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FFY 2021 IPPS FINAL RULE CHANGES TO MEDICARE BAD DEBT POLICIES

The Centers for Medicare & Medicaid Services (CMS) used the federal fiscal year (FFY) 2021 inpatient prospective payment system (IPPS) [final rule](#) to clarify and codify longstanding Medicare bad debt policy. According to CMS, these policies have been the subject of questions and litigation since the repeal of the 1987 Bad Debt Moratorium in the [Middle Class Tax Relief and Job Creation Act of 2012](#). Some of these finalized policies are retroactive (effective prior to and after Oct. 1, 2020), while others are prospective (effective on and after Oct. 1, 2020). This fact sheet summarizes the changes in the FFY 2021 IPPS final rule and categorizes finalized policies by effective date. Please contact your contracted cost reporting firm with questions about these new policies.

RETROACTIVE POLICIES: EFFECTIVE PRIOR TO AND AFTER OCT. 1, 2020

Definition of non-indigent beneficiary

CMS finalized the definition of a non-indigent beneficiary as a beneficiary who has not been determined to be categorically or medically needy by a State Medicaid Agency to receive medical assistance from Medicaid, and has not been determined to be indigent by the provider for Medicare bad debt purposes.

Issuing a Bill for Non-Indigent Beneficiaries

CMS finalized requirements for complying with a reasonable collection effort for a non-indigent beneficiary. Reasonable collection efforts must be similar to the effort the provider and/or collection agency puts forth to collect comparable amounts from non-Medicare patients.

For cost reporting periods beginning before Oct. 1, 2020, a provider must issue a bill to the beneficiary (or the party responsible for the beneficiary's personal financial obligations) on or shortly after discharge or death of the beneficiary.

For cost reporting periods beginning on or after Oct. 1, 2020, a provider must issue a bill to the beneficiary (or the party responsible for the beneficiary's personal financial obligations) on or before 120 days after the latter of the following:

- (1) The date of the Medicare remittance advice that is produced from processing the claim for services furnished to the beneficiary that generates the beneficiary's cost sharing amounts;
- (2) The date of the remittance advice from the beneficiary's secondary payer, if any; or

- (3) The date of the notification that the beneficiary's secondary payer does not cover the service(s) furnished to the beneficiary.

Providers must also perform other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party. Personal contacts may include emails and text messages as long as such efforts are genuine efforts and are auditable and verifiable.

120-day collection effort and reporting period for writing off bad debts

A provider's reasonable collection effort requirement for non-indigent beneficiaries must also start a new 120-day collection period each time a payment is received within a 120-day collection period.

CMS stated that the clarification and codification of this longstanding Medicare bad debt policy into the regulations with a retroactive effective date "does not affect prior transactions or impose additional duties or adverse consequences upon providers or beneficiaries, nor does it diminish rights of providers or beneficiaries."

Similar Collection Effort Required, Including Collection Agency Use

Providers must put forth the same effort to collect Medicare deductible and coinsurance amounts as they do to collect comparable amounts from non-Medicare patients. CMS states that efforts must be genuine, meaning a "serious and concerted effort by the provider to collect the unpaid debt." A genuine effort requires the provider to engage in continuous collection efforts over at least 120 days, and includes advising the beneficiary of the amounts to be collected, engaging in subsequent follow-up and billing, and may include the use of a collection agency.

Documentation Required for a Reasonable Collection Effort for Non-Indigent Beneficiaries

Providers must maintain and furnish (upon request) verifiable documentation to its Medicare administrative contractor (MAC) the following:

- (1) The provider's bad debt collection policy, which describes the provider's collection process for Medicare and non-Medicare patients;
- (2) The patient account history, documenting the dates of various collection actions such as the issuance of bills to the beneficiary, follow-up collection letters, reports of telephone calls and personal contact, etc.; and
- (3) The beneficiary's file with copies of the bill(s) and follow-up notices.

Reasonable Collection Effort for Dual Eligible Beneficiaries and the Medicaid Remittance Advice

CMS typically requires providers to submit a Medicaid remittance advice indicating that the state will not reimburse a provider for bad debt eligible amounts associated with services rendered to a dual eligible beneficiary. Providers that cannot present a Medicaid remittance

advice for dual eligible beneficiaries will be considered compliant with reasonable collection effort requirements if such providers submit all of the following:

- (1) The State Medicaid notification indicating that the State has no obligation to pay the beneficiary's Medicare cost sharing, or notification indicating the provider's inability to enroll in Medicaid for purposes of processing a crossover cost sharing claim;
- (2) Documentation setting forth the State's liability, or lack thereof, for Medicare cost sharing; and
- (3) Documentation verifying the beneficiary's eligibility for Medicaid for the date of service.

Please note that in [Illinois](#), for Medicare-covered services rendered to dual eligible beneficiaries, the Illinois Department of Healthcare and Family Services (HFS) will pay the deductible and coinsurance to the extent that such payment, plus Medicare's payment, does not sum to an amount that exceeds HFS' maximum rate. If the payment from Medicare exceeds HFS' maximum rate for the service, the claim will appear on the HFS 194-M-2, Remittance Advice as approved, but the provider will not receive payment from HFS.

Medicare Bad Debt and Contractual Allowances

For cost reporting periods beginning before Oct. 1, 2020, providers must not write off Medicare bad debts to a contractual allowance account. Instead, providers must charge Medicare bad debts to an expense account for uncollectible accounts.

CMS reiterated that it is never appropriate for a provider to write off Medicare-Medicaid crossover bad debt amounts to a contractual allowance account simply because they are unable to bill the beneficiary for the difference between the billed amount and the Medicaid claim payment amount. It is likewise inappropriate to present these amounts to Medicare for reimbursement as Medicare bad debts.

PROSPECTIVE POLICIES: EFFECTIVE ON OR AFTER OCT. 1, 2020

Reasonable Collection Effort for Beneficiaries Determined Indigent by Provider Using Required Criteria

CMS defined an indigent non-dual eligible beneficiary as a Medicare beneficiary who is determined indigent by the provider and not eligible for Medicaid as categorically or medically needy. CMS did not finalize a proposal to require a provider to evaluate a beneficiary's liabilities and expenses to determine indigence. Instead, in order to conclude that a beneficiary is an indigent non-dual eligible beneficiary, the provider:

- (1) Must not use a beneficiary's declaration of their inability to pay their medical bills or deductibles and coinsurance amounts as sole proof of indigence or medical indigence;
- (2) Must take into account the analysis of both the beneficiary's assets (only those convertible to cash and unnecessary for the beneficiary's daily living) and income;
- (3) May consider extenuating circumstances that would affect the determination of the beneficiary's indigence or medical indigence which may include an analysis of both the

beneficiary's liabilities and expenses, if indigence is unable to be determined under (ii)(A)(2);

- (4) Must determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill, such as a legal guardian or State Medicaid program; and
- (5) Must maintain and furnish (upon request) to its MAC the indigence determination policy describing the method by which indigence or medical indigence is determined and all the verifiable beneficiary specific documentation supporting the provider's determination of each beneficiary's indigence or medical indigence.

Once indigence is determined, a provider may deem bad debt uncollectible without attempting to collect unpaid deductible or coinsurance amounts. However, reasonable collection effort requirements change depending on a beneficiary's status, which can change within a cost reporting period. CMS expects a provider to reclassify a beneficiary should their financial circumstances change.

CMS clarified through sub-regulatory guidance that *providers may not use presumptive eligibility tools to evaluate whether a beneficiary is indigent*. CMS stated that many presumptive eligibility tools are not detailed enough to accurately determine a beneficiary's indigence or medical indigence.

Accounting Standard Update Topic 606 and Accounting for Medicare Bad Debt

CMS finalized what they consider to be a terminology change in accordance with the Financial Accounting Standards Board's (FASB) Accounting Standards Update (ASU) 2014-09, Revenue from Contracts with Customers (Topic 606), (i.e., [ASU Topic 606](#)). Published in May 2014, CMS first implemented ASU Topic 606 in 2018. Instead of reporting bad debts separately as an operating expense, ASU Topic 606 generally treats bad debts as "implicit price concessions," including them as a reduction in patient revenue rather than uncollectible accounts or notes receivable.

CMS finalized the use of ASU Topic 606 terminology in the FY 2021 IPPS final rule. Specifically, CMS finalized that for cost reporting periods beginning before Oct. 1, 2020, bad debts were amounts considered uncollectible from accounts and notes receivable created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

For cost reporting periods beginning on or after Oct. 1, 2020, bad debts are "implicit price concessions," or amounts considered uncollectible from accounts created or acquired in providing services. "Implicit price concessions" are designations for uncollectible claims arising from the furnishing of services, and may be collectible in money in the relatively near future and recorded in the provider's accounting records as a component of net patient revenue.

Regardless of terminology, CMS clarified that bad debts (or implicit price concessions), charity and courtesy allowances represent reductions in revenues. CMS also noted that ASU Topic 606 may require different reporting for providers and changes the terminology around bad debts, but maintains there is no change in the required criteria a provider must meet to qualify a

beneficiary's bad debt account for Medicare bad debt reimbursement. Additionally, CMS agreed with commenters' suggestions to incorporate implicit price concession terminology into the Worksheet S-10 for uncompensated care calculations. CMS will adopt this policy with a future effective date.

Medicare Bad Debt and Contractual Allowances

For cost reporting periods beginning on or after Oct. 1, 2020, providers may not write off Medicare bad debts to a contractual allowance account. Instead, providers must charge Medicare bad debts to an uncollectible receivables account that results in a reduction in revenue.