Medicare reimbursement uncompensated care strategies

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Abstract As the ageing population in the US expands, more people will become health system users, and the number of uninsured will increase. Uncompensated care will continue to be a risk to healthcare institutions, and collaboration among the financial functions of institutions is essential to ensure healthcare providers do not miss Medicare and Medicaid reimbursement opportunities. This article identifies what healthcare organisations should be focusing on to drive reimbursement.

KEYWORDS: uncompensated care, Medicare reimbursement, Medicare cost report, Centers for Medicare and Medicaid Services (CMS), 340B

INTRODUCTION

According to the Centers for Medicare & Medicaid Services (CMS), by 2025, the national spend on healthcare services in the United States will exceed USD $5.5tn, almost double that of 2010, driven by an ageing population.[1] This might be considered great news for the healthcare industry and service providers; however, these projections come with a downside. As the number of

people seeking services increases, so too will the number of patients with no insurance. The strain of uncompensated care (UCC) on healthcare institutions is already showing, with a USD $2.6bn rise in the cost of bad debt and charity care to US-registered community hospitals from 2015 to 2016.[2]

As the ageing population in the US increases, more patients will flood the healthcare system, and UCC will continue to be a growing risk to institutions. Mitigating this risk requires collaboration among the reimbursement, finance, revenue cycle, patient financial services and tax areas of a healthcare organisation. The implications of Medicare UCC reporting and the connection to Medicare cost reporting and the revenue cycle functions have never been more relevant. As healthcare organisations look for ways to improve margins, they must understand the different methodologies to make sure they do not miss Medicare and Medicaid reimbursement opportunities.

On 16 August 2019, CMS published the Inpatient Prospective Payment System (IPPS) final rule for federal fiscal year (FY) 2020.[3] In it, CMS estimates that total Medicare disproportionate share hospital (DSH) payments will be just under $12.5bn for FY20, which is $140m more than FY19 levels. Of this total, $8.35bn will apply to UCC payments, which is $78m more than UCC payments in FY19.

Without a consistent and defensible approach to UCC reporting, an organisation's share of related Medicare reimbursement for Medicare DSH, UCC and Medicare bad debt might be at risk. In addition, eligibility for the 340B Drug Pricing Program might be at risk. Most hospitals and health systems have processes and tools in place to limit revenue leakage, protect and enhance governmental payer reimbursement and improve margins. Organisations can use these existing processes and tools to develop strategies in the following areas of Medicare reimbursement.

DSH and UCC reimbursement

DSH payments began in 1986 to provide an additional reimbursement to hospitals that serve a disproportionate number of low-income patients, addressing the financial burdens of serving this patient population.

Historically, the most common method for qualifying for the DSH payment has centred on a hospital's disproportionate patient percentage (DPP), which is the sum of two fractions, known as the Medicare fraction and the Medicaid fraction. The Medicare fraction calculation, also known as the Supplemental Security Income (SSI) ratio, divides the number of inpatient days furnished to patients entitled to both Medicare Part A and SSI benefits by the total number of patient days for patients entitled to Medicare Part A benefits. The Medicaid fraction calculation divides the number of inpatient days for patients eligible for Medicaid but not entitled to Medicare Part A by the total number of inpatient days in the same period.

$$\textbf{Medicare DPP} \quad \frac{\text{Medicare Supplemental Security Income Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid,Non-Medicare Days}}{\text{Total Patient Days)}}$$

While a hospital does not have much control over the Medicare and SSI eligibility of patients that walk through the doors, it can influence the Medicaid fraction through front-end revenue cycle efforts to identify Medicaid eligibility and document the related allowable days that correspond to dates of service within the cost reporting period.

In March 2010, the *Patient Protection and Affordable Care Act* (ACA) made significant changes to the Medicare DSH payment. Starting in FY14, hospitals that qualify for Medicare DSH receive 25 per cent of the amount they previously would have received under the statutory formula, referred to as the 'empirically justified Medicare DSH

payment'. The amendment also provides for an additional payment for a hospital's UCC.

Whereas traditionally, the formula for determining DSH payments centred on Medicare SSI ratios and Medicaid Title 19 patient days, under the ACA, 75 per cent of the formula is driven by UCC. The UCC formula is based on a hospital's share of UCC compared with all hospitals nationally. The prospectively determined annual amount is equal to an estimate of 75 per cent of what otherwise would have been paid as Medicare DSH payments, adjusted for decreases in the rate of uninsured individuals and other factors.

Each qualifying hospital's UCC payment is the product of three factors, which are published annually by CMS:

- **Factor 1.** 75 per cent of the estimated DSH payments that otherwise would be made under the old DSH methodology (Section (d)(5)(F) of the *Social Security Act*)
- **Factor 2.** 1 minus the percent change in the percentage of individuals under the age of 65 who are uninsured (as estimated by the secretary of Health and Human Services, based on data from the Census Bureau or other sources the secretary determines appropriate, and certified by the chief actuary of CMS) (reduced by 0.1 percentage points for FY14, and reduced by 0.2 percentage points for FY15 through FY19)
- **Factor 3.** A hospital's amount of UCC relative to the amount of UCC for all DSH hospitals, expressed as a percentage

Of the aforementioned, the only hospital-specific component and one dependent on hospital cost report data is Factor 3. For federal fiscal years 2014, 2015, 2016 and 2017, CMS used inpatient Medicaid days and Medicare SSI days (low-income insured days) from filed Medicare cost reports to determine Factor 3 of the UCC component of the new DSH formula. This was essentially the same data used under the old DSH calculation.

During the 2018 IPPS rule-making process, CMS specified time periods for incorporating UCC data from Worksheet S-10 of the Medicare cost report in the calculation of Factor 3:

- FY18 payments use FY12 and FY13 low-income insured days and FY14 S-10 data.
- FY19 payments use FY13 low-income insured days and FY14 and FY15 S-10 data.
- FY20 payments use FY14, FY15 and FY16 S-10 data.

For FY19, CMS continued the phase-in of the three-year average reflected previously, which still included elements from the old DSH calculation in the form of low-income insured days.

Per the final rule for FY20, CMS will use only one year of S-10 data rather than the blend of three years for the Factor 3 calculation. Considering the significant and growing amount of reimbursement at stake and increased audit scrutiny, it is more critical than ever that hospitals focus efforts on aligning policies, processes, data and supporting documentation.

Table 1 shows the amounts for Factor 1 and Factor 2 since the inception of the UCC payments for FY14 through FY20.

Worksheet S-10 audit developments

As pointed out in the Crowe article 'Connecting the Dots on Uncompensated Care Reporting: IPPS Updates', UCC payments continue to increase, as does the level of scrutiny from CMS.[4] The significance of these payments highlights the importance of accurate reporting of UCC on the Medicare cost report. Because the amount of charity care and bad debt reported can greatly affect the UCC payment, Medicare administrative contractors (MACs) appear to be focusing their audits on these elements.

FY15 reports represent those selected for the first round of audits, which focused on:

Table 1: Uncompensated care amounts

Fiscal Year-End	DSH Estimate (Dollars)	Factor 1 (75% of Total DSH) (Dollars)	Percentage of Uninsured	Factor 2 Percentage	Factor 2 Dollar Amount
2014	12,772,000,000	9,579,000,000	17.00%	94.30%	9,032,997,000
2015	13,383,462,196	10,037,596,647	13.75%	76.19%	7,647,644,885
2016	13,411,096,528	10,058,322,396	11.50%	63.69%	6,406,145,534
2017	14,396,635,710	10,797,476,782	10.00%	55.36%	5,977,483,146
2018	15,552,939,524	11,664,704,643	8.15%	58.01%	6,766,695,164
2019	16,339,055,838	12,254,291,878	9.48%	67.51%	8,272,872,447
2020	16,583,455,657	12,437,591,743	9.40%	67.14%	8,350,599,096

Source: 2014 Federal Register (FR) Vol. 78 No. 160, August 19, 2013; 2015 FR Vol. 79 No. 163, August 17, 2014; 2016 FR Vol. 80 No. 158, August 18, 2015; 2017 FR Vol. 81 No. 162, August 22, 2016; 2018 FR Vol. 82 No. 155, August 14, 2017; 2019 FR Vol. 83 No. 160, August 17, 2018; 2020 FR Vol. 84 No. 159, August 16, 2019.

- Review of the financial assistance policy (FAP) and its application
- Explanation of determination of insurance status and charity care eligibility
- Descriptions of logic and processes used to identify charity care charges
- Detailed listing of charges and payments, including demographic data and revenue codes (to identify and eliminate professional fees before the sampling process)
- Detailed listing of all hospital bad debt, including Medicare
- Reconciliation of reported bad debt to audited financial statements

Common themes experienced during audits include:

- Condensed time frame imposed on hospitals and MACs from the outset
- Inconsistent application of audit programme and scope by MACs
  - Sampling techniques and size
  - Documentation requirements
  - Error rate extrapolation
- Not auditing to the FAP
- Short response times for hospitals to provide supporting documentation
- Inconsistent interpretation of ambiguous cost report instructions by MACs
- Lack of CMS process to challenge or appeal MAC audit adjustments

The single most problematic issue faced by hospitals in responding to the audits was a lack of sufficient supporting documentation. For accounts selected for audit, MACs requested:

- Charity care applications and supporting documentation, such as pay stubs and bank statements showing the patient qualified for charity care
- Uniform billing (UB) and explanation of benefits materials
- Medicaid remittance advice (RA) documentation, if applicable
- Patient accounting system (PAS) notes

Lack of clear guidance and inexperience led to the auditors making subjective interpretations, which led to inconsistent error rate calculations, extrapolation and sizeable negative adjustments. This represents considerable risk to hospitals and illustrates the importance of coordination and communication among the revenue cycle, reimbursement, patient financial services, finance and tax areas to enhance policies and procedures around reporting and documenting UCC.

Medicare bad debt

Allowable Medicare bad debts consist of a Medicare-eligible beneficiary's unpaid

deductible and co-insurance amounts related to covered services. In most cases, the allowable Medicare bad debts that are reported do not correspond with current year expense. A recorded bad debt could be from a prior year owing to the collection efforts that are required (and the time it takes to determine and document if an account is worthless) before claiming it as a Medicare bad debt. Since 1 October 2012, bad debt is reimbursed at 65 per cent of the uncollectible Medicare co-insurance and deductible amounts from beneficiaries.

Per 42 Code of Federal Regulations Section 413.89(e), the criteria for allowable Medicare bad debt are as follows:

- The debt is related to covered services and derived from deductible and co-insurance amounts.
- The provider can show that it made reasonable efforts to collect the debt and that the debt was not written off until at least 120 days after the first bill to the patient.
- The debt was uncollectible when claimed as worthless.
- The provider used sound business judgment to determine that future recovery was unlikely.

Medicare patients' co-insurance and deductible amounts that are excluded from allowable Medicare bad debt include:

- Amounts related to fee-reimbursed services
- Amounts related to professional services
- Amounts still at collection agencies and not deemed worthless
- Accounts for which payments have been made within the previous 120 days

Categories

Medicare bad debts are categorised into traditional Medicare bad debt, Medicare/Medicaid crossover (dual-eligible) Medicare bad debt and indigent/charity care Medicare bad debt.

Traditional Medicare bad debt

A traditional Medicare bad debt consists of the co-insurance and deductible amounts of a beneficiary who is not eligible for Medicaid and does not qualify as an indigent patient under the hospital's charity care policies. In order for this bad debt to be allowable, the following conditions must be met:

- Reasonable collection efforts must have been completed and consist of the following per Provider Reimbursement Manual, 15-1, Chapter 3, Section 310:
  - Efforts for collecting Medicare bad debts must be similar to the efforts put forth to collect comparable amounts from non-Medicare patients.
  - Efforts must involve the issuance of a bill on or shortly after discharge to the party responsible for the patient's personal financial obligations.
  - Efforts should include other actions that constitute a genuine, rather than a token, collection effort:
    - Subsequent billings
    - Collection letters
    - Telephone calls
    - Personal contacts
  - Efforts may include the use of collection agencies besides or instead of subsequent billings and follow-up letters.
- Documentation to prove these collection efforts must be kept in the patient files and be readily available during an audit.

Medicare/Medicaid crossover (dual-eligible) Medicare bad debt

A dual-eligible bad debt consists of the co-insurance and deductible amounts of a Medicare primary and Medicaid secondary beneficiary. To claim this category of bad debt, the hospital must complete the following processes:

- Bill Medicaid the same charges billed to Medicare.
- Receive and maintain the Medicaid RA.
- Subtract the co-insurance and deductible paid by Medicaid from the total co-insurance and deductible.
- Prove no other insurance exists and no other party is responsible for the patient's financial obligations.

Indigent/charity care Medicare bad debt

A charity care bad debt consists of the co-insurance and deductible amounts of a traditional Medicare beneficiary who is deemed to be indigent, is not eligible for Medicaid and meets the charity care policies of the organisation.

To claim this category of bad debt, the hospital must determine indigence as follows:

- Consider the patient's total resources.
- Determine no other source would be legally responsible.
- Document indigence determination in the patient's file.

No further collection efforts are necessary for claiming this category of bad debt.

Recoveries

At times, a Medicare beneficiary will make payment on an account that the hospital had written off in a prior year. When this occurs the organisation is required to offset current year allowable Medicare bad debts by the amount of the recovery.

When a beneficiary makes a payment on an account that has not yet been written off, the account is not deemed worthless and cannot be written off until another 120 days pass. The partial payment on an account will restart the 120-day period.

MBD audit issues

Hospitals might experience a variety of issues during a Medicare bad debt audit, some of which are dependent on the specific category that is under review.

Some of the typical considerations for traditional bad debts:

- Bad debts relating to Health Maintenance Organisation (HMO) plans are reimbursed as part of capitation rates established by the Medicare Advantage plan and should not be included on the Medicare cost report.
- Bad debts relating to deductible and co-insurance for fee-reimbursed services should not be included.
- Collection efforts should have ceased as of the write-off date.
- Documentation should support billing the beneficiary consistently for a minimum of 120 days.
- The first bill should be sent in a timely manner to the beneficiary — typically within 45–60 days of the date of service or the Medicare RA date.

Some typical considerations for crossover bad debts:

- Crossover claims should be billed to Medicaid.
- Crossover listings should include Medicare health insurance claim (HIC) numbers.
- Crossover bad debts should not have been claimed on denied Medicaid remits.

Some typical considerations for indigent/charity bad debt accounts:

- CMS expects documentation of indigence to include the patient's application with an analysis of net worth (analysis of assets to liabilities) and verification of income (bank statement, copy of SSI checks).
- The provider must make a determination of indigence and not from a patient declaration.
- The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill.

- Collection efforts, including an estate search, are required for deceased Medicare beneficiaries. (Estate searches can be performed using an online service or documented call to probate court to determine whether an estate has been filed with the court.)

Other more general considerations for an audit:

- Auditors might ask for copies of written policies.
- Use of collection agencies.
  - Collection agencies must be able to provide patient transaction histories to document communications to collect debt; otherwise, related bad debt accounts will be at risk.
  - Collection agency fees are an allowable administrative and general cost and should not be claimed as an allowable bad debt.
  - Hospitals must be able to document that uncollected accounts of like amount are referred to the collection agency without regard to patient class.
  - Collection agency efforts must be genuine, not token, and the same for all patients.

340B reimbursement

The federal 340B Drug Pricing Program, which came into effect in 1992, requires participating pharmaceutical companies to provide outpatient drugs to qualified healthcare facilities (covered entities) at reduced prices so that healthcare organisations can stretch federal resources to reach more patients and provide more comprehensive services.

A hospital's participation in the programme is, in part, determined by its allowable DSH percentage. The allowable DSH percentage is the amount calculated through the DSH formula, which should not be mistaken for the DPP previously discussed. Table 2 shows the DSH allowable percentage necessary for a hospital to be eligible for the 340B programme.

Table 2: DSH allowable percentage by hospital type

Hospital Type	Allowable DSH %
Disproportionate share hospital	>11.75
Children's hospital	>11.75
Free-standing cancer hospital	>11.75
Critical access hospital	N/A
Rural referral centre	≥8
Sole community hospital	≥8

Source: Apexus. (2015) '340B hospital eligibility criteria', available at: //docs.340Bpvp.com/documents/public/resourcecenter/hospital_eligibility_criteria.pdf

The May 2015 Medicare Payment Advisory Commission (MedPAC) report to the U.S. Congress found that the average minimum discount was 22.5 per cent less than group purchasing organisation prices. For drugs acquired through the 340B programme billed to Medicare, hospitals received average sales price (ASP) plus 6 per cent before 1 January 2018.[5] In the 2018 Medicare Hospital Outpatient Prospective Payment System (OPPS) final rule, HHS proposed and finalised a significant reduction in 340B reimbursement of ASP minus 22.5 per cent to come into effect for payments after 1 January 2018. The final rule estimated the change would result in a USD $1.6bn reduction in OPPS payments to 340B hospitals and redistribution of the savings by increasing OPPS payments for non-drug services applicable to all hospitals.[6]

CMS' goal through this reduction in 340B payments is to align Medicare payments for these drugs with the cost required for purchase. CMS stated that it is not appropriate to subsidise other hospital programmes through Medicare payments for these drugs.[7]

Hospitals not affected by the reduction in payments include:

- Critical access hospitals
- Rural sole community hospitals

- Children's hospitals
- Prospective Payment System-exempt cancer hospitals

The American Hospital Association (AHA) challenged the payment reduction, and on 27 December 2018 the U.S. District Court for the District of Columbia issued a ruling that placed a permanent injunction on the reimbursement reduction policy. Ramifications of this ruling are still being ironed out as to how and when the reductions will be reversed and how or whether hospitals subject to the reduction in 2018 will be refunded the reductions in payments.

The 2019 OPPS rule has expanded this payment reduction to non-exempted, off-campus, provider-based departments (PBD) to the ASP minus 22.5 per cent payment under the Medicare Physician Fee Schedule. In the past these were reimbursed at ASP plus 6 per cent. The U.S. District Court for the District of Columbia's ruling on the permanent injunction did not address the OPPS 2019 final rule on the expansion of this payment reduction to PBDs.

The AHA also challenged this additional payment reduction, and on 6 May 2019 the U.S. District Court for the District of Columbia ruled to place a permanent injunction on the 2019 reimbursement reduction policy. Again, the ramifications of this ruling remain to be seen.

Strategies to optimise reimbursement

As healthcare organisations face changing reimbursement methodologies, new incentive payment models, penalties for not meeting quality initiatives and shrinking reimbursement, operating procedures must keep up. All functions of the healthcare organisation have to work collaboratively to drive methodologies and processes to protect current levels of reimbursement and increase future levels.

Following are important drivers and strategies related to optimising reimbursement for Medicare DSHs, UCC, Medicare bad debt and 340B drugs.

Disproportionate share hospitals

Even though reimbursement for DSH payments has decreased significantly since the ACA, hospitals need to continue to look for ways to improve processes for identifying and capturing data supporting diagnosis-related group payments, Medicaid-eligible days and SSI percentage. These strategies may help to optimise DSH reimbursement:

- Investigate case management, payment accuracy and transfers to verify that proper reimbursement is being received.
- Establish processes to update Medicare rates on an interim and annual basis to confirm proper amounts are being billed and received.
- Implement and follow denial management processes with audits to verify compliance with procedures.
- Implement processes to identify, verify and report all Medicaid-eligible days.
- Obtain SSI data from CMS and compare with internal data to identify trends and opportunities to request recalculation based on fiscal year-end versus fiscal year.

Uncompensated care

Hospitals need to continue to look for ways to improve UCC processes for charity care and bad debt reporting. These strategies may help to optimise UCC reimbursement:

- Review policies, and update as necessary to verify that charity care eligibility agrees with financial assistance policies.
- Review bad debt write-off policies, and update as necessary.
- Implement S-10 documentation strategies:
  - Identify/update transaction codes for charity care and bad debts, and use them for pulling all accounts.

- Develop a detailed listing of charity care and bad debts, and submit with Medicare cost reports.
- Conduct interim self-audits to ensure processes adhere to policies and appropriate documentation (UB, RA, PAS notes) is maintained.

While hospitals must develop a standardised approach to improve the accuracy and consistency of documentation to support UCC reimbursement in the immediate term (audits of FY17 cost reports are already under way), they should prepare to share detailed support of charity care amounts reported on the Medicare cost report and provide a reconciliation of this data with amounts reported on IRS Form 990, Schedule H and the audited financial statements.

Medicare bad debt

Hospitals should look for ways to improve processes specific to the auditable supporting documentation for Medicare bad debt accounts. Strategies for the patient financial services and reimbursement areas to collaborate and optimise reimbursement may include these:

- Verify that processes exist to confirm compliance with MAC documentation requirements.
- Determine that policies for returns from collection agencies are being followed before claiming a Medicare bad debt on the cost report.
- Implement and follow timely billing processes.
- Consistently use proper transaction codes for co-insurance and deductibles so that all Medicare bad debts are being identified (for example, establish a specific code for MBD write-off).
- Exclude non-allowable co-insurance and deductible amounts (for example, by using detailed provider statistical and reimbursement reports versus individual Medicare remittances).
- Track associated co-insurance for recurring patients.
- Track and net recoveries against reported Medicare bad debts.
- Complete Medicaid billings.
  - Claim out-of-state Medicaid patients (including validating other state explanation of benefits codes).
  - Claim managed Medicaid patients.
  - Bill Medicaid for total charges. (Charges must match those billed to Medicare.)
- Conduct an interim bad debt assessment during the year to confirm that processes are being followed and documentation is being maintained.

340B

Hospitals should look for ways to improve processes related to 340B programme compliance and pharmacy billing procedures. Strategies to minimise the impact of changes to the 340B programme may include these:

- Control the cost for acquiring 340B drugs.
- Confirm the hospital's billing and pharmacy departments work together to verify billing and modifiers are accurate.

Focus on what is needed to drive reimbursement

An increase in UCC will require healthcare organisations to find ways to improve the business of healthcare. Organisations must understand the different reimbursement methodologies to make sure they do not miss Medicare and Medicaid reimbursement opportunities.

By understanding the important drivers of each UCC component and the opportunities for collaboration and improvement, healthcare organisations can focus on what is needed from the revenue cycle, regulatory reimbursement, patient financial

services, finance and tax areas to improve the accurate reporting of UCC elements and reimbursement that occur within each of these areas. Improved processes will help to reduce revenue leakage in an age of shrinking healthcare reimbursement and evaporating healthcare margins.

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