Reimbursement to Hospitals for Medicare Patients' Unpaid Deductibles and Coinsurance (Bad Debts)

Congress long ago determined that Medicare patients should be required to share in the cost of their care through deductibles and coinsurance. Many Medicare beneficiaries purchase Medigap policies or have other supplemental health insurance that covers their coinsurance and deductibles. But many others do not, and some of them cannot or do not pay all or a portion of these cost-sharing amounts. Those unpaid amounts ultimately become hospital bad debts.[1]

In addition, about 20% of Medicare beneficiaries are dual eligibles – low-income seniors and younger persons with disabilities who are enrolled in both the Medicare and Medicaid programs. These Medicare beneficiaries receive coverage under Medicaid, as well as Medicaid's assistance in paying Medicare deductibles and coinsurance. But Medicaid typically pays much less than the full deductible ($1,156 in 2012) and coinsurance amounts ($289 per day for the 61st-90th days of a hospital stay), and the unpaid amounts are classified as bad debt. Beneficiaries with incomes above the dual-eligible qualification level but below 120% of the Federal Poverty Level (currently $10,890) also may qualify for Medicaid assistance in paying Medicare deductibles and coinsurance. For these beneficiaries as well, Medicaid typically pays much less than the full deductible and coinsurance due, and the unpaid amounts are classified as bad debt.

Since its inception, the Medicare program has paid hospitals for the costs of deductible and coinsurance amounts that many dual eligible and other Medicare patients are unable or unwilling to pay. These uncollectible Medicare deductible and coinsurance amounts are substantial and steadily growing.[2] For 2009, Medicare patients' hospital bad debts totaled about $2.7 billion and accounted for as much as 1.6% of some hospitals' Medicare revenues. Medicare pays a portion of these bad debts because the Medicare statute prohibits shifting the costs of Medicare patients to non-Medicare patients and vice versa.[3] If Medicare did not pay for beneficiary bad debts, they ultimately would get passed along to non-Medicare patients, which would violate the statute. Moreover, to the extent that hospitals already suffer from negative margins on their Medicare business, they would need to offset those losses from other sources.

Currently, by law, Medicare pays 70% of Medicare patients' bad debts,[4] but only if the uncollectible amounts meet stringent criteria. In order to get reimbursed for Medicare beneficiaries' bad debts, hospitals must meet a heavy burden. They must:

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1 State and federal fraud and abuse laws such as antikickback statutes prohibit hospitals from routinely waiving beneficiary cost-sharing amounts.

2 *See* Options to Reform Payment for Medicare Bad Debts, Office of Inspector General, Office of Audit Services, Management Advisory Report A-14-90-00339 (June 28, 1990); Office of Inspector General, Compendium of Unimplemented Recommendations, Part I, p. 10 (Mar. 2011).

3 *See* 42 U.S.C. § 1395x(v)(1)(A).

4 42 U.S.C. § 1395x(v)(1)(T). This means that hospitals absorb the 30% of Medicare deductibles and coinsurance that are uncollectible.

(1) be able to show that the debt related to covered services and was derived from deductible and coinsurance amounts;
(2) establish that reasonable collection efforts were made;
(3) establish that the debt was actually uncollectible when claimed as worthless; and
(4) use sound business judgment to conclude that there was no likelihood of recovery of the debt at any time in the future. [5]

The Centers for Medicare & Medicaid Services (CMS) has developed guidance to explain several of these requirements.[6] For example, the second requirement for claiming bad debts is that a hospital show it made "reasonable collection efforts." To be considered reasonable, a hospital's effort to collect Medicare deductible and coinsurance amounts must:

- be similar to the effort put forth to collect comparable amounts from non-Medicare patients;
- 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; and
- include other actions such as subsequent billings, collection letters and telephone calls or personal contacts with the responsible party that constitute a genuine, rather than a token, collection effort.[7]

Indeed, CMS has urged hospitals to take strong action to collect beneficiary cost-sharing amounts and said that the collection efforts should be documented in the patient's file by copies of bills, follow-up letters, reports of telephone and personal contact, and the like.[8] The agency's guidance says that hospitals' collection efforts may include using or threatening to use court action to obtain payment.[9] Yet at the same time, hospitals have been harshly criticized for making strenuous efforts to collect bad debts.[10]

Other than in very limited circumstances explained below, CMS does not allow a hospital to claim even a small Medicare bad debt – say $10 – without satisfying <u>all</u> of the requirements listed above. Thus, a hospital that wants to write off $10 would have to show that (1) the debt related to covered services and was derived from deductible and coinsurance amounts, (2) reasonable collection efforts were made, (3) the debt was actually uncollectible and (4) the hospital used sound business judgment to conclude that there was no likelihood of future recovery.

CMS's guidance does allow a hospital to write off a bad debt without collection efforts, but only if the hospital first determines the patient to be indigent or medically indigent. But as with the general test for Medicare bed debts, <u>a hospital must meet a high bar to establish indigence</u>:

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5 42 C.F.R. § 413.89(e).

6 Provider Reimbursement Manual (PRM), CMS Pub. 15-1 §§ 308, 310.

7 PRM, CMS Pub. 15-1 § 308.

8 PRM, CMS Pub. 15-1 § 310.

9 *<u>Id.</u>*

10 *See, e.g.*, C. Pryor, et al., "Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt, p. 14, n. 48 (June 2003).

- The patient's indigence must be determined by the hospital and not, for example, by a declaration from the patient;
- The hospital should take into account a patient's total resources;
- The hospital must determine that no source other than the patient would be legally responsible for the patient's medical bill; and
- 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.[11]

In order to conclude that a patient is indigent, a hospital must devote substantial resources to ascertain the patient's assets and resources and the liability of anyone else for the patient's debts as well as to document all of this. These activities – like those generally applicable to claiming bad debts – would almost certainly cost more than the $10 the hospital is owed, yet hospitals cannot avoid undertaking them. And, in the case of dual-eligible beneficiaries, even where a state has publicly said that it will pay less than the Medicare deductible or coinsurance amount, a hospital still must bill Medicaid before classifying unpaid amounts as bad debts. To do otherwise would risk disallowance of the bad debt by CMS or adverse findings in an audit by, for example, the Department of Health and Human Services Office of Inspector General .

Thus, hospitals must dot their I's and cross their T's in order to receive even 70% of cost-sharing amounts Medicare beneficiaries cannot or do not pay.

Hogan Lovells US LLP

[11] PRM, CMS Pub. 15-1 § 312.