

Helping Healthcare Providers Recover Every Dollar.





Understanding & Recouping More Value from Medicare Bad Debt







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About the Presenters



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Who We Are and What We Do



Who We Are

Meduit is a proven, national, innovative, revenue cycle solutions provider focused solely on healthcare. We serve as a true partner and turn accounts receivable into *cash faster* and *improve the patient financial experience*.



Meduit delivers efficient and effective revenue cycle solutions that lead to measurable, high-performing results and maximize ROI for hospitals, health systems and physician groups.

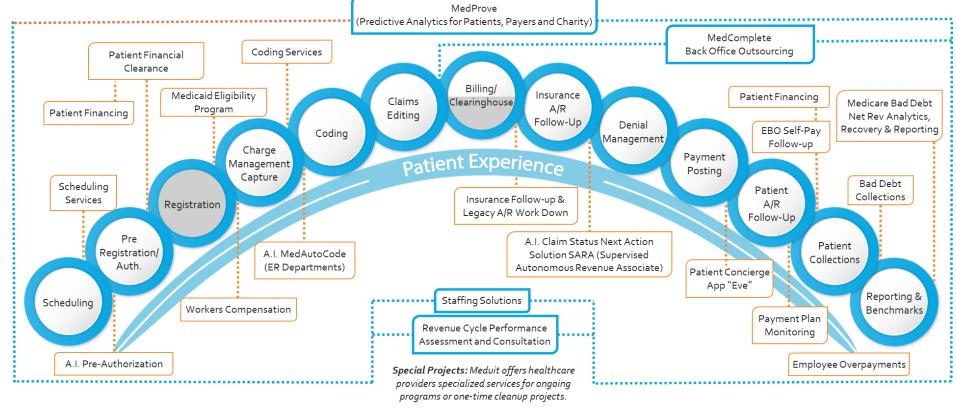
What We Do











What We'll Cover in this Webinar

- Understanding growing patient financial responsibility, particularly for Medicare/Advantage beneficiaries
- Industry changes impacting Medicare bad debt
- Timeline considerations in Medicare bad debt
- Data sets impacting Medicare bad debt reporting
- Strategies to increase Medicare Bad Debt net revenue recovery and collections on outstanding Medicare/Advantage accounts







Rising Patient Financial Responsibility

What is Medicare Bad Debt, and Why Does It Matter?

\$910B

(spent annually on Medicare)

~63M

(people on Medicare in 2021)

\$25B

(due from patients each year)

\$3.5B

(paid to hospitals for MBD each year)

(estimated as under-reported each year)



US Gov't is (by far) the biggest single payor to hospitals.



Using their leverage of volume, Medicare negotiates very low payment to hospitals for rendering services.



Many Medicare patients are still unable to pay their portion (deductible & coinsurance) of the bill to the hospital.



To keep hospitals incentivized to serve Medicare patients, Medicare reimburses 65% of unpaid bills.

6-7%



Hospitals submit annual reports of unpaid bills (MBD) for reimbursement from Medicare. They can also "amend" reports from previous underreported periods.





Traditional Medicare Patient Responsibility in Kentucky

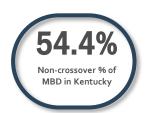
| Inpatient (Part A) & Outpatient (Part B) | | | | | | | | |
|---|---------------|----------------|---------------|---------------|---------------|---------------|---------------|--------------------|
| | | | | | | | | |
| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | Grand Total |
| Deductibles & Coinsurance | \$418,044,660 | \$421,442,453 | \$435,702,266 | \$440,736,830 | \$446,717,838 | \$389,265,140 | \$373,167,610 | \$2,925,076,797 |
| Claimed Allowable Bad Debts | \$84,621,177 | \$77,003,813 | \$97,116,476 | \$87,556,166 | \$91,483,332 | \$80,406,483 | \$77,723,430 | \$595,910,877 |
| Expected Cash Collections | \$333,423,483 | \$344,438,640 | \$338,585,790 | \$353,180,664 | \$355,234,506 | \$308,858,657 | \$295,444,180 | \$2,329,165,920 |
| Claimed Rate | 20.24% | 18.27% | 22.29% | 19.87% | 20.48% | 20.66% | 20.83% | 20.37% |
| Collection Rate | 79.76% | 81.73% | 77.71% | 80.13% | 79.52% | 79.34% | 79.17% | 79.63% |
| Crossover Allowable Bad Debts | \$44,047,163 | \$43,326,799 | \$40,880,068 | \$42,728,858 | \$38,162,310 | \$32,812,775 | \$29,669,316 | \$271,627,289 |
| Crossover Allowable Bad Debts Percentage | 52.05% | 56.27 % | 42.09% | 48.80% | 41.72% | 40.81% | 38.17% | 45.58% |
| | | | | | | | | |
| Non-Crossover Allowable Bad Debts | \$40,574,014 | \$33,677,014 | \$56,236,408 | \$44,827,308 | \$53,321,022 | \$47,593,708 | \$48,054,114 | \$324,283,588 |
| Non-Crossover Allowable Bad Debts Percentage | 47.95% | 43.73% | 57.91% | 51.20% | 58.28% | 59.19% | 61.83% | 54.42% |
| Non-Crossover Deductibles & Coinsurance | | | | | | | | |
| Deductibles & Coinsurance Less Crossover Allowable Bad Debts | \$373,997,497 | \$378,115,654 | \$394,822,198 | \$398,007,972 | \$408,555,528 | \$356,452,365 | \$343,498,294 | \$2,653,449,508 |
| Non-Crossover Allowable Bad Debts Percentage of Non-Crossover Deductibles & Coinsurance | 10.85% | 8.91% | 14.24% | 11.26% | 13.05% | 13.35% | 13.99% | 12.22% |

State of Kentucky Summary Stats:







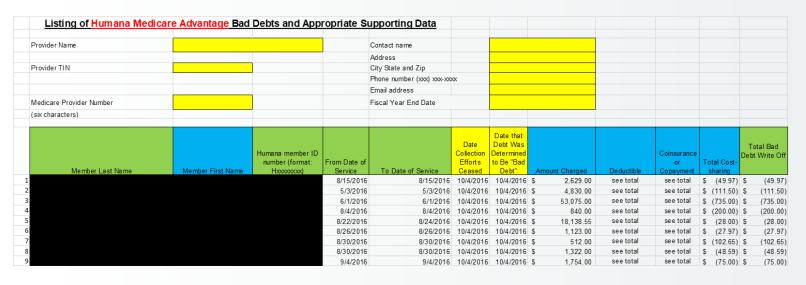




Medicare Advantage Patient Responsibility

Overview -

- Advantage increasing % of "Medicare"
- Many payers do allow for bad debt 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 similar to traditional
- Typically, no limit on lookback periods; subject to 50% penalty annually



Annual filing process -

- Payer specific department(s) and forms for filing bad debts
- Due within 90-270 days of fiscal year-end
- Payment within 90 days subject to audit/review requests





INDUSTRY CHANGES IMPACT ON MEDICARE BAD DEBT

Hospital MBD is consistently impacted by rapid industry change...



New Staffing



New Regulations



Changed Processes



System Upgrades



Affiliations & Mergers

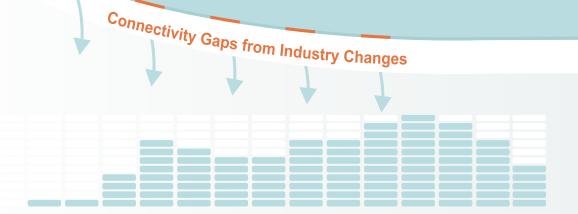


Agencies & Policies









Status quo approach creates risk of

millions of dollars

per facility per year in lost revenue.









LIVE POLL – QUESTION 1





Changing Regulations

Crossovers | Indigent | Agency

- Final Rules Primary driver of regulatory change at national level
 - October 1, 2020 (FY21 Final Rule): substantial
 - October 1, 2021 and 2022: less MBD updates
- Varying/Retroactive/Modified regulatory regulation implementation
 - By Fiscal Intermediary applying new rules to old MBD logs OR applying uncodified rules by region
 - 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
- S-10 Audit/Review processes vs Medicare Bad Debt
- Legal challenges





Changing Regulations: Crossover Accounts

- Recent Key Trends and Changes
 - Crossovers recorded to a contractual allowance account
 - Medicaid managed care vs traditional Medicaid
 - Payment denials, spend-down, out-of-state





- Historic/issue(s) snapshot:
 - Crossovers Medicare with Medicaid/MCO as secondary
 - Bill/No Bill regulations on Medicaid crossovers (i.e., "Must Bill" rules)
 - Medicaid is a "contracted payer" (i.e., a contractual)
 - Related "indigent" regulations confirm MBD status
 - In general, all write-offs get to "net revenue" anyway
 - JM (Palmetto FI) "issues" lead to national changes





- Regulation as of 10/1/20 (First Coast website): "Providers claiming Medicare bad debt must meet 42 CFR 413.89 in conjunction with all requirements set forth in CMS Pub. 15–1, Chapter 3. The unpaid deductible and coinsurance amounts for Medicare–Medicaid crossover claims must be classified correctly in providers' accounting records pursuant to CMS Pub. 15–1, Chapter 3. These Medicare bad debt amounts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts (bad debt). Effective for cost reporting periods beginning on or after October 1, 2019, providers must comply with these longstanding Medicare bad debt requirements"
- Published 9/18/20, effective 10/1/20? Or, as worded, 10/1/19? Has varied by Fiscal Intermediary.





- 4 Primary Implementation and Ongoing Issues:
 - 1. The transaction code description, general ledger/financial statement mapping
 - Competing GAAP(financial) vs Medicare vs State/other reporting
 - 2. Late to implement issues; not done by year-end with competing (e.g., covid) priorities
 - Backlog of incorrect accounts and/or procedures to correct
 - 3. Things still go wrong (see original list conversions++)
 - 4. S-10/Uncompensated Care reporting charity and bad debt; where do contractual allowances fit long-term



- Prospective considerations and planning:
 - 1. Level setting and documenting status on this issue(s) including proactive discussion with Fiscal Intermediaries (legal) as deemed applicable
 - 2. Monthly/quarterly monitoring of known issues with corrective action(s)
 - As mentioned, opportunity for AI and RPA within the RCM function for providers
 - 3. Annual+ review of Medicare primary and "Medicaid" secondary; review of all write-offs; system conversions and clearinghouse changes that drive write-offs
 - 4. Legal challenges pending; record keeping for any associated issues



Other Trends: Crossover Accounts (continued)

- Medicaid Managed Care vs Traditional Medicaid
 - Certain states, becoming more common to have various Medicaid-secondary programs that are linked with MCO plans; secondary layer of complexity
 - Should operate as-if all the same associated regulations apply
 - Previous comment on understating ALL Medicare accounts and where the secondary write-off is being recorded
- Payment denials, spend-down, out-of-state
 - Certain states are now not covering Medicare allowed covered services and/or have additional coverage criteria associated (e.g., Medicare/Medicaid IP psych and 60-day re-admissions)
 - Medicaid spend-down amounts may create different RCM processing for crossover adjustment
 - Out-of-state Medicaid accounts may have different RCM processing for crossover adjustment





Changing Regulations: Indigent Accounts

- Recent Key Trends and Changes
 - Charity not allowed?
 - Presumptive Charity not allowed?
 - Indigence focus area in need of considerable clarification





- Historic/issue(s) snapshot:
 - Long-term blending of terms: in many policies, procedures and other operational guidebooks, charity/indigent/presumptive charity meant much the same thing and/or had the same net outcome
 - Transactional write-offs frequently use many of the same codes, regardless of payer or definition
 - FY21 regulations created harder lines with key statements -
 - "Charity care" is not allowed for Medicare
 - "Presumptive eligibility tools" cannot be used for Medicare indigence determination
 - S-10/Uncompensated care items have contributed to confusion similar to contractual allowances, "bad debt" vs "charity care" as reported for Medicare vs all other payers
 - Clearly defining these terms and their use in the RCM function are critical go-forward issues; almost 100% of the time, these 3 items have very different RCM roles
 - Timing and documentation drive many issues





- Regulation as of 10/1/20 (First Coast website):
 - "charity allowances are reductions in charges made by the provider because of the indigence or medical indigence of the patient."
 - "charity care, courtesy, and third-party payer allowances are not reimbursable Medicare costs and cannot be claimed as Medicare bad debts"
 - "An additional and frequently used approach to determine if a debt is uncollectible by other means is to determine that the beneficiary is indigent or medically indigent."
 - "Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible, from the beneficiary, without applying the procedures outlined"
- Published September 18, 2020 and effective October 1, 2020





- Key discussion items:
 - 1. Medicare, in general, does not use the term(s) charity or presumptive charity when discussing Medicare Bad Debt; need to move towards removal of these terms anywhere in the Medicare(insured) processing
 - 2. Indigence is the key Medicare term and indigence is determined
 - By documented application for financial assistance, OR
 - By the hospital's determination of indigence with application materials and any other associated procedures (e.g., presumptive scoring tools); see discussion
 - 3. Policies/procedures AND associated write-off codes are critical long-term
 - 4. "120 days and reasonable collection efforts" drives a lot of determination
 - AFTER 120 days (e.g., reasonable collection, letters, calls), Medicare criteria has largely been met
 - Use of presumptive tools AFTER 120 days to determine additional collection efforts should be allowable assuming it is applied to ALL payers; making a business decision with technology



- Prospective considerations and planning:
 - 1. Level setting and documenting status on this issue including proactive discussion with Fiscal Intermediaries (legal) as deemed applicable
 - 2. Policies/procedures and associated write-off codes (long-term documentation)
 - 3. Implementation, as needed, of "regular accounts" 120-day reasonable collection (not indigent; not sent to outside collections)
 - 4. Monthly/quarterly monitoring of known issues with corrective action(s)
 - Opportunity for AI and RPA within the RCM function for providers
 - 5. Legal challenges pending
 - Sentara case involving presumptive eligibility tools





Changing Regulations: Agency(Self-Pay) Accounts

- Recent Key Trends and Changes
 - Presumptive eligibility tools
 - 1st bill to patient within 120 days
 - Zero balance on account general and regular accounts





Changing Regulations: Agency (Self-Pay) Accounts (continued)

- Presumptive eligibility tools:
 - Many items discussed for Indigent accounts carry-over to Agency (Regular) accounts
 - Accounts that have in-house (or outsourced) 120-day collection efforts but are NOT sent to secondary+ collections should be documented and claimed as regular non-agency MBD
- 1st Bill to Patient within 120 Days:
 - Reasonable collection efforts typically involve billing the patient "shortly after" Medicare RA
 - This had not historically been codified and the test was largely FI-specific
 - 120 days implemented as reasonable definition of "shortly after"; clock resets after each payment; not retroactive BUT...
 - Fl's have been retroactively applying this rule; was not clear before new rule and should be challenged if issue being raised for older periods
 - Issues hospitals may encounter-
 - Believe that patient has secondary insurance which is pursued before patient billing
 - Financial assistance steps occur for extended period before patient billing
 - Look for similar RCM issues if large population of accounts do not meet 120-day requirement



Changing Regulations: Agency (Self-Pay) Accounts (continued)

- Zero-balance on Accounts (General):
 - In general, requires that account be at \$0 balance in the patient accounting system before claiming as MBD
 - JM/Palmetto issue that was expanded nationally and NOT codified; still largely FI-specific issue; many challenges and regional discussions underway
 - General discussion -
 - Many patient accounting systems do not \$0 the account when returned
 - Accounts must be kept on the ATB in order to be available for future reference
 - If zeroed, many systems have a purge feature and details on the account would not be available if audited/reviewed in the future
 - Hospitals must keep in inactive but balance status in order to be able to access records long-term





Changing Regulations: Agency (Self-Pay) Accounts (continued)

- Zero-balance on Accounts (General):
 - When not to claim account is moved from the "regular ATB" to the "bad debt ATB" and account is still at collection; must wait until account is returned from collection and "all efforts ceased"
 - Sensitive issue(s) if accounts are retained on system for long-term "re-activation" if they present for future services; may be considered "active" by some FI's
 - Regular accounts limited national incidence where partial portion of balance is determined to be presumptively indigent and remainder of balance goes to outside collections. Some FI's have argued that accounts cannot be claimed until the full D&C balance has been put to \$0. Requires tracking over a few collection periods.





Timeline Considerations & Agency (Self-Pay) Analytics for MBD

- Day 1-120 after Medicare payment: reasonable collection efforts (statements, calls+)
 - Write-offs before this (e.g., indigence auto-approved for a year; no bills) tend to be hard to document unless specific situations met (e.g., bankruptcy, deceased)
- Business decisions at "Day 121"
 - Presumptive eligibility(indigence) tools at Day 121? What gets passed on for additional collection efforts (must apply to all payers).
- Day 121+ at Agency
 - Applying policies and procedures to all payers
 - Indefinite at agency models \$ left on the table vs long-term returns of \$
 - Varying hold periods optimize by facility with applicable data; cost benefit model
 - Segmentation of accounts generally "ok" if not done by payer (e.g., accounts on a payment plan)









LIVE POLL – QUESTION 2



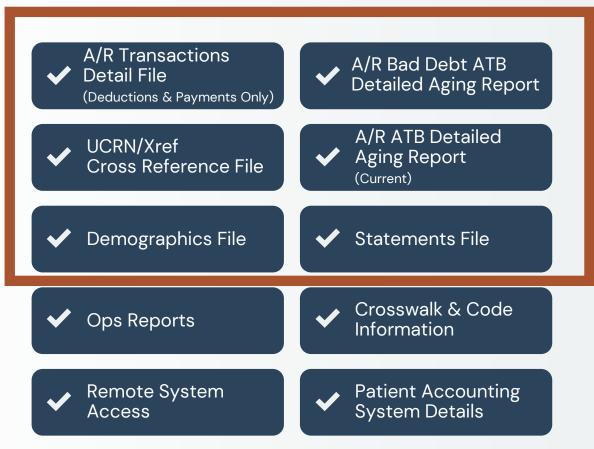




Data Sets Involved in Medicare Bad Debt

Sample listing of data useful in 360-degree view of MBD/Advantage activity -



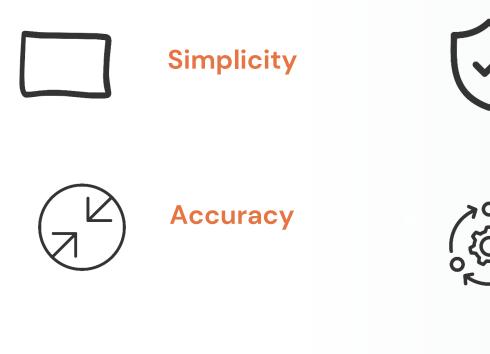






Pillars for Medicare Bad Debt Process Development

An efficient and productive approach includes six characteristics







Integration

Automation



What to Look For In a MBD Partner or Team Development













LIVE POLL – QUESTION 3





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 (1st bill < 90/120 days; date resets+)
- S-10/uncompensated care integration (bucket cross-referencing++)
- Legal pipeline retroactive application; see HC Alert

- Long-term catch issues real-time with AI; eliminate worklists with RPA; getting things right and optimized first-time through
- Artificial Intelligence Solutions (Al for MBD)
 - Crossovers MCR + PA + transaction code(?)
 - Indigent MCR + transaction code (?)
 - Presumptive/regular MCR + codes/timelines
- Robotic Process Automation (RPA for MBD) –
 converting Al worklists into programmed corrections
- Integrated MBD/S-10 exception reports; integration across reporting
- Integrated Policies, Procedures and Support –
 financial assistance, charity, indigent, MBD, agency+;
 best practices and compliance updates; supporting
 source data systems

Contact Information

For specific questions about today's content, you can contact **Dave Frank**:

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For more general information about Medicare Bad Debt Solutions from F2 and Meduit, contact us:

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For a facility-specific D&C analysis visit: https://www.f2healthcare.com/free-d-and-c-analysis









