

Questions On Charges For The Uninsured

Q1: Can a hospital waive collection of charges to an indigent, uninsured individual?

A1: Yes. Nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy. By "indigency policy" we mean a policy developed and utilized by a hospital to determine patients' financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses.

In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in that agency's rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program – a highly unlikely circumstance.

Q2: What if a hospital wants to discount charges to patients with large medical bills?

A2: In the same way that a hospital can waive collection of charges for individuals under its indigency policy, a hospital may also offer discounts to those who have large medical bills. Hospitals have flexibility in establishing their own indigency policies. The separate issue of how Medicare reimburses for the uncollectible deductibles and coinsurance of Medicare beneficiaries will be discussed in answers below.

The OIG advises that discounts to underinsured patients can raise concerns under the Federal anti-kickback statute, but only where the discounts are linked in any way to business payable by Medicare or other Federal health care programs. In addition, depending on the circumstances, discounts to underinsured patients may trigger liability under the provision of the civil monetary penalties statute that prohibits inducements offered to Medicare or Medicaid beneficiaries. But again, if no inducement is being offered, neither statute is implicated. The OIG's views on the related issue of reducing or waiving Medicare cost-sharing amounts on the basis of financial hardship is addressed in answers to questions below. Further information on these fraud and abuse issues is available on the OIG webpage.

Q3: Does a hospital need to get prior approval from either CMS or its fiscal intermediary before offering discounts? How should discounted charges be reflected on a Medicare cost report?

A3: No, a hospital does not need permission before offering discounts. However, the Medicare cost report should reflect full uniform charges rather than the discounted amounts. The hospital should also make the intermediary aware that it has reported its full charges on its cost report.

Q4: Does offering discounts to the uninsured/underinsured affect a hospital's cost to charge ratio or Medicare cost apportionment?

A4: No, as long as the provider properly reports full charges on the Medicare cost report. This is important because a hospital's cost-to-charge ratio is used to set reimbursement in certain areas of the Medicare program, such as some features of the outpatient prospective payment system.

Q5: How is the above any different than a hospital giving a discount to Blue Cross or any other insurer?

A5: For apportionment purposes, discounting charges to uninsured or underinsured patients is no different than giving an allowance to Blue Cross or other commercial insurers for non-Medicare patients. The Provider Reimbursement Manual directs a provider to report its full uniform charges for courtesy, charity, and third-party payer allowances. The Medicare program sees no complications where a provider offers discounts or allowances to uninsured or underinsured patients versus allowing discounts or allowances to third-party payers.

Q6: Does the Medicare program's lesser of costs or charges (LCC) principle alter any of the above advice or prohibit hospitals from offering discounts to the uninsured or the underinsured?

A6: The LCC principle is a feature of the prior cost method of reimbursing hospitals, before the current payment rules were enacted in the 1980s and 1990s. Under these old rules, Medicare paid hospitals the lesser of the hospital's costs or charges. If that system were still in effect for most services, the LCC principle could be implicated by discounting charges for the uninsured, because if a hospital discounted its charges below its costs or failed to collect from a substantial percentage of charge-paying patients, Medicare reimbursement to the hospital may be reduced.

The reality is that this LCC principle has limited applicability today. For example, the LCC principle might apply in the first year of reimbursement for pediatric or certain cancer hospitals. But the vast majority of services provided in hospitals in America today are not subject to the LCC principle.

In the cases where LCC is applicable, however, the Provider Reimbursement Manual provides that if a hospital offers free care or care at a reduced charge to patients determined to be financially indigent, and meets the provisions in the manual, the reduced charges do not result in adjustment to charges under LCC. And since charges are not adjusted, Medicare reimbursement to the hospital is not affected either.

Q7: Will Medicare pay a hospital's bad debts for non-Medicare patients who don't pay their bills?

A7: No. Medicare does not pay the bad debts of non-Medicare patients.

Q8: Does Medicare provide any special compensation to hospitals that treat a large number of uninsured patients – especially those hospitals that have to write off a large number of bills for the uninsured?

A8: Yes. CMS makes payments – significant payments – to hospitals that treat a large number of low-income and uninsured patients. For example, the Medicare and Medicaid disproportionate share provisions paid \$22 billion to hospitals last year. And under the rules we explain in Question 9, Medicare pays over \$1 billion per year to hospitals for the bad debts of Medicare patients.

Q9: Can a hospital be reimbursed by Medicare for a Medicare patient's unpaid deductibles or coinsurance? Are there special rules for this "bad debt" if the patient meets the hospital's indigency guidelines?

A9: Yes. In the case of Medicare patients generally, the program reimburses a hospital for a percentage of the "bad debt" of a Medicare beneficiary (i.e., unpaid deductibles or coinsurance) as long as the hospital sends a bill to a patient and engages in reasonable, consistent collection efforts.

However, if a hospital, using its customary methods, can document that a Medicare patient is indigent or medically indigent (as we used that term in question 1), the hospital can then forgo any collection effort aimed at the patient. And, if the hospital also determines that no source other than the patient is legally responsible for the unpaid deductibles and coinsurance, the hospital may claim the amounts as Medicare bad debts.

Hospitals may, but are not required to, determine a patient's indigency using a sliding scale. In this type of arrangement, the provider would agree to deem the patient indigent with respect to a portion of the patient's account (e.g., a flat percentage of the debt based on the patient's income, assets, or the size of the patient's liability relative to their income). In the case of a Medicare patient that is determined to be indigent using this method, the amount the hospital decides, pursuant to its policy, not to collect from the patient can be claimed by the provider as Medicare bad debt. The provider must, however, engage in a reasonable collection effort to collect the remaining balance.

Q10: Can a hospital determine its own individual indigency criteria?

A10: Yes. It must, however, apply the criteria to Medicare and non-Medicare patients uniformly.

Q11: Does CMS have any requirements as to what documentation a hospital must secure in order to make an indigency determination? If so, what are those requirements?

A11: For indigent patients who are not Medicare patients, the Medicare program does not prescribe any specific rules for providers to make indigence determinations; rather, the hospital is permitted to use its own business judgment in determining whether or not a non-Medicare patient is indigent and therefore entitled to a discount pursuant to its own indigency policy. For Medicare patients, however, if a provider wants to claim Medicare bad debt reimbursement CMS does require documentation to support the indigency determination. To claim Medicare bad debt reimbursement, the provider must follow the guidance stated in the Provider Reimbursement Manual. A hospital should examine a patient's total resources, which could include, but are not limited to, an analysis of assets, liabilities, income and expenses and any extenuating circumstances that would affect the determination. The provider should document the method by which it determined the indigency and include all backup information to substantiate the determination. Medicare also requires documentation where a collection effort is made. The effort should be documented in the patient's file with copies of the bill(s), follow-up letters, and reports of telephone and personal contacts. In the case of a dually-eligible patient (i.e., a patient entitled to both Medicare and Medicaid), the hospital must include a denial of payment from the State with the bad debt claim.

Q12: Are hospitals required to take low-income patients to court, or seize their homes, or send claims out to a collection agency when those patients don't pay their hospital bills?

A12: No. Nothing in the Medicare instructions requires the hospital to seize a patient's home, take them to court, or use a collection agency. Hospitals aren't required under federal law to engage in any specific level of collection effort for Medicare or non-Medicare patients.

However, as we noted and explained more fully above in question 9, the Medicare program does contain a special feature that allows a hospital to be paid for its Medicare bad debts. If a hospital wants this special reimbursement adjustment, it must, at the very least, send the Medicare patient a bill for the debt and must make the same reasonable effort to collect from Medicare patients as it does for its non-Medicare patients. In other words, if the hospital sends non-Medicare patients' bills to a collection agency but does not do so for Medicare patients, the hospital has not engaged in uniform collection efforts and cannot ask Medicare to reimburse it for Medicare patients' bad debt.

Q13: Can a hospital write off a Medicare patient's bill but take aggressive collection action against a non-Medicare patient who doesn't pay his/her bill?

A13: Again, this is a decision to be made by the hospital. If a hospital decides that it wants the special Medicare reimbursement allowing for payment of Medicare bad debts, however, then it must engage in uniform collection efforts for all patients, both Medicare and non-Medicare.

Q14: Can a hospital be subject to criminal sanctions or penalties if it writes off a patient's bill?

A14: As explained more fully on its webpage, the OIG advises that offering a discount to an uninsured patient will not implicate the Federal anti-kickback statute, so long as the discount is not linked in any way to referrals of Federal health care program business.

Q15: What if the hospital wants to write off a Medicare patient's deductible and coinsurance regardless of their income level? Is that permissible?

A15: Yes. If a hospital does not want to collect, but wants to write off the uncollected debt regardless of income level, as "charity care" or as a "courtesy allowance," Medicare rules don't prohibit that, but Medicare will also not reimburse these amounts. Furthermore, a hospital may also forgo collection of deductible and coinsurance amounts using its customary methods for determining indigency, according to the bad debt policy stated in the Provider Reimbursement Manual. Bad debt reimbursement policies are governed by Medicare, but, as we note in the answers to Questions 12 and 13, these apply only where a hospital which has unpaid Medicare coinsurance and deductibles wants Medicare reimbursement for them.

Moreover, as explained in detail on its webpage, the OIG advises that under the Federal anti-kickback statute, there is an available safe harbor for waivers of Part A deductible and coinsurance amounts without regard to financial need. In addition, hospitals have the ability to provide relief to Medicare beneficiaries who cannot afford to pay their hospital bills by waiving all or part of a Medicare cost-sharing amount, so long as the waiver is not advertised, not routine, and made after there has been a good faith, individualized determination of financial need or failure of reasonable collection efforts. Advertised cost-sharing waivers, routine waivers, or waivers not based on good faith, individualized determinations of financial need or failed collection efforts potentially implicate both the anti-kickback statute and the civil monetary penalties provision barring the offering of inducements to Medicare and Medicaid beneficiaries.

Q16: What steps can hospitals take to assist the uninsured? The underinsured?

A16: The Department of Health and Human Services notes with interest the many steps that state hospital associations such as the Hospital Association of New York State and the Florida Hospital Association, and community hospitals across the country, have taken recently to address the issue of charges to the indigent and medically indigent. As these hospitals have already discovered, they can take several steps to assist patients with payment for hospital care. For example, hospitals can ensure that all written policies for assisting low-income patients are applied consistently. In addition, hospitals can review their current charge structures and ensure that they are reasonably related to both the cost of the service and to meeting all of the community's health care needs. Finally, hospitals could also implement written policies about when and under whose authority patient debt is advanced for collection. For example, a hospital could decide that only the CEO of the hospital can authorize collection action for a patient debt. As we have noted, this is a decision to be made by the hospital; the only Medicare requirement is that whatever decision the hospital makes, it must be consistently applied if the hospital wishes to seek Medicare reimbursement for Medicare bad debts.