Medicare Bad Debts

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- Medicare Bad Debt Regulations
- Types of Medicare Bad Debts
- Medicare Bad Debt Reimbursement
- Court Cases
- Reporting of Bad Debts for various filings

Definition of a Medicare Bad Debt
- A Medicare Bad Debt is the unpaid and uncollectible balance of the patient’s Medicare coinsurance and deductible amount *AFTER* reasonable collection efforts
Definition of an Allowable Medicare Bad Debt

- 42 CFR 413.89(e)*
  
  (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.
  
*Reiterated also at PRM 15-1, Section 108

Types of Medicare Bad Debts

- Crossovers
- Operating
  - Charity Care
  - Regular

Crossover Bad Debts

- Crossover bad debts are the unpaid portion of the individual State Medicaid program responsibility related to deductibles and coinsurance for patients who have Medicare and Medicaid insurance coverage.
  
  - If the State does not pay for the deductibles and coinsurance, then this is a bad debt that can be claimed on the Medicare cost report.
Crossover Bad Debts

• QMB - Qualified Medicare Beneficiary
  – One of 4 kinds of Medicare savings programs
    • Medicare Savings Program 2013 Income Limits
      – Qualified Medicare Beneficiary (QMB) Program
        – Individual monthly income limit = $978
        – Married couple monthly income limit = $1,313
        – Program helps pay for:
          » Part A premiums
          » Part B premiums
          » Deductibles, coinsurance, and copayments

Crossover Bad Debts

• State of Maine - QMB - Qualified Medicare Beneficiary
  – State of Maine program is called Medicare Buy-In

SECTION 2. QUALIFIED MEDICARE BENEFICIARY (QMB)

A Qualified Medicare Beneficiary is an individual who:
7. is entitled to Medicare Part A; or is entitled to Medicare Part A:
6. has income equal to or less than 135% of Federal Poverty Level (FPL) and
5. above 135%, there is no asset limit

Under this group:
1. Medicaid pays the cost of Medicare Part A and Part B premiums, as well
2. Medicare Part B and D deductibles and coinsurance (See Appendix A)
3. an individual may be eligible for QMB and Medicaid at same time
4. cannot begin the month after an eligibility decision is made. There is no
5. New Month Rule application
Crossover Bad Debts

• State of Maine - QMB - Qualified Medicare Beneficiary
  – State of Maine **CURRENTLY** pays 100% of the QMB's

Crossover Bad Debts

• State of Maine - QMB - Qualified Medicare Beneficiary
  – June 28, 2013 list serve email - Qualified Medicare Beneficiary (QMB) Program
    
    – The Department will eliminate MaineCare's payments of coinsurance and deductible. Providers cannot bill recipients for the reimbursement they are no longer receiving from MaineCare. This applies to individuals who are eligible for the Medicare Savings Program (MSP), but are not eligible for full MaineCare. This change is effective July 5, 2013, upon approval by CMS.

Crossover Bad Debts

• State of Maine - QMB - Qualified Medicare Beneficiary
  – July 12, 2013 list serve email - ATTN: MaineCare Providers, regarding Qualified Medicare Beneficiary (QMB) Program
    
    – This is to inform you that we will not be implementing the previously announced changes to the QMB program, which were sent via 6/28 listserv. We are currently awaiting further clarification of the legislative intent of this change and we will provide more information as soon as possible. Thank you for your patience.
Crossover Bad Debts

• State of Maine - QMB - Qualified Medicare Beneficiary
  -- October 29, 2013 proposed rule- Proposed Rule, Chapter 101, MaineCare Benefits Manual, Chapter 1, General Administrative Policies and Procedures
  -- (6) Pursuant to P.L. 2013, c.368, Part A-34, effective January 1, 2013, if approved by CMS, the Department will limit cost sharing payments, for the Qualified Medicare Beneficiary without other Medicaid (QMB only) population, to hospital and nursing facility providers the amount necessary to provide a total payment equal to the amount MaineCare would pay for these services under the State Plan. The Department will seek CMS approval to amend its State Plan for this change.

Operating Bad Debts

• Charity Care
  -- Audit Issue
    • Did you follow your Charity Care policies?
      -- Does your Charity Care policy include an assets test?
        » Criteria should include the following per CMS Pub. 15-1 §312:
        » Assets - Tax returns and bank statements
        » Liabilities
        » Income
        » Expenses
        » Any extenuating circumstances that would affect the determination of a patient’s indigence

• Regular
  -- Audit Issue
    • Did you follow your Collection policy?
      -- Did you treat all patients equally?
        » Do you have support for the letters, phone calls, etc.?
Operating Bad Debts

- **Audit Issue – Filed Bad Debt Log**
  - Log must contain the following information
  - Include Bad Debt Recoveries

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACCOUNT NUMBER</th>
<th>AMOUNT</th>
<th>MEDICARE</th>
<th>OTHER</th>
<th>OUTSTANDING</th>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Bad Debts

- **Audit Issue**
  - Medicare is applying an error ratio from a limited sample to the whole bad debt log

Reasonable Collection Efforts

- **PRM 15-1, Section 310**
  - 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.)
Reasonable Collection Efforts

- **PRM 15-1, Section 310, continued**
  - **310. REASONABLE COLLECTION EFFORT**
    - **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.

Reasonable Collection Efforts

- **PRM 15-1, Section 312**
  - **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 bills, 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 has 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.)
Bad Debt Reimbursement Rates

<table>
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<tr>
<th></th>
<th>Through 9/30/12</th>
<th>10/1/12-9/30/13</th>
<th>10/1/13-9/30/14</th>
<th>10/1/14-</th>
</tr>
</thead>
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<tr>
<td>PPS Hospital</td>
<td>70%</td>
<td>65%</td>
<td>65%</td>
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</tr>
<tr>
<td>CAH</td>
<td>100%</td>
<td>88%</td>
<td>76%</td>
<td>65%</td>
</tr>
<tr>
<td>SB Xover</td>
<td>100%</td>
<td>88%</td>
<td>76%</td>
<td>65%</td>
</tr>
<tr>
<td>SB Operating</td>
<td>70%</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td>RHC</td>
<td>100%</td>
<td>88%</td>
<td>76%</td>
<td>65%</td>
</tr>
<tr>
<td>SNF Xover</td>
<td>100%</td>
<td>88%</td>
<td>76%</td>
<td>65%</td>
</tr>
<tr>
<td>SNF Regular</td>
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<td>65%</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td>Renal</td>
<td>100%</td>
<td>88%</td>
<td>76%</td>
<td>65%</td>
</tr>
<tr>
<td>FQHC</td>
<td>100%</td>
<td>88%</td>
<td>76%</td>
<td>65%</td>
</tr>
</tbody>
</table>

*PPS*’s cannot generate bad debts per CMS regulations.

Clarification of Medicare Bad Debt Policy Related to Accounts at a Collection Agency

Medicare Learning Network (MLN) Matters number SE0824


Clarification of Medicare Bad Debt Policy Related to Accounts at a Collection Agency

It has been the Centers for Medicare & Medicaid’s (CMS) longstanding policy that when an account is in collection, a provider cannot have determined the debt to be uncollectible and cannot have established that there is no likelihood of recovery under the regulations found at 413.89(e) (See 31 FR 14813; published November 22, 1966), and in Chapter 3 of the Provider Reimbursement Manual (PRM). Section 310.A of the PRM explicitly states that “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.”
Clarification of Medicare Bad Debt Policy Related to Accounts at a Collection Agency

Until a provider’s reasonable collection effort (including the use of a collection agency as well as in-house efforts) has been completed, a Medicare bad debt may not be deemed as uncollectible. Section 310.2 of the PRM, Presumption of Noncollectibility, provides that, “if after reasonable and customary attempts to collect a bill, the debt remains unpaid for more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.” However, section 310.2 must be read within the context of the regulations and Section 310.

Clarification of Medicare Bad Debt Policy Related to Accounts at a Collection Agency

As noted above, the manual makes it clear that CMS deems the use of a collection agency to be part of the provider’s ongoing collection effort, and as long as the debt remains with a collection agency (even if more than 120 days), the debt cannot be deemed “uncollectible.” Therefore, in accordance with the regulation/policy in effect prior to the moratorium, effective August 1, 1987, until a provider’s reasonable collection efforts have been completed, including both in-house efforts and the use of a collection agency, unpaid deductible and coinsurance amounts cannot be recognized as a Medicare bad debt.


The United States District Court for the District of Columbia ruled in March, 2013 that the CMS should not be disallowing bad debts only on the basis that the bad debt is still at a collection agency. In part, The District Court found no support from the Secretary that its presumption of collectability for accounts still at a collection agency existed prior to August 1, 1988.

As such, the court held that the Secretary’s policy violated the Bad Debt Moratorium Laws. Thus, the court found that the Secretary is prohibited from making any changes to its bad debt policy in effect on August 1, 1987. The court also found that the first time the Secretary’s presumption of collectability appeared in writing was in a Medicare Intermediary Manual transmittal letter, issued in 1989.

CMS has not appealed this decision in federal courts and is reported to be forthcoming with a program memorandum to instruct the MAC’s to no longer disallow bad debts only on the basis that the bad debt is still at a collection agency.

To date, CMS has NOT issued the program memorandum and the MAC is STILL offsetting bad debts that are still at a collection agency.
Other Reporting of Bad Debts

- Medicare Cost Report
  - Reimbursement of Bad Debts
  - S-10 Line 26
- IRS Form 990, Schedule H (990H)
- Community Health Needs Assessments (CNHA)
  - 501(r) Requirements

Other Reporting of Bad Debts

- S-10 Line 26
  - Non-Medicare bad debt--Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim.
  - Non-reimbursable Medicare bad debt--The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are not reimbursed by Medicare under the requirements of §413.89 of the regulations and of Chapter 3 of the Provider Reimbursement Manual Part 1.
  - Line 26--Enter the total facility (entire hospital complex) amount of bad debts written off on balances owed by patients during this cost reporting period. Include such charges for all services except physician and other professional services. The amount reported must also include the amounts reported on Worksheets E, Part A, line 64; E, Part B, line 24; E, line 17, columns 1 and 2; E, Part I, line 11; E, Part II, line 23; E, Part III, line 24; E, Part IV, line 14; E, Part V, line 25; E, Part VI, line 8; E, Part VII, line 34; J-3, line 5; line 5.05, column 2 for cost reporting periods that overlap or begin on or after or January 1, 2011; J-3, line 21; and M-3, line 23. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.

Other Reporting of Bad Debts

- IRS Form 990, Schedule H (990H)
  - Part III – Bad Debt, Medicare and Collection practices
    - F/S bad debts * Cost to Charge Ratio (as calculated via 990H worksheet 2)
Other Reporting of Bad Debts

Community Health Needs Assessments (CHNA)

- Section 501(r)(3) requires a hospital to conduct a community health needs assessment (CHNA) at least once every three years. In addition, hospitals must adopt an implementation strategy to meet community health needs identified through the assessment and identify when they will finish the implementation of this strategy. There was a proposed regulation for Section 501(r)(3) released in April of 2013.
- Section 501(r)(4) requires that a hospital establish a written Financial Assistance Policy and an emergency medical care policy.

Other Reporting of Bad Debts

Community Health Needs Assessments (CHNA)

- Section 501(r)(5) requires that a hospital organization limit the amounts it charges for emergency and/or other medically necessary care provided to individuals eligible for assistance under the hospital organization’s Financial Assistance Policy.
- Section 501(r)(6) requires that a hospital organization make reasonable efforts to determine whether an individual is eligible for its Financial Assistance Policy before engaging in extraordinary collections actions against individuals.
- New proposed regulations for Sections 501(r)(4) through (6) were released in June of 2012.

Other Reporting of Bad Debts

Community Health Needs Assessments (CHNA)

- Section 501(r)(5), in more detail, requires that:
  - Patients eligible for the hospital’s Financial Assistance Policy MUST not be charged more than the amounts generally billed to insured individuals for emergency and other medically necessary care.
Community Health Needs Assessments (CHNA)

- Section 501(r)(5), in more detail, requires that:
  - The hospital must use one of the following methods to determine its amounts generally billed amounts:
    - Prospective Medicare method - Amounts generally billed would be limited to what the patient would have paid as a Medicare fee-for-service beneficiary
    - Look-back method (may be calculated based on either - Medicare fee for service claims or a combination of fee-for-service claims paid by Medicare and claims paid by private health insurers)

- Section 501(r)(6) requires that a hospital organization make reasonable efforts to determine whether an individual is eligible for its Financial Assistance Policy before engaging in extraordinary collections actions against individuals.

- Section 501(r)(6) of the proposed regulation requires hospitals to make a reasonable determinations regarding eligibility of its Financial Assistance Policy for patients before the hospital pursues any extraordinary collections actions and the timelines for when those activities may occur.
Community Health Needs Assessments (CHNA)

• Extraordinary collection efforts are described as:
  – Selling an individual’s debt to another party
  – Reporting adverse information about the individual to credit reporting agencies or credit bureaus
  – Any action taken by the hospital in obtaining payments for care provided that require legal or judicial process, including:
    » A lien on property
    » Foreclosure on real estate
    » Attachment or seizure of bank accounts
    » Civil action
    » An individual’s arrest
    » Body attachment
    » Garnishment of wages

• For facilities to meet the threshold of making reasonable determinations of eligibility for its Financial Assistance Policy, they must meet the time period requirements
  – Notification Period - Starts on the date of the first billing statement and continues for 120 days:
    » The hospital is restricted from pursuing extraordinary collection efforts during this time period
  – Application Period - Starts at the conclusion of the notification period and continues for 120 days:
    » The hospital can pursue extraordinary collection efforts during this time period with certain restrictions

• Failure to comply with the CHNA and the rest of the ACA requirements starts with an excise tax of $50,000
• The IRS must review every non-profit hospital’s exempt status every three years
• The CHNA is effective tax years beginning after March 23, 2012.
• The CHNA must be submitted with the 990H
Any Questions?

Thank You!

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