PUBLICATION

CMS Proposes to "Clarify" Its Bad Debt Policy

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From the early days of the Medicare program, Medicare has had in place rules allowing payment for Medicare "bad debt" – that is, uncollected deductible and coinsurance amounts associated with a Medicare beneficiary's receipt of covered provider services. As set forth in the Medicare regulations at 42 C.F.R. § 413.89 and as further detailed in Chapter 3 of the Medicare Provider Reimbursement Manual (PRM), to be reimbursed for bad debt, the provider must establish that it made "reasonable collection efforts" and that "sound business judgment" established that there was no likelihood of recovery at any time in the future.

These bad debt standards, however, are inherently ambiguous, and providers have long questioned how they should be applied. What is a reasonable collection effort? When and how frequently must bills be sent out? What follow-up measures are required, if any? If the debt is sent to a collection agency, what is the effect of the collection agency's continuing to hold the debt even when there is no real likelihood of collection? How much effort must a provider and collection agency demonstrate to recover the amount due? When may a bad debt be totally written off, particularly if there has been a partial payment? What if the beneficiary is also a Medicaid recipient? What must be done to show that the amount of Medicare deductible and coinsurance is not collectible? And how must all of this be documented? These questions and many more have been repeatedly the subject of controversy in matters before the Provider Reimbursement Review Board (PRRB) and in courts.

Now, however, CMS is proposing as part of its inpatient prospective payment system rules update (85 Fed. Reg. 32,460, 32,866-32,876, 32,895-32,896 (May 29, 2020)) to amend its current bad debt regulation and "clarify" its policies. In so doing, CMS largely restates positions that the agency has long taken both in the PRM and in litigation, while providing further explanation and possible justifications for those positions. CMS further proposes that, as clarifications, most of the changes to the regulation will be applied not just prospectively, but retrospectively as well.

In the proposed language, CMS continues to apply many of its more controversial bad debt policies – policies such as those applicable to worthless claims that remain at a collection agency and its Medicaid "must bill" approach – but it presumably expects that the "clarifying" amendments will bolster its litigation position in on-going matters involving those policies.

Among the many policies that CMS proposes are the following:

- Reasonable collection efforts must include –
  - Collection efforts put forth both in-house and by a collection agency that are similar for Medicare and non-Medicare patients when pursuing comparable amounts. CMS states, for example, that if the provider refers non-Medicare bad debts to a collection agency, it must refer Medicare bad debts of a like amount (such as above a specified minimum amount) to the collection agency;
  - Effective for cost reporting periods after October 1, 2020, the provider's issuance of a bill to the beneficiary, or the responsible party, on or before 120 days following the date of the Medicare remittance advice or the date of the remittance advice from the beneficiary's secondary payer, whichever is later;

  - Additional steps such as subsequent billings, collection letters and telephone calls or personal contacts with the party evidencing a genuine, rather than token, collection effort;
  - Efforts that last at least 120 days before the debt is written off as uncollectible, with a new 120-day period beginning to run each time a partial payment is made; and
  - Documentation made available for MAC review, with such documentation including the collection policy and process for Medicare and non-Medicare patients, and patient account history documents showing bills, collection letters, follow-up notices and reports of calls.

- For indigent, non-dual-eligible beneficiaries, the provider –

  - May not use the beneficiary's declaration of inability to pay as sole proof of indigence;
  - Must consider the beneficiary's total resources, including assets that are convertible to cash and not necessary for the beneficiary's daily living, liabilities, income and expenses;
  - Must consider extenuating circumstances that would affect the determination;
  - Must determine that no other source would be legally obligated to make payment;
  - Must maintain and provide upon request to the MAC the indigency policy and its beneficiary-specific application; and
  - May determine that the debt is uncollectible without actually having to collect if the beneficiary's indigence has been determined by the provider and the provider concludes that there has been no improvement in the beneficiary's financial condition.

- For dual-eligible beneficiaries –

  - The provider must determine that the state's Medicaid program is responsible to pay all or a portion of the beneficiary's deductible or coinsurance amounts by submitting a bill to the Medicaid agency to pay all or a portion of the deductible or coinsurance amount, and submitting to the MAC the Medicaid remittance advice received from the state; and
  - CMS is requesting suggestions about what to do when a state does not process Medicare crossover claims and does not issue Medicaid remittance advices. CMS asks whether some form of alternative documentation should suffice to show the state's liability.

Comment

Too often in the past, providers have been denied bad debt reimbursement because CMS or its MACs have concluded that the provider failed to comply with one or more of CMS's many policies in this area. Frequently, however, those policies were not nearly as clear as they should have been, and in other instances, such as the must bill policy, the position adopted by CMS appeared to impose on providers an unnecessary burden that was too often impossible to satisfy. Through this proposed rule, CMS is putting providers on notice as to the agency's expectations. At a minimum, providers should review their bad debt policies and procedures in light of the proposed rules, so that they are ready when CMS issues final rules. Comments to the proposed rule are due by July 10, 2020.

For more information or any question regarding these issues, please contact any member of Baker Donelson's Reimbursement team.