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How Will Elimination of Hospital Bad Debt Reimbursement Affect Rural PPS Hospitals?

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Policy Implications

- *Rural hospitals likely will face financial strain if Medicare bad debt reimbursement is eliminated.*
- *Bad debt reimbursement elimination would likely adversely affect not only Medicare beneficiaries, but all rural patients.*
- *Policy-makers should consider rural hospitals' differing circumstances, such as payer-mix and sole-provider status, when making decisions relating to Medicare bad debt reimbursement.*

In an effort to curtail cross subsidization by other payers, the Medicare program has historically reimbursed hospitals for a portion of bad debt incurred by beneficiaries' failures to pay deductibles and coinsurance. Since the enactment of the Benefits Improvement and Protection Act of 2000, prospective payment system (PPS) hospitals have been reimbursed 70 percent of bad debt incurred as a result of treating Medicare beneficiaries; critical access hospitals have been reimbursed at 100 percent.[1] Most recently, the President's 2007 Fiscal Year (FY) budget proposed a four-year phase-out of Medicare bad debt reimbursements.

In general, rural hospitals are at great risk for bad debt and are particularly vulnerable to budget cuts. Contributing to this vulnerability, a high proportion of rural residents, about one-quarter, have incomes less than 125 percent of the poverty line; 17 percent of rural residents under age 65 are uninsured[2] and, estimates from 2004 indicate that the average Medicare inpatient margin among rural hospitals was -1.4 percent compared to -0.2 percent among urban hospitals.[3] At the same time, many rural hospitals are small in size and are unable to offer the more financially lucrative medical services and programs which could offset financial losses due to bad debt.

The study described in this brief was conducted to examine the financial effect that changes in current Medicare bad debt payment policy, as proposed in the FY2007 budget, might have on rural hospitals.

[1] Critical Access Hospitals are reimbursed 100% because of their cost-based reimbursement.

[2] Kaiser Family Foundation. Kaiser Commission on Medicaid and the Uninsured. *The Uninsured in Rural America.* April 2003. http://www.kff.org/uninsured/upload/The-Uninsured-in-Rural-America-Update-PDF.pdf. Accessed January 17, 2007.

[3] MedPAC. *A Data Book: Healthcare Spending and the Medicare Program.* June 2006. p. 87.

METHODS

In the first phase of this project, we used data from the 2005 Medicare Cost Reports and the 2005 Hospital Inpatient PPS Payment Impact File to simulate the financial effect of the proposed change in Medicare bad debt payment policy on rural PPS hospitals. The financial effect of this policy change was estimated as a percentage change in total Medicare reimbursement, comparing hospitals' 2005 total Medicare reimbursement to estimates of reimbursement if the bad debt policy had not been in place at that time. Only reimbursable bad debt, calculated as 70 percent of the total Medicare bad debt amount, is considered in this calculation. Estimates were generated for both urban and rural hospitals separately, as well as by hospital size, region of the country, ownership status, special payment status (e.g., rural referral center, sole community hospital), disproportionate patient percentage[4] by quartile, and total Medicare margin by quartile.[5]

In the second phase of this study NORC interviewed ten rural PPS hospital representatives from across the country to gain a better understanding of current debt collection practices, the predicted impact of the loss of this funding source on rural hospitals, and possible hospitals' responses to the elimination of bad debt reimbursement. Interviewees included hospital Chief Financial Officers (CFO), Chief Executive Officers (CEO), and a head of a consortium of rural hospitals; hospitals were located in the southwest (n=2), northwest (n=4), midwest (n=1), southeast (n=2), and northeast (n=1). Respondent hospitals ranged in size from 22 to 206 beds.

FINANCIAL EFFECT OF CHANGES IN MEDICARE BAD DEBT POLICY

A total of 2,244 urban hospitals and 1,156 rural hospitals were included in the simulation analyses. As a group, urban hospitals would have experienced an average 2.4 percent reduction and rural hospitals would have incurred an average 3.7 percent reduction in reimbursement if Medicare had ceased bad debt reimbursements (refer to Table 1). Overall, among urban hospitals, Medicare margins would have changed from -3.2 to -3.4 percent if Medicare had not reimbursed hospitals for beneficiaries' bad debt. Among rural hospitals, Medicare margins would have declined from -2.2 percent to -2.6 percent. A small number of hospitals with positive Medicare margins, (a total of 46), would have had negative margins if bad debt payments had been eliminated. Of these hospitals, a total of 22 (48 percent), were rural. Differences between urban and rural hospitals in the amount of lost revenue and reductions in margin were statistically significant at the $p < .0001$ level.

Among rural hospitals, an inverse relationship between size and reduction in reimbursement was noted, from a 2.2 percent decrease in Medicare reimbursement among the largest hospitals (those with 150 + beds) to a 4.6 percent reduction among the smallest hospitals (those with less than 25 beds). Although a similar pattern was anticipated among urban hospitals, data indicated that the largest financial losses (3.4 percent) would have occurred among urban hospitals with between 100 and 149 beds. Percentage differences in lost revenue were not statistically significant among rural hospitals. Nonetheless, bedsize was significantly ($p < .0001$) related to reduction in Medicare revenue among urban hospitals.

[4] Several factors are believed to drive the amount of Medicare bad debt that a hospital incurs. Chief among these is the population of low-income, uninsured population that a hospital serves. Low-income patients, particularly those that are not dual eligible (for Medicare and Medicaid) or that are not covered by a Medigap policy, are less likely to have the financial resources to meet co-payment and deductible obligations. The disproportionate share patient percentage, a factor that is used to calculate hospitals' disproportionate share (DSH) payment add-on amount, is a proxy for the financial burden of treating a low income population.

[5] Medicare margins are believed to be associated with bad debt; albeit the nature of this relationship is not entirely clear. On the one hand, the greater the margin, the greater the providers' ability to withstand loss of Medicare's bad debt reimbursement policy; these providers may also have more effective debt collection systems in place. On the other hand, hospitals with lower margins could be less effective in debt collection and may be more financially vulnerable to changes in Medicare policy designed to eliminate bad debt payments.

Hospital location was significantly ($p < .0001$) associated with a reduction in Medicare reimbursement among both rural and urban hospitals. In particular, rural hospitals located in the South would have experienced a significantly greater reduction in Medicare reimbursement (4.7 percent) than their Northern (1.2 percent) and Midwestern (2.6 percent) counterparts. Ownership status was also related to loss in Medicare reimbursement. Among urban hospitals, proprietary facilities would have experienced a greater reduction in Medicare reimbursement, 3.9 percent, compared to voluntary hospitals, which would have only experienced a 1.9 percent reduction in reimbursement. A similar pattern was noted among rural hospitals, where proprietary facilities would have faced a 5.4 percent reduction and voluntary hospitals a 3.0 percent reduction in Medicare payments.

Simulation analyses examined the relationship between special payment status and reduction in reimbursement if Medicare's bad debt payment policy were not in effect in 2005. Data suggested that Medicare dependent and rural PPS hospitals would have experienced a 5.0 percent reduction in reimbursement, compared to 2.9 percent and 1.9 percent for sole community hospitals and rural referral centers, respectively.[6] Differences in the percentage reduction in reimbursement by special payment status were statistically significant, $p = .002$.

We anticipated a positive relationship between hospitals' disproportionate patient percentage (DPP), a proxy for the low income population served by the hospital, and decrease in Medicare revenue. Indeed, among urban hospitals, those in the top DPP quartile would have experienced a 3.9 percent reduction in Medicare revenue compared to only a 1.4 percent reduction among those in the bottom quartile. Among rural hospitals, changes in Medicare reimbursement by DPP were not statistically significant.

Finally, hospital profitability was found to be associated with a reduction in Medicare reimbursement. Among urban hospitals, those that were the most profitable would have experienced a less than 2 percent reduction in Medicare reimbursement compared to more than 3 percent among the least profitable urban hospitals. Albeit not statistically significant, the most profitable rural hospitals would have experienced a reduction of 3.6 percent in Medicare reimbursement compared to 4.5 percent among the least profitable rural hospitals.[7]

HOSPITAL RESPONSES TO ELIMINATION OF MEDICARE BAD DEBT PAYMENTS

Respondents contacted for interviews raised similar issues and concerns regarding the potential elimination of Medicare's bad debt reimbursement. Many of the ten respondents indicated that their hospitals have already begun considering ways to deal with the financial strain that could be caused by the elimination of bad debt payments. Among the responses noted were the following:

(1) **Eliminating Programs or Services:** Five respondents indicated that the programs most in jeopardy are those currently being subsidized by the hospitals; these include home health programs, hospice/respite care, personal care attendant services, ambulance services (EMS), mental health, and specialty clinics. One hospital

[6] Medicare-dependent hospitals might be more vulnerable to prospective payment systems because Medicare patients compose a significant percentage of inpatient days or discharges. Institutions designated as sole-community hospitals are geographically isolated (criteria: 35 miles from a like hospital; or 25-35 miles from a like hospital along with an additional qualifier; or 15-25 miles from a like hospital but inaccessible due to topography or weather; or at least 45 minutes in travel time, regardless of distance, from a like hospital). Rural referral centers are large hospitals that treat many complicated cases and need extra support for the intensity of the work that they do.

[7] Several factors could drive the relationship between profitability and foregone Medicare revenue, including the effectiveness of the debt collection systems and the Medicare or public/private insurance patient mix.

administrator indicated that it was important to remember that repercussions associated with these service cuts extend well beyond the Medicare population to the private sector and the community overall, since they would also lose access to these services.

(2) Reducing Charity Care: Four hospitals indicated that they might attempt to reduce the amount of charity care they provide by making qualifying criteria more stringent. Although these respondents thought that lowering charity care expenses would be ideal, to minimize the financial impact of Medicare's change in bad debt payment policy, most respondents also noted that, in practice, it would be difficult to implement, given that many of the hospitals with large Medicare bad debt expenditures are located in high poverty areas; particularly in those communities where the hospital is the sole provider, it would not be possible to turn patients away. In fact, one respondent, representing a larger hospital, felt that her institution might make charity care qualifications less rigorous if reimbursement were to be eliminated.

"We're the safety net in this area for ambulance services and mental health and we're already losing money for these. If reimbursement is eliminated, that puts both these programs at risk."

(3) Staff and salary reductions: Another way that hospital administrators discussed compensating for financial losses associated with elimination of the Medicare bad debt reimbursement is by reducing either staff size or pay increases. One Chief Financial Officer pointed out that if employees failed to receive cost of living increases or salaries were not competitive, it would not be possible to retain and attract qualified staff. On a related note, some respondents indicated that changes to Medicare's bad debt policy could force hospitals to delay or entirely forego purchasing new equipment or expanding facilities as anticipated and necessary. Respondents expressed concern about their ability to maintain and improve standards of care.

"…it prohibits growth. We're less able to offer new services or programs or attract new people to the area, like orthopedic surgeons or other staff who are reluctant to relocate to rural areas. The people that suffer are the consumers in the community. Everybody suffers—not just the Medicare patients. It has a downward spiraling effect."

Moreover, as with program cuts, respondents indicated that staff reductions would decrease the hospital's quality of care and that the access and quality of care available to all persons in the community, not just the Medicare population, would be affected.

(4) Renewed Emphasis on Bad Debt Collections: Ongoing collection procedures range in degree of aggressiveness (i.e. phone calls, letters, legal action). Most hospital administrators reported that they attempted to avoid harsh collection practices, such as the placement of property liens, and were amenable to flexible financial arrangements with patients. The interviewees also sought to qualify clients into financial assistance programs (i.e., state indigent care programs, Medicaid), benefiting both the hospital and the patient.

Hospital representatives indicated that they might re-examine their debt collection strategies, particularly when the outstanding account balance is large. One

Table 1: *Medicare Bad Debt Reimbursement and Reduction in Medicare Payments Resulting from Elimination of Bad Debt Payment, Urban and Rural Hospitals, 2005*

	Urban			Rural		
	N	Bad Debt Payment ($)	Decrease in Payment (%)	N	Bad Debt Payment ($)	Decrease in Payment (%)
Overall	2,244	288,858	2.4	1,156	116,119	3.7
Bedsize		p < .0001	p < .0001		p < .0001	p = NS
≤ 25	34	54,612	2.1	68	26,224	4.6
26 – 49	137	47,420	2.6	385	50,529	4.6
50 – 99	298	90,539	2.9	410	104,421	3.5
100 – 149	501	192,587	3.4	181	185,580	2.9
150 +	1,274	405,319	1.9	112	326,734	2.2
Location		p < .0001	p < .0001		p < .0001	p < .0001
North	477	204,998	1.2	88	65,560	1.2
South	815	378,109	3.6	646	154,210	4.7
Midwest	626	223,347	1.6	368	70,611	2.6
West	326	314,230	2.9	64	68,782	4.7
Ownership		p = NS	p < .0001		p < .0001	p = .01
Government	1,465	281,254	2.9	575	84,360	4.0
Proprietary	509	285,184	3.9	208	160,004	5.4
Voluntary	270	291,536	1.9	373	120,847	3.0
Special Payment Status					p = NS	p = .002
PPS				391	110,410	4.8
Rural Referral Center				144	218,606	1.9
Medicare Dependent				173	60,433	5.0
Sole Community				448	109,644	2.9
DPP Percent		p < .0001	p < .0001		p < .0001	p = NS
Top quartile	545	419,478	3.9	306	154,145	4.2
Second quartile	552	244,466	2.0	298	95,412	3.9
Third quartile	500	364,539	2.7	350	130,425	4.2
Bottom quartile	647	158,218	1.4	202	64,277	2.0
Medicare Margin		p = .04	p = .003		p < .0001	p = NS
Top quartile	559	268,677	1.9	290	141,521	3.6
Second quartile	549	301,351	2.6	298	104,694	3.8
Third quartile	565	318,532	2.0	283	143,865	3.1
Bottom quartile	569	267,563	3.2	279	72,250	4.5

Notes: Statistical significance determined for group using ANOVA. NS = Not statistically significant.

hospital respondent thought that institutions facing greater financial strain might be forced to be more insistent or aggressive in their collection efforts. Even though most hospitals already attempt to refer eligible patients to public programs to determine their qualification for health and financial assistance, respondents indicated that they may need to step up efforts to ensure that individuals who qualify for these programs receive these benefits. More aggressive collection efforts which could be employed include legal actions, such as liens. In general, hospital representatives that we spoke with indicated that although they currently try to avoid using such extreme measures to collect on unpaid accounts, harsher collection tactics may be necessary.

> *"We would have to have more stringent requirements for charity care qualification if Medicare bad debt reimbursement was eliminated. Right now, we're not putting liens on anyone's houses. But maybe we'll have to do that—put liens on Medicare recipients' houses."*

CONCLUSIONS

Findings from this study suggest that the FY2007 budget proposal, which would phase-out bad debt reimbursement to hospitals, could have a non-trivial impact on rural hospitals. Depending on size, financial losses could be expected to range anywhere from an average of 2.2 to 4.6 percent of 2005 Medicare revenue among rural hospitals. Rural and urban payer mixes differ, with rural hospitals seeing more Medicare patients, and thus relying more heavily on Medicare reimbursement. Although the overall impact on Medicare margins would, in many cases, be small, repercussions could be significant. Of particular concern is the fact that many rural hospitals are already financially constrained and the elimination of bad debt reimbursement could result in the loss of essential health services and programs or a reduction in the quality of care available to community residents. Because many smaller hospitals already fail to offer the sorts of services that private-payers and privately-insured individuals prefer, conceivably, hospitals will experience even greater difficulty attracting those patients who are financially able to pay.

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