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Medicare Reimbursement:

Optimizing Your Medicare Bad Debt Reimbursement

August 22, 2024

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About HORNE

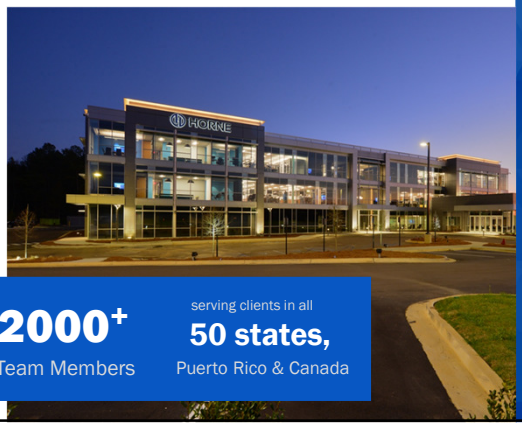
We are a **professional services** firm founded on a cornerstone of public accounting.

Our Services

Our CPA heritage brings trust and discipline to our brand. Strategic choices brought us the talent, skills and mindset to solve our clients' biggest issues.

- Economic Recovery
- People Development
- Organization Growth
- Enhanced Productivity
- Technology
- Compliance
- Risk Management
- Building Wealth
- Cybersecurity

Industries We Serve



2000+ Team Members

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Topics

01 Growing Patient Financial Responsibility

02 Industry Changes

03 Strategies to Increase

04 Regulatory and Audit Considerations

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Knowledge

- Recognize the different causes for connectivity gaps between Medicare reimbursement owed to providers versus actual Medicare reimbursement claimed on cost reports
- Identify the changing Medicare Bad Debt Regulations and how the regulators' interpretations of these regulations are impacting the compilation of Medicare Bad Debt Logs and Fiscal Intermediary Audits across the country
- Respond to these Medicare Bad Debt Industry changes with proactive future planning relating to Medicare Bad Debt and other areas of the cost report

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What are Medicare Bad Debts?

$944B (spent annual on Medicare)
The US Government is the biggest single payor to providers.

~67.2M (people on Medicare as of June 2024)
Due to their volume, Medicare negotiates very low payment to providers for rendering services.

~$30B (due from patients each year)
A large portion of Medicare patients are still unable to pay their deductibles & coinsurance of the bill to the provider.

~$3B (paid to hospitals for Medicare Bad Debts each year)
Medicare reimburses 65% of unpaid bills to keep providers incentivized to serve Medicare patients.

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$1.8 – 2.1 Billion

(6-7% estimated as under-report each year)

Providers submit annual reports of unpaid bills (Medicare Bad Debts) for reimbursement from Medicare. Providers can also amend reports from previous underreported periods.

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Arkansas' Traditional Medicare Statistics

Inpatient (Part A) & Outpatient (Part B)								
	2017	2018	2019	2020	2021	2022	2023	Grand Total
Deductibles & Coinsurance	$293,533,937	$305,385,839	$306,174,822	$280,316,134	$278,100,369	$282,202,046	$277,599,638	$2,023,312,785
Claimed Allowable Bad Debts	$23,287,014	$32,719,972	$33,827,654	$32,837,913	$26,422,467	$23,419,835	$22,702,266	$195,217,121
Unclaimed Deductibles & Coinsurance	**$270,246,923**	**$272,665,867**	**$272,347,168**	**$247,478,221**	**$251,677,902**	**$258,782,211**	**$254,897,372**	**$1,828,095,664**
Claimed Rate	**7.93%**	**10.71%**	**11.05%**	**11.71%**	**9.50%**	**8.30%**	**8.18%**	**9.63%**
Unclaimed Rate	**92.07%**	**89.29%**	**88.95%**	**88.29%**	**90.50%**	**91.70%**	**91.82%**	**90.37%**
Crossover Allowable Bad Debts	$2,228,252	$12,994,985	$11,554,550	$12,331,956	$10,980,344	$11,050,516	$11,169,385	$72,309,988
Crossover Allowable Bad Debts Percentage	**9.57%**	**39.72%**	**34.16%**	**37.55%**	**41.56%**	**47.18%**	**49.20%**	**36.99%**
Non-Crossover Allowable Bad Debts	$21,058,762	$19,724,987	$22,273,104	$20,505,957	$15,442,123	$12,369,319	$11,532,881	$195,217,121
Non-Crossover Allowable Bad Debts Percentage	**90.43%**	**60.28%**	**65.84%**	**62.45%**	**58.44%**	**52.82%**	**50.80%**	**63.01%**

Analytics determined from Centers for Medicare & Medicaid Services (CMS) cost report information as reported to the Healthcare Cost Report Information System (HCRIS) by Medicare Administrative Contractors.
Meduit is not responsible for data that is misrepresented, misinterpreted or altered in any way.
Derived conclusions and analysis generated from this data are not to be considered attributable to Meduit.

$195M
Arkansas Medicare Bad Debts Claimed (7 years)

9.63%
Average Provider claimed rate in Arkansas

36.99%
Crossover Percentage of Medicare Bad Debt in Arkansas

$1.828B
Unclaimed Medicare Bad Debts in Arkansas

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Medicare Advantage Patient Responsibility

- Medicare Advantage payments are an increasing percent of "Medicare" and are projected to continue to rise.
- Many payers do allow for bad debts to be filed.
- Terms, if any, are payer and provider specific – all are different (typically even in a large system).
- Language varies by contract
  - Included
  - Excluded
  - Silent
- Reimbursement rates are similar to traditional Medicare Bad Debt.
- Typically, no limit on lookback periods; subject to 50% penalty annually.

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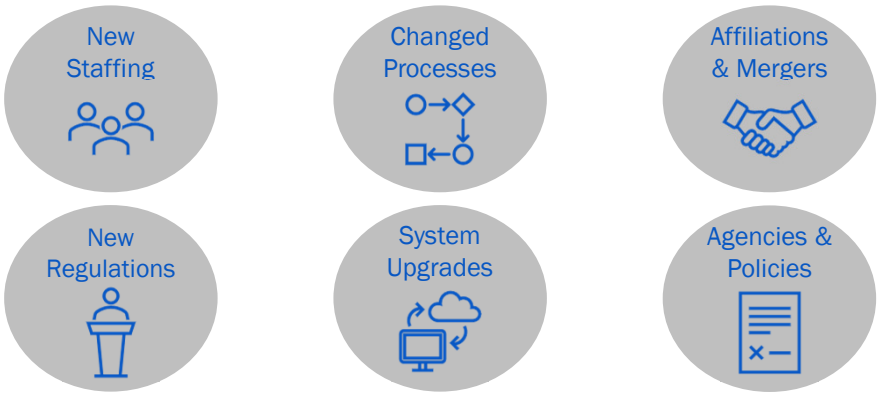
Are You Missing Value?

INDUSTRY CHANGES IMPACTON MEDICARE BAD DEBT

Below are some of the changes in your system that can create extended gaps in the connectivity of revenue cycle and reporting operations.



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Compilation vs. Analytics "Gap"

WHY IS VALUE OFTEN MISSED?

Expertise & Technology

PEOPLE & PROCESS

- ✓ Understanding the nuances
- ✓ Resolve the discrepancies
- ✓ Reconcile your agency files
- ✓ Identify the outlier data
- ✓ Advance to an outcome

Traditional Compilations

- Internal and/or vendor annual cost reporting process
- Historical reports and methodologies
- Consistent "same thing as last year" approach

Software Only Compilations

- Unique "outside-in" approach reconciles entire portfolio.
- Consider the impacts of dynamic changes.
- Account for every dollar: Paid, already claimed, etc.: all remaining deductibles and coinsurance should be analyzed.

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Changing Regulations

Crossovers | Indigent | Self Pay

- Final Rules - Primary driver of regulatory change at national level
  - October 1, 2020 (FY21 Final Rule): substantial
  - October 1, 2021, 2022, and 2023: less Medicare Bad Debt updates
- Varying, Retroactive, and Modified regulatory regulation implementation by Fiscal Intermediary.
  - Example: Zero-balance on Agency Accounts
  - Example: Crossovers written off to Contractual Allowances
  - Example: 1st bill within 120 days of Medicare payment
  - Example: Indigent vs Charity vs Presumptive Charity

Changing Regulations

Crossovers

- Crossovers must not be written off to a contractual allowance account; instead, they must be written off to an expense account for uncollectible accounts.
- Medicare bad debt must be treated as an implicit price concession and recorded as a reduction in net patient revenue.
- Current FASB guidance requires writing off implicit price concessions to a contra-revenue account instead of an expense account.
- Reasonable collection efforts will be met without a Medicaid RA if the following documentation is submitted as an alternative:
  - State Medicaid notification indicating State has no obligation to pay
  - Documentation supporting state's liability, or lack thereof, for the Medicare cost sharing amount
  - Beneficiary's Medicaid eligibility documentation for date of service

Crossover Best Practice Recommendation: Crossovers are Dual Eligible Beneficiaries with valid supporting Medicare RA and Medicaid RA. Account balance is reduced to $0.00 when valid Medicaid RA is received using a write off code that is mapped appropriately to financial statements as a reduction in net patient revenue (i.e., no C/A and mapped to bad debt on GL).

Changing Regulations

Indigent | Clarifying Terms

- When referring to Medicare bad debts, the terms charity, indigence, financial assistance, presumptive charity, and similar have been historically used, often interchangeably, by providers and many in the healthcare field. Medicare has historically allowed providers to claim charity/indigent accounts on the MBD Logs as long as internal written policies are followed.
- CMS has determined that charity and indigence may not be used interchangeable related to Medicare. (CMS Publication 15-11, §4012 (Hospital Cost Reporting Instructions for Worksheet S-10) specifically states that "for Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as allowable bad debt."
- Charity, as defined by CMS in the bullet above, relates to the uncompensated charges given to uninsured patients (often called a self-pay discount). Medicare patient portion accounts, by nature of the patient being insured, cannot be considered as Charity when using this definition.
- Medicare does, however, allow Indigent accounts to be claimed as Medicare Bad Debt. Non-Crossover Indigent accounts are accounts that have been deemed indigent according to the Hospital's Financial Assistance Policy and the hospital has retained documentation to support the patient's determination of indigence (i.e., approved financial assistance application, bankruptcy documentation, deceased with no probate documentation, etc.).
- As noted, due to interchangeable use of terms over a long period, this has generally been a gray area that providers need to address proactively. Distinction of terms across many aspects of the revenue cycle function is critical.

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Changing Regulations

Indigent | Financial Assistance

Financial Assistance Best Practice Recommendations:

- Traditional financial assistance is defined as financial indigency granted based on a provider's Financial Assistance/Indigency Policy, which includes approved Financial Assistance application, supported by proper supporting documentation , as outlined in the Providers Financial Assistance/Indigency Policy (and follows regulatory requirements). All supporting documentation is maintained and available on demand.
  - Must perform both an asset and income test in determining indigency
  - May consider extenuating circumstances affecting indigency which may include analysis of liabilities and expenses
  - Must not use beneficiary's own declaration of indigency as sole proof of indigency
  - Must determine no other legally responsible party
- Providers should utilize one transaction code for true financial assistance, when an approved application and proper documentation are on file.
- Categories on log should be labeled as Indigent/Financial Assistance.
- If policies require more than the CMS Medicare requirements, adjustments to policies should be made to avoid disallowances/questions during audit. Auditors are going to review if the provider followed their policy and if the policy/supporting documentation aligns with the requirements. All Medicare and non-Medicare must be treated the same.
- CMS clarified through sub-regulatory guidance that providers may not use presumptive eligibility tools to evaluate whether a beneficiary is indigent.

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Changing Regulations

Indigent | Bankruptcy and Deceased

Bankruptcy Best Practice Recommendations:

- Best practice for Bankruptcy Medicare Bad Debts is to retain proof of discharge from debtor (along with Chapter #, Case #, and File date), which is producible during audit and transcribes discharge of debtor was confirmed before the account balance was written-off.

Deceased Best Practice Recommendations:

- The best practice for Deceased, No Estate Medicare Bad Debts, is to retain proof of no probate (a letter from the county), which is producible during audit and transcribes deceased no estate was confirmed before the account balance was written-off.

Changing Regulations

Indigent | Presumptive Charity

Presumptive Charity Best Practice Recommendations:

- CMS has clarified through sub-regulatory guidance that providers may not use presumptive eligibility tools to evaluate whether a Medicare beneficiary is indigent.
- As such, Medicare patient portion indigence cannot be solely supported with the use of presumptive eligibility tools. These accounts have the potential to be removed during audit of the Medicare Bad Debt Logs.
- To avoid unnecessary audit adjustments, we recommend determining presumptive indigence after reasonable collection efforts have been made. In this model, reasonable 120-day efforts have occurred, and indigence is typically determined before further collection agency efforts are pursued in a Pre-Agency scoring process. When reasonable collection efforts have been made, these accounts can be categorized on the Medicare Bad Debt log as “Regular” self-pay accounts meeting valid collection efforts and any reference to presumptive indigence is removed as not relevant to the account.
- Medicare and Non-Medicare accounts must be treated the same in the above scenario.
- Further, and a likely necessary change, these regular (pre-agency scoring) accounts should have their own codes that clearly define the account as “Regular” and any reference to presumptive eligibility should be removed from the codes that are used to avoid auditor confusion.

Changing Regulations

Self-Pay

Medicare Bad Debt is allowable for non-indigent beneficiaries only to the extent the provider complies with "reasonable collection efforts." Reasonable collection efforts were not clearly defined prior to the FY21 IPPS Final Rule.

- Guarantor bill must be issued on or before 120 days after the latter of the following:
  - Medicare RA Date
  - 2nd Payer RA Date
  - Date of notification of 2nd payer that services are not covered
- Reasonable collection efforts must start a new 120-day collection cycle each time a payment is received.
- Emails and text messages are acceptable collection efforts as long as they are auditable and verifiable.
- Providers must put forth the same efforts to collect Medicare D&C amounts as they do in collecting comparable amounts from non-Medicare patients (which includes collection agency use).
- Documentation supporting reasonable collection efforts must be provided upon request:
  - Current bad debt collection policy (covering both Medicare and non-Medicare patients)
  - Patient account history, including all collection efforts
  - Beneficiaries file with copies of bill(s) and follow-up notices

Changing Regulations

Self-Pay

Self-Pay Best Practice Recommendations:

- **Regular (No Agency)** – Self Pay balances that have been through internal collections and, based on hospital's policy, do not meet criteria to send to an outside collection agency.
- **Agency** – Self Pay balances that have been through internal collections, been sent to an outside collection agency, and have been returned from Agency as uncollectible.
- For both categories, the account balance is reduced to $0.00 when account is deemed uncollectible after reasonable collection efforts have occurred (as least three collection attempts spanning over 120 days from first bill to patient with collection efforts re-starting after every payment). Medicare and Non-Medicare accounts must be treated the same. I.E., Recommendation would be to write account balance down to zero and have a transaction code, mapped to bad debt on the GL, that describes the write-off (for example: Reasonable Efforts, Terminal Bad Debt, Uncollectible).

Audit Observations

- New Medicare Bad Debt Submission Template in effect for 09/30/2023 FYE's and forward
- Indigent versus Charity versus Presumptive Charity
  - Remove any reference to "Charity" or "Presumptive" from Medicare Accounts.
  - Transaction Code(s) should reference "Financial Assistance" or "Indigent" for patients qualifying under the provider's Financial Assistance policy.
  - Transaction Code(s) should reference "Pre-Agency Scoring" for regular collections not going on to further bad debt collections.
- 1st Bill Within 120 days of Medicare Payment
  - New MBD Template calculates Timely Billing.
  - Audit Observations –first thing the auditors are looking at.
- Crossovers and Agency Written off Timely
  - We have anecdotally heard that some auditors are disallowing agency and crossovers accounts that are not written off "timely" after the Medicaid Payment for Crossovers or Agency return for Agency accounts.
  - Not in regulations and is being applied inconsistently and should be appealed.
- S-10 Audit/Review processes vs Medicare Bad Debt
  - It is imperative that the Medicare Bad Debt Log is compared to the S-10 Log and **ALL** Medicare Bad Debt Accounts are contained on Line 26 of the S-10 Log.
  - S-10 Logs are audited significantly earlier than Medicare Bad Debt Logs so is very hard to go back and "amend" an S-10 Log after the fact.
  - Auditors are starting to review the S-10 Log in comparison to the Medicare Bad Debt Log and if the Medicare Bad Debt accounts is incorrectly on Line 20, it is becoming an issue in the MBD audit.

Industry Change

Future Planning in MBD+

- **Crossovers recorded** to contractual allowance codes (large scale vs ongoing issues)
- **Indigent vs charity accounts** (policies, procedures, MBD log labeling, transaction codes+)
- **Presumptive "charity"/indigent accounts** (tools, processes, transaction codes, timing (for regular treatment))
- **New compliance regulations** (1st bill < 120 days; date resets+)
- **Integrated Policies, Procedures and Support** (financial assistance, charity, indigent, MBD, agency+; best practices and compliance updates; supporting source data systems)
- **Integrated MBD/S-10** (exception reports; integration across reporting, bucket cross-referencing++)
- **Robotic Process Automation (RPA for MBD)** Converting AI worklists into programmed corrections
- **Legal pipeline** (retroactive application; HC Alerts)
- **Artificial Intelligence Solutions (AI for MBD)**
  - Catch issues real-time with AI; getting things right and optimized first-time through
  - Crossovers – MCR + PA + transaction code
  - Indigent – MCR + transaction code
  - Presumptive/regular – MCR + codes/timelines

Questions?

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THANK YOU!

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