

OPTIONS TO REFORM PAYMENT
FOR MEDICARE BAD DEBTS



OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES

A-14-90-00339



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

JUN 28 1990
 Date *R. Kusserow*
 From Richard P. Kusserow
 Inspector General
 Subject Options to Reform Payment
 for Medicare Bad Debts (A-14-90-00339)
 To Gail R. Wilensky, Ph.D.
 Administrator
 Health Care Financing Administration

This is a management advisory report presenting options for changing Medicare's current policy of reimbursing hospitals for uncollectible beneficiary liabilities. It is submitted for your review and comment. A change to the current policy is needed since bad debt payments represent a large drain on the Medicare trust funds.

BACKGROUND

Historically, hospitals have been unable to collect a certain percentage of the Medicare coinsurance and deductible amounts from program beneficiaries. Under a policy that costs attributable to Medicare beneficiaries are not to be shifted to non-Medicare patients, the Health Care Financing Administration (HCFA) reimburses hospitals for these bad debts. This policy was adopted in 1966 when hospitals were reimbursed retrospectively by Medicare based on principles of reasonable cost, a requirement of law. In order to receive reimbursement, the hospital must make a reasonable attempt to recover this debt.

Under Medicare's prospective payment system (PPS), bad debts are paid as pass-through costs and continue to be reimbursed under reasonable cost principles. Because hospitals under PPS are allowed to retain profits (or absorb losses) based on their operational efficiencies, the original intent of paying bad debts is no longer appropriate. In fact, there is a trend toward waiver of the coinsurance and deductible amounts by hospitals to induce Medicare beneficiaries to utilize inpatient services because of the profit potential inherent in PPS reimbursement. OIG studies have shown that since the inception of PPS in 1983, hospitals have earned significant profits by treating Medicare patients. One of our more recent studies (CIN: A-07-88-00111) indicates that hospitals earned approximately \$15.2 billion of profits during the first 4 years that PPS was operating.

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Other of our audits have shown that hospital collection efforts of bad debts have often been less than adequate since there is presently little incentive for a hospital to collect the unpaid deductible and coinsurance amounts. Medicare will pay these amounts.

A 1987 Department task force analyzed data from the first year of PPS (PPS-1) and found that urban, public hospitals have the highest percentage of bad debts. While these are principally disproportionate share hospitals, less than 50 percent of the bad debt payments go to disproportionate share hospitals overall. There also is a significant difference among individual hospitals in the amount of bad debt charged to Medicare as a percent of coinsurance and deductibles, with at least one hospital as high as 50 percent. This may represent, in part, poor collection efforts on the part of these hospitals.

CURRENT STATUS AND OPTIONS

We reviewed data on HCFA's Hospital Cost Report Information System. Details are shown on the attachment and are summarized as follows:

- o Total bad debts for PPS hospitals jumped from \$159.11 million in PPS-2 to \$398.82 million PPS-5.
- o During that same period, the average bad debt for each hospital submitting a claim rose from \$41,895 to \$90,806.

These data demonstrate that the payment of Medicare bad debts continues to represent a sizable draw on Medicare's trust funds. Furthermore, under the current procedure, hospitals have little incentives to pursue aggressive collection action against beneficiaries. The "path of least resistance" is merely to submit the claim to the Medicare program.

We believe that the Department as well as the Congress should reevaluate the policy options available for bad debts. These options (which were reported in previous OIG studies) and issues that need to be considered in their evaluation are presented in the following narrative:

- o Do not pay for bad debts. This option would provide incentives for hospitals collections. It is simple and direct. It could reduce HCFA's administrative claims processing costs since fiscal intermediaries would no longer be required to audit providers' bad debts. However, it may disadvantage those hospitals that serve the most needy beneficiaries, although

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this is less clear since hospitals that serve a disproportionate share of low-income patients are compensated explicitly. It may also increase pressure for a government program for uncompensated care.

- o Offset Medicare bad debts against SSA Title II payments. This procedure currently is being used to recoup Medicare and social security overpayments. But, it would be administratively complex, would remove incentives from hospitals to collect deductible and coinsurance from beneficiaries, and may create financial hardship on beneficiaries. It is also extremely unpopular within the Congress.
- o Pay bad debts to PPS hospitals only to the extent that the bad debt amount exceeds Medicare profits. This option is patterned after the procedure currently used in the ESRD program. It assumes, however, that such hospitals can be identified as a group, is likely to be administratively complex, and will engender equity arguments. Furthermore, it could lead to increased administrative costs since fiscal intermediaries would have to validate the financial data of unprofitable hospitals.
- o Fold bad debts into DRG rates. This option would add a "bad debt factor" to the DRG payment. It is simple and direct and easy to administer. It would save some administrative costs since fiscal intermediaries would no longer have to audit providers' bad debt claims. It could have hospitals an incentive to collect from beneficiaries since such amounts would be "pure profit". Given the current yearly increase in bad debts, this option could generate savings if the "bad debt factor" were based on a prior year, e.g. PPS-2.

We firmly believe that a new policy is needed with respect to reimbursing hospitals for bad debts. HCFA should consider our opinions when developing the new policy.

Should you or your staff wish to discuss the issues raised by this report, please let me know or contact Larry K. Simmons, Assistant Inspector General for Health Care Financing Audits. We would appreciate receiving your comments within 60 days from the date of this memorandum.

Attachment

Attachment

SCHEDULE OF BAD DEBTS

<u>PPS Year</u>	<u>Total Bad Debts (\$ millions)</u>	<u>No. of Hospitals Claiming Bad Debts</u>
2	\$ 159.11	3,774
3	\$ 175.31	3,674
4	\$ 310.38	4,203
5	<u>\$ 398.82</u>	4,392
Total	<u>\$1,043.62</u>	

Source of data: Hospital Cost Report Information System
(latest available data)

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