

Northern California HFMA - Spring Conference

MEDICARE BAD DEBTS

Identification, Documentation, Claiming Medicare
Allowable Bad Debts on Your Medicare Cost Report

Presented by :

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My Background

43 years healthcare experience

1975 - 1982 Blue Cross of Oregon - Medicare Auditor

1982 - 1989 Brim Healthcare / NME Managed Svc.

Regional CFO - 10 hospitals

Director Reimbursement Services - 60 Hospitals

1989 - Present Reimbursement Consultant

Major Assignments

- part of team opening new teaching hospital San Juan Puerto Rico
- Director Reimb. Scripps Health San Diego
- Director Reimb. - Oregon Health Science University
- Interim CFO El Centro Reg. Med. Ctr.
- Interim CFO Merced Med. Ctr.

Currently I have about 14 hospitals on contract in the states of California, Arizona, and Oklahoma

CPA licensed 1981

FHFMA 1991

CGMA 2012

Medicare History

Program approved 1965

Medicare Part A (with deductible)

Medicare Part B (With Ded. & Coinsurance)

Expansion of Program 1972

Included End Stage Renal Disease (ESRD)

Under 65 Disabled coverage

TEFRA (Tax Equity Fiscal Responsibility Act) 1982

Set per discharge Target with penalty / bonus pmt

DRG Program introduction - 1983

No longer inpatient Cost Based - no change to Part B

Revised Physician Payment to RBRVS from Reasonable and Customary - 1989

Outpatient PPS System based upon APCs -
Patient coinsurance revised to % of Payment
from % of Charges

Also Introduction Medicare Part C - 1997

BBA 1997 - Created Critical Access Hospital
Type

Medicare Part D (Drugs) introduced - 2003

Affordable Care Act - 2010

Takeaway on Changes :

1. As # of Beneficiaries increased, and cost increased, Medicare made changes to control costs
2. When Rural Hospitals began to disappear they created CAH Hospital Status to save rural hospitals from extinction
3. However with the change, they reverted the Part B coinsurance back to 20% of billed charges

Other Demographics

Increasing rise in # of Beneficiaries from 20 million in 1970 to an estimated 113 million projected in 2080

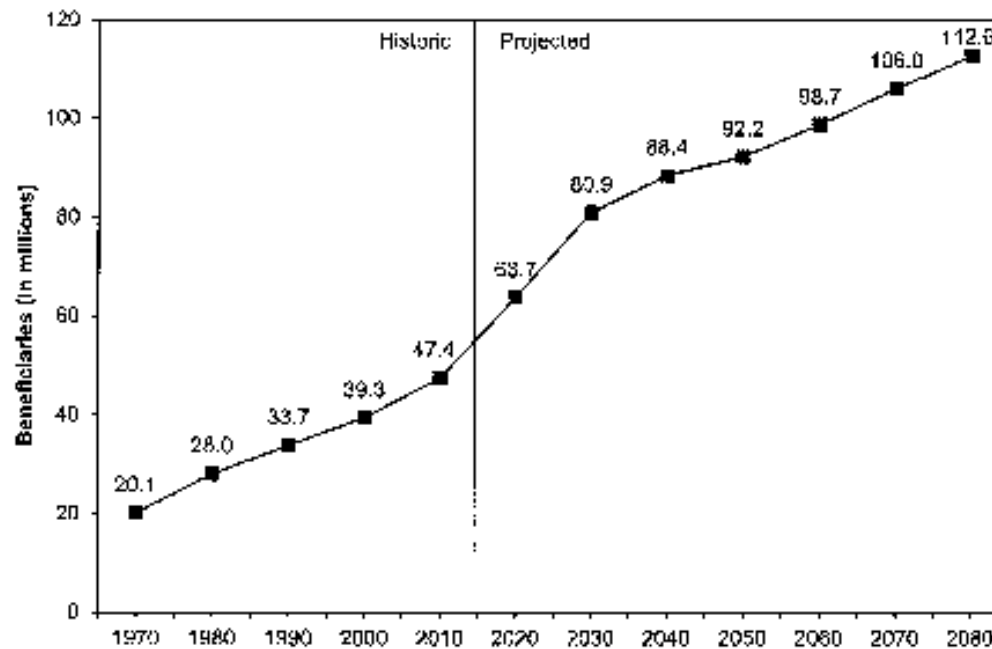
Increasingly retirees will have fewer assets as wage growth stagnates and interest rates are low resulting in lower savings for retirement

Rural Areas will continue to see seniors staying and younger populations leave for better jobs in the cities

There will be large increases in seniors trending toward Medicare HMO products in the urban areas but many rural areas may not see much growth in Medicare HMO products

As more seniors are forced to access QMB programs (Medicaid secondary) pressure will build on Congress to control Medicare expenditures including QMB programs

Chart 2-4. Enrollment In the Medicare program Is projected to grow rapidly in the next 20 years



Note: Enrollment numbers are based on Part A enrollment only. Beneficiaries enrolled only in Part B are not included.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2016.

- The total number of people enrolled in the Medicare program will increase from about 50 million in 2013 to about 81 million in 2030.
- 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.

MEDICARE BAD DEBTS

What is a “Covered” Medicare Bad Debt

Criteria to qualify claim as allowable Medicare bad debt

Types of Medicare Bad Debts

Format of Logs for Claiming Bad Debts

Payment by Medicare for Bad Debts

Medicare Audits of Bad Debts

Medicare Appeals

WHAT IS AN “ALLOWABLE” MEDICARE BAD DEBT

- Related to Medicare Part A deductible or Coinsurance Amount
 - Hospitals
 - SNF
 - Swing Beds (usually coinsur.)
 - Distinct Part Psych. Or Rehab. Units

- Related to Medicare Part B Deductible or Coinsurance Amounts (also Inpat. Part B)
 - Hospitals
 - Provider Based Clinics
 - Rural Health Clinics

WHAT IS NOT AN ALLOWABLE BAD DEBT ?

- Non-covered services items
- Dr. Professional Fees or copays thereof
- Outpatient P.T. coinsurance amts paid under PPS
- ESRD (Outpatient Dialysis) Copays
- DME paid on fee schedules
- Mammography Copays paid under Fee Schedule
- Medicare Advantage claims (any part of)

WHAT ARE THE REQUIREMENTS TO CLAIMS SUCH AMOUNTS IN THE COST REPORT ?

- Covered in 42 CFR 413.89(e) and PRM Section 308
- The write off must be related to a covered Part A or Part B service and directly related to the established deductible or coinsurance for such service
- Reasonable Collection Efforts were made to collect such deductibles or coinsurance amounts
- The Debt was actually uncollectible at time of WRITE OFF
- Sound business judgement established that there was no likelihood of recovery at any time in the future
- The collection efforts must be similar for Medicare and non-Medicare accounts
- The hospital must furnish a file in excel to its FI with all pertinent required information on the claims
(See old CMS form 339 Exhibit 5)

THREE TYPES OF BAD DEBT CLAIMS

- Accounts which Meet Charity Write off policy
- Accounts billed to Medicaid as Secondary
- Accounts sent to collection agencies

Reasonable collection efforts and rules vary with each type of claim

DUAL ELIGIBLE BAD DEBTS

- Medicare is Primary / Medi-cal is Secondary
- Patient qualifies based upon State Medicaid Rules
- Covers Medicare Ded. & Coinsur. If Medicaid would have paid more than Medicare
- Write off code 442 on Medicaid RA s
- Unrecovered Amount after Medicaid are an allowable bad debt on date of Medi-cal Remittance
- 120 day rule would not apply
- Claim in period you receive the Medicaid RA

DUAL ELIGIBLE BAD DEBTS (continued)

- May register claim in Medicare Bad Debt Log or
- Some hospitals use outside contractors who pull claims data and create log for a fee
- Medical Share of Cost can be an issue with logs
- POS tapes used to determine SOC amounts
- Separate Share of Cost Claims from other claims to avoid audit issues with the logs
- Prior FI First Coast Services Options allowed a presumptive 2% reduction in lieu of identifying SOC

INDIGENT CARE BAD DEBTS

- Hospitals need to have up to date Policy Procedures Manual to outline rules to apply in approving Indigent Care write offs
- Medicare must be treated same as non-Medicare patients in regard to Indigent determinations
- Medicare Ded. & Coinsur. Which are deemed allowable as Indigent Care may be written off to Medicare Bad Debt
- Date Deemed uncollectible is date for logs
- Use separate sheet in excel bad debt log for these
- Update Policy and Procedures manual
- 120 day rule does not apply

COLLECTION AGENCY ACCOUNTS

- Hospital uses ordinary & customary collection procedures for Medicare and Non-Medicare Accts
- Generally 3 billings sent
- follow up phone calls
- Be able to produce these up front collection efforts
- Policy & Procedure Manual should be updated to reflect current practices
- Account sent to collection agency
- Agency employs similar collection efforts for Medicare and non-Medicare accts?
- 120 day rule applies - 120 days from first billing or last payment by patient

COLLECTION AGENCY (Continued)

- Not a Medicare Bad Debt UNTIL Agency turns account back to hospital
- Keep Documentation on Accounts turned back
- Must have more than just Medicare Accounts turned back to Hospital
- Account deemed uncollectible only when turned back to Hospital (date of write off in the logs)
- May have more than one Agency used
- These Accounts more contested than the other two
- Many Hospitals in California have not been claiming these accounts
- Accounts need analysis to separate allowable from non-allowable portions of account

COLLECTION AGENCY (continued)

- Effort Must be more than a “TOKEN” effort to be allowable
- Some accounts could be years old, but still eligible once Agency turns them back to hospital
- Date of write off is when account is turned back not date of service
- Needs good working relationship with your Agency
- Recoveries on accounts must be offset against bad debt logs if original claim was in current or prior bad debt logs

SUBMITTING BAD DEBT LOGS

- Logs In excel must meet minimum elements as noted in CMS 339 Exhibit 5 (see attached)
- I suggest using separate tabs for each type of bad debt and one for inpatient and one for outpatient
- Six Tabs for submission
- Submit in electronic form with other cost report filing materials and a summary page
- Allowable Amount is now 65% of claimed amount

FISCAL INTERMEDIARY PROCESS

- Noridian will make a tentative settlement for the claimed Medicare Bad Debts
- They have a lot of discretion on how much to pay during the tentative settlement
- FI will schedule an audit of the bad debt logs as part of its overall audit process
- Audits usually conducted by email - watch for notices or requests for information

FISCAL INTERMEDIARY AUDIT

- A “statistical sample” will be requested for each type of claim (Cross Over, Indigent, Agency Write Off)
- Request for information must be handled timely
- Usually includes copy of current Policy and Procedure for bad debt handling
- Be sure to assign a person to handle the requests from the auditor
- Failure to timely present documentation may result in partial or full denial of Medicare Bad Debts

FISCAL INTERMEDIARY AUDIT (Continued)

- Cross over claims will need copy of Medicare and Medical remittances showing write off code and amount of recovery (if any)
- They will verify whether any outpatient PT copays were included (not allowed for PPS facilities)
- For clients who use Type 2 billing, confirm whether professional copays were excluded from log
- Confirm date of RA is within period of cost reporting period
- Confirm whether Share of Cost was handled correctly

FISCAL INTERMEDIARY AUDIT (Indigent Write offs)

- Obtain relevant documents to show patient qualified for Write off under Indigent policy
- Does the Date of determination match reporting period of bad debt write off
- Does the claim exclude professional fee copays, PT copays, or other non-allowable items ?
- Errors in the sample will be applied to the population for amount not to recognize as allowable

FISCAL INTERMEDIARY AUDIT (Agency Write Off)

- Confirm that claim was returned by Agency and date of return is in cost reporting period
- Confirm 120 days elapsed since date of first bill or date of last payment (later of)
- Verify Date sent to agency, date returned by Agency
- Be prepared to show Agreement with Agency on the return of claims
- Were amounts paid on the claim offset against the write off
- Was the process at the Agency more than “Token” efforts
- Does the amount on the log EXCLUDE non-allowable items, professional fee copays, PT copays ?

- Amounts determined as not correctly handled will be disallowed and rate applied to population of claims
- Disallowance rate will affect future interim rates paid on bad debts and future testing of claims
- May want to involve your consultant during the audit to provide guidance during this process
- May need to work with your Agency to get the process right with Medicare rules

FISCAL INTERMEDIARY AUDIT

- FI should provide hospital with proposed adjustments to bad debts
- Two weeks to dispute the findings
- FI statistical methods are arbitrary and drive excessive disallowances to the population
- A \$ 2,000 disallowance in the sample can end up being a population disallowance of \$ 200,000.
- Best to fight every claim disallowance no matter how small because of the application to the population
- Stratifying the claims into 3 categories should help

FISCAL INTERMEDIARY AUDIT

- After two week period, findings go to a final NPR or Notice of Program Reimbursement Settlement
- Now hospital has 180 days to request a hearing on matters in disagreement
- Hearings handled by the Medicare Provider Reimbursement Review Board or PRRB
- Provider can file Position Papers with documentation to dispute the disallowances
- Parties are encouraged to try to settle prior to any formal appeal hearing
- Depending upon dollar amount involved, will require a consultant who handles appeals, and or a Healthcare Attorney

FISCAL INTERMEDIARY AUDIT

- Disallowed Bad Debts will become an audit issue in future Medicare audits (higher review level)
- Appeals can sometimes take more than a year to settle
- Best to try to resolve cases prior to hearings
- Even if PRRB agrees with the Hospital CMS Administrator likely overturns their decision thus forcing the appeal to go the US District Court.
- Might be financially wise to have your consultant assess your documentation and processes before claiming them in the cost report

CRITICAL ACCESS HOSPITALS (CAH)

- Part A is mostly deductible which is same as for a PPS Hospital
- Outpatient however is different since CAH hospital claims are subject to a 20% of billed charges not 20% of fee schedule for the patient pay amount
- Difference can be substantial - see example
- Even if they are covered under Medicaid still not collecting 35% due to program reductions

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: RHPFRGN
 Psc Date: 05/01/07 1HR11 01/17/18
 Report Run Date: 01/31/18
 Provider FIC: 09/09

PROVIDER SUMMARY REPORT
 OUTPATIENT - OPPS

Page: 3
 Report #: 01044002
 Report Type: *3P

REV CODE	DESCRIPTION	SERVICES FOR PERIOD 08/01/16 - 08/30/17		SERVICES FOR PERIOD No Data Requested		SERVICES FOR PERIOD No Data Requested		SERVICES FOR PERIOD No Data Requested	
		UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0771	VACLINE ADMIN	84	\$11,970.00						
0826	OTHER DX SVS	7	\$20,081.00						
0921	PHYS VASCUL LAB	14	\$41,650.00						
0922	EMG	28	\$58,636.00						
TOTAL UNBILLED CHARGES		41,266	\$12,656,108.43						

REIMBURSEMENT SECTION

GROSS OPPS PAYMENT	\$1,119,577.77								
PLUS									
OUTLIER	\$10,370.20								
GROSS REIMBURSEMENT	\$1,190,347.97								
LESS									
CASH DEDUCTIBLE	\$23,092.95								
BLOOD DEDUCTIBLE	\$0.00								
COINSURANCE	\$219,013.99								
NET MSP PAYMENTS	\$97.80								
PIONEER REDUCTION	\$0.00								
SEQUESTRATION	\$17,767.25			\$0.00		\$0.00		\$0.00	
REBILLING ADJUSTMENT	\$0.00								
MSP RECONCILIATION	\$0.00								
OTHER ADJUSTMENTS	\$0.00								
NET REIMBURSEMENT	\$870,375.98								

ADDITIONAL INFORMATION SECTION

CLAIM INTEREST PAYMENTS \$0.00

Jan 31, 2018

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**Example of Hospital Part B coinsurance
Compare PPS to CAH**

	PPS	CAH
Outpatient Charges	12,656,108	12,656,108
Deductible	23,093	23,093
Coinsurance	219,014	2,531,222
Net before Payment	12,414,001	10,101,793
Est. Cost to Charge Ratio		30.00%
Gross Reimb.	1,130,348	3,796,832
Patient Portion %	21.42%	67.27%

Based upon 30% RCC patient pay is 2/3 of entire claim

CAH STRATEGIES

- May need to look at Hospital pricing since copay based upon 20% of billed charges
- Send Letters to Congress representatives on unfair nature of CAH coinsurance
- Establishing Indigent Plan critical
- Requiring Collection Agency to return claims critical
- It leaves rural hospitals in a competitive disadvantage if their patients do not have a supplemental plan
- Local seniors may not have ability to get Medicare Advantage Plan in the area

FINAL THOUGHTS

- Medicare Bad Debts are still a substantial amount of cash that should not be left on the table
- Many hospitals in California are not claiming Agency Write offs or Charity Write offs for Ded. & Copays
- Patient Accounting staff may not be versed in what is a Medicare Bad Debt
- For CAH hospitals the situation is critical due to the higher amounts not collected as % of total billing
- Increasing number of eligible beneficiaries in the future will mean substantial increase in copays to collect from patient
- Due to Program fund decreases projected, it is likely that the patient pay portions will increase

QUESTIONS

PART II

MEDICARE UPDATE

- OPPS CHANGES
- Payment update 1.35% increase in OPPS payments
- 340 B reduction in payments to Hospitals from Avg. Sales price plus 6% to ASP minus 22.5%
- Estimated to be 1.6 billion decrease to be applied to updates for other services
- Exempts Sole Community Hospitals , Children Hospitals, PPS exempt Cancer Hospitals
- Lawsuit filed by various groups
- Inpat. Only list / Qual. Reporting Changes

- CR passed Friday Feb. 9 - Major Issues
 - CHIP extended to 10 years
 - IPAB eliminated
 - Reduces caps on Medicare O/P Therapy
 - CHC funding extended 2 years
 - ACA Prevention and Public Health Fund reduced
 - Increase in wealthier Medicare Ben. Premiums
 - Changes to ACO flexibility in regard to Telemedicine coverage

THANK YOU

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