The Impact of New Medicare Bad Debt Rules on YOU and Your Collection Agencies

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Who Are We?

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- President of Americollect
- Past-President of Wisconsin HFMA

Nick McLaughlin, FHFMA
- Director of Ridiculously Nice Sales
- Past-President of Indiana HFMA

*People seeking legal advice should always consult with an attorney.

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Intro to Medicare Bad Debt

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Part of IPPS (Hospitals Only)

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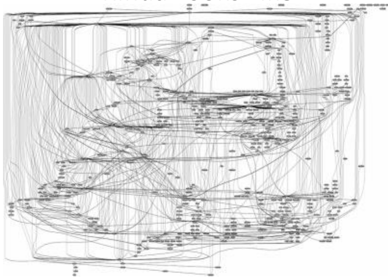
Healthcare Reimbursement Kinda Looks Like



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Long Story Short

65%

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Long Story More Accurately

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But Still…

65%

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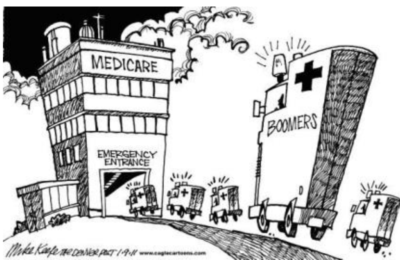
Especially Considering Baby Boomers



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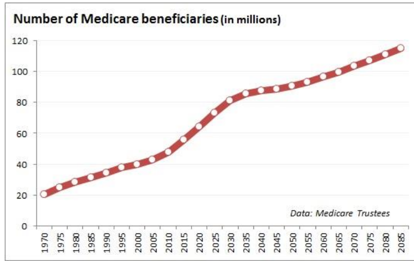
20 Million More Next 10 Years



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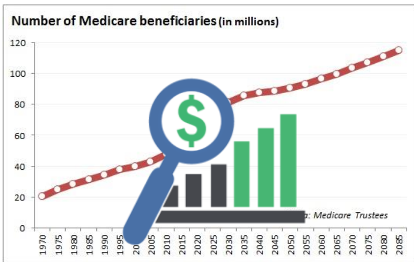
That's A Lot Of 65%!



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Areas Addressed in IPPS Final Rule 2021

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Areas Addressed

- Genuine collection effort required
- New collection activity documentation requirements
- Timing of the 120-day collection period and what resets the clock
- Posting payments back to patient accounts
- Claiming Medicare accounts at collections for reimbursement
- How collection agency fees need to be accounted for

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Areas Addressed

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Genuine Collection Effort

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Genuine Collection Effort - What It Means

- CMS's Goal – Ensuring more than a token effort at collecting Medicare Bad Debt accounts.
  - "Shoot! If I get 65% for uncollected MBD, why try to collect on it at all?!"

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Genuine Collection Effort - What It Means

- Requirements generally met during internal patient billing processes. 120 days of:
  - Sending patient bills
  - Subsequent billings
  - Telephone calls
  - Personal contacts

- **ONE LARGE CAVEAT!**
  - The Similar Collection Effort requirement

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Genuine Collection Effort - What It Means

- Similar Collection Effort requirement – treat Medicare and non-Medicare accounts similarly:
  - If you make collection calls to non-Medicare accounts, you need to make collection calls on Medicare accounts, too.
  - If you send non-Medicare accounts to collections, you need to send Medicare accounts to collections, too.
  - If you send non-Medicare accounts to secondary collection agency, you need to send Medicare accounts to a secondary agency, too.

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Genuine Collection Effort - What It Means

- I don't treat all my accounts the same. What about larger balances?
  - Primary example CMS gives is balance size – accounts "of like amount."

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Genuine Collection Effort - What It Means

- "The provider must ensure…"
  - CMS now holds YOU responsible for everything that falls under Genuine Collection Efforts as it relates to similar efforts on Medicare and non-Medicare accounts.
  - **This includes collection activities done by your collection agencies – and documentation.**

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Genuine Collection Effort – What We are Doing

1. Treating your Medicare and non-Medicare accounts the same.

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Genuine Collection Effort – What We are Doing

2. If it helps you with reporting, creating a second client code in our system for your Medicare Accounts.

3. In addition to our common Cancel and Return report, we send a special report with your cancelled Medicare Bad Debts from that year, including all required supporting data fields.

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New Collection Agency Documentation Requirements

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New Collection Activity Documentation Requirements – What It Means

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New Collection Activity Documentation Requirements – What It Means

- Expanded documentation requirements for collection activities.
- Previously: Provide reporting for in-house activities only.
- **Now: Documentation requirements apply to both in-house and external agency activities.**

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New Collection Activity Documentation Requirements – What It Means

You now need your collection agencies to maintain, and upon request, furnish verifiable documentation to your MAC, including patient account history documents that show dates of various collection actions:

- Issuance of bills
- Follow-up collection letters
- Dates/times of telephone calls
- **AND,** copies of bills and follow up notice(s) sent.

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New Collection Activity Documentation Requirements – What We Are Doing

Reporting Activity Through Notes Files:

- For our clients with EHR systems capable of handling the data, we report our collection activity with a notes file on a weekly basis.
- This way, if audited, the MAC would be able to find all necessary data in your own system.

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New Collection Activity Documentation Requirements – What We Are Doing

Maintaining and Furnishing Upon Request:

- For our clients unable to accept that kind of data, we maintain all required info and provide upon request.
- Americollect's expansion of services with our notice vendor to include notice image storage for 3 years.

Available Upon Request

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Timing of the 120-Day Collection Period and What Resets the Clock

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Timing of the 120-Day Collection Period – What It Means

- Previously – If the account is 120 days past date of first bill, requirement met.
- Now – The 120-day collection period restarts after any payment is made within the "120-day" period.

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Timing of the 120-Day Collection Period – What It Means

- MACs will be checking to see if there are any payments on your Medicare Bad Debt accounts within 120 days of claiming reimbursement and denying those.

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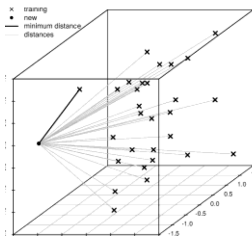
Timing of the 120-Day Collection Period – What We Are Doing

- **Adding new data point to cancellation criteria.**
- “Date of Last Payment Plus 120 Days”
- This ensures that no accounts you receive back from us will be DQ’d for not meeting this requirement.



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Posting Payments Back to Patient Accounts

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Posting Payments to Patient Accounts – What It Means

- This is mostly a clarification – hospitals can only claim **uncollected amounts** for Medicare Bad Debt reimbursement.
- This clarification requires that GROSS amount collected needs to be posted at the account level to claim the final account balance for reimbursement.

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Posting Payments to Patient Accounts – What We Are Doing

- Providing electronic payment reports to post payments to your accounts with no manual intervention.
- **GROSS amount collected, not NET.**

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Can I Claim Accounts Still in Collections for Medicare Bad Debt Reimbursement?

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Can I Claim Accounts Still in Collections? – What It Means

- The answer is no.
- CMS's reasoning – if "there was no likelihood of recovery at any time in the future, you wouldn't have it at a collection agency."
- But wait – 46 Hospitals v. Sec. Alex Azar filed December 28, 2020

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Can I Claim Accounts Still in Collections? – What It Means

46 Hospitals v. HHS

- Prior to 2006, hospitals could claim Medicare Bad Debts for reimbursement that were pending at outside agencies.
- In 2006, HHS reversed that policy, and the current lawsuit seeks a reversal of the reversal.
- Hospitals allege the decision violates a moratorium that restricted the HHS secretary from amending bd debt policies prior to 2012.
- The disallowed bad debts from fiscal years 2006-2009 will result in those hospitals needing to pay nearly $1.4 million back to CMS.

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Can I Claim Accounts Still in Collections? – What It Means

46 Hospitals v. HHS

- How does this impact you?
  - If the hospitals win, likely will only impact accounts between 2006 and 2009. No change to 2020 update.
  - Do not claim accounts still in collections for Medicare Bad Debt reimbursement.

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Can I Claim Accounts Still in Collections? – What We Are Doing

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Accounting for Collection Agency Fees

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Accounting for Collection Agency Fees – What It Means

- There are fees associated with collection agency work.
  - (Thank you very much!)
- Unfortunately, CMS says you must post the gross payment amount to your accounts, not the amount after the collection agency fee.
  - For example: $1,000 payment, 30% fee → hospital must post the full $1,000 payment to the patients account, not the $700 they receive after paying the contingency fee.

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Accounting for Collection Agency Fees – What It Means

- Good news – so long as the reasonable collection effort requirements are met, collection agency fees are recognized as an allowable administrative cost to the provider.
  - Back to the example: $1,000 payment, 30% fee:
    - Record full $1,000 collected in the patient account.
    - Record the collection fee ($300) in administrative costs.

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Accounting for Collection Agency Fees – What We Are Doing

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How to Report Medicare Bad Debt

Form **990** — **Return of Organization Exempt From Income Tax**

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

Department of the Treasury Internal Revenue Service

▶ The organization may have to use a copy of this return to satisfy state reporting requirements.

OMB No. 1545-0047 — 2005 — **Open to Public Inspection**

A For the 2005 calendar year, or tax year beginning , 2005, and ending , 20

B Check if applicable: ☐ Address change ☐ Name change ☐ Initial return ☐ Final return ☐ Amended return ☐ Application pending

Please use IRS label or print or type. See Specific Instructions.

C Name of organization

Number and street (or P.O. box if mail is not delivered to street address) Room/suite

City or town, state or country, and ZIP + 4

D Employer identification number

E Telephone number ( )

F Accounting method: ☐ Cash ☐ Accrual ☐ Other (specify) ▶

• **Section 501(c)(3) organizations and 4947(a)(1) nonexempt charitable trusts must attach a completed Schedule A (Form 990 or 990-EZ).**

H *and* **I** *are not applicable to section 527 organizations.*

H(a) Is this a group return for affiliates? ☐ Yes ☐ No

H(b) If "Yes," enter number of affiliates ▶

H(c) Are all affiliates included? ☐ Yes ☐ No (If "No," attach a list. See instructions.)

H(d) Is this a separate return filed by an organization covered by a group ruling? ☐ Yes ☐ No

G Website: ▶

J Organization type (check only one) ▶ ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

I Group Exemption Number ▶

K Check here ▶ ☐ if the organization's gross receipts are normally not more than $25,000. The organization need not file a return with the IRS; but if the organization chooses to file a return, be sure to file a complete return. **Some states require a complete return.**

M Check ▶ ☐ if the organization is not required to attach Sch. B (Form 990, 990-EZ, or 990-PF).

L Gross receipts: Add lines 6b, 8b, 9b, and 10b to line 12 ▶

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990 Excel Log - Link

990 Excel Log:

- Beneficiary name
- HIC number
- Discharge date
- Indigence status
- Date of 1st bill to beneficiary or supplemental
- (Last or Qualifying) Medicare remit date Amount of deductible and co-insurance
- Write-off amount (amount being claimed)
- Write-off date (posting date or close report date)
- Medicaid remit date (if applicable)
- Medicaid (number if applicable) - I/P or OP indicator

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Audit Defense #1 - Policy

Strong - Billing and Collection Policy

1st line of defense against an audit is a STRONG billing and collection policy!!!

Sample – Link

Billing and Collection Policy Sample

Premier Health	
Policy Title:	Collection Policy
Policy #	12345
Effective Date:	01/01/2014
Revision Date:	
Review Responsibility and Final Authority to Determine Reasonable Effort has been made:	Director of Patient Financial Services

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Audit Defense #2 - Data

Internal Log– Audit Defense – Excel Document

- Account number - Admit date - Admitting FC - Current FC - Ins1, 2 & 3 plan code & policy number - Total charges per last Medicare remit - Hosp Total charges - Total Medicare payment - Total insurance payment - Total patient payment - Grand total payment - Total Medicare Adjustment Amt - First, last, "qualifying" Medicare remit dates - Total non-Medicare Adjustment Amount - Account balance - File indicator (BD v AR) - Date of 1st statement to patient - Date account transferred to early out agency - Date account returned from early out agency - Date account transferred to collection agency - Date account returned from collection agency – Number of Statements sent by Collection agency- Number of Phone attempts by collection agency - Reason account was returned from agency if < 120 days from payment - Date of 1st bill to supplemental insurer - Date supplemental bill auto crossed over from Medicare to supplemental payer - Date of initial supplemental payment (including zero pays) - "Include on cost report" Y or N indicator - Unpaid co-insurance as of fiscal year-end date - Unpaid deductible as of fiscal year-end date - Medicaid remit date (including zero pays) - Medicaid payment amount - Supplemental Remit date - Deceased w/o (code, amount, date) indicator - Bankruptcy w/o (code, amount, date) indicator - Charity w/o (code, amount, date) indicator - Comments (internal) - Comments for auditor - Amount claimed on External log

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Q&A

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