revenue recognition standards.
  - Contractual allowance = GAAP concept.

Recent CMS Clarification

- In the past, Medicare Administrative Contractors (MACs) have consistently allowed bad debt claims regardless of accounting treatment and accepted dual-eligible adjustment as a Medicaid contractual to represent the account has been deemed worthless.
- Interpretations have varied between MACs during performance of audits and desk reviews.
- Recent CMS announcement states specifically, "***Do not write off to a contractual allowance account***."
- CMS has decided to apply Palmetto's policy **prospectively and nationally, effective October 1, 2019**.

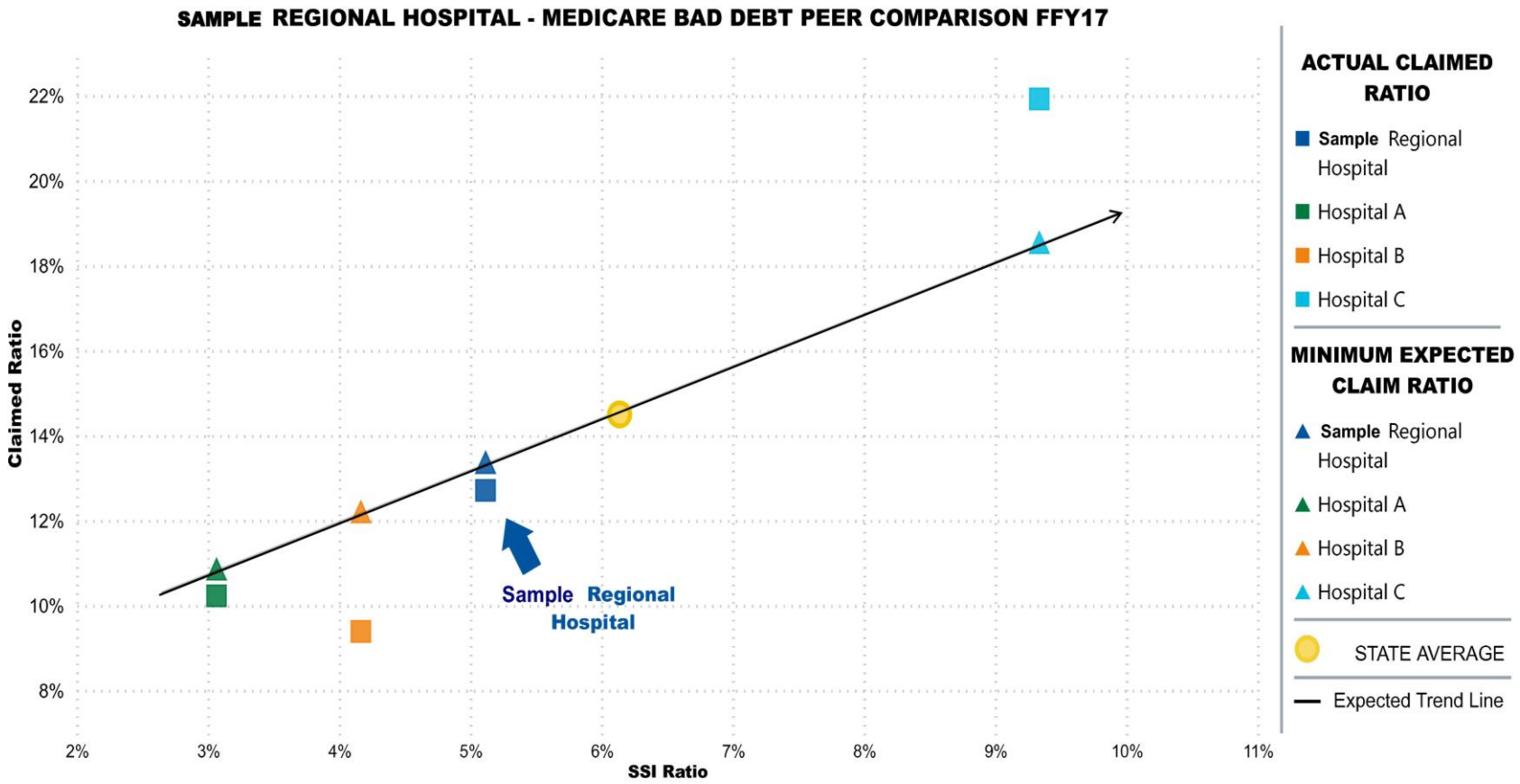
CMS Clarification - Recommendations

- Communicate recent CMS clarifications.
- Evaluate the process of recording these write-offs in the general ledger.
- Ensure write-off adjustments for dual-eligible (crossover) balances are recorded in a bad debt expense account
- Closely review all cost report communications.
- Request reopening for any denials related to this issue
- Contact your MAC if a notice of bad debt rejection is received related to this issue.

Other Recommendations

- Take action! Taking steps now to accurately and efficiently identify bad debt that is reimbursable is particularly important now (growth and availability).
- Implement critical controls and measures:
  - Ensure accurate record keeping
  - Track throughout the year
  - Maintain standard procedures
  - Perform basic log testing procedures (provided checklist)
  - Perform occasional mock audits
  - Leverage technology
  - Benchmarking - to quantify opportunity and measure performance

Sample Peer Comparison



^ **Sample** Regional Hospital Total Deductible + Coinsurance FY17 = $4,000,000 (excludes subunits) with 12.7% claimed as Medicare bad debt in FY17.

^ Peer comparisons are based on FFY 2017 (SSI Ratios) for cost reports beginning on or after October 1, 2016 and before October 1, 2017.

^ In 2017, the "insert state" unweighted state average SSI ratio = 6.1% and claim ratio = 14.6%.

^ The Expected Trend Line in the graph above shows the expected percentage of claimed Medicare bad debt as SSI ratios increase.

^ Providers below the Expected Trend Line may have financial opportunities available to increase claimed Medicare bad debt on their FFY17 Cost Report.

^ *Source: Most recently available as-filed or amended FFY17 Medicare Cost Report in HCRIS as of May 2019*

Thank You!

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