SKILLED NURSING REVENUE CYCLE

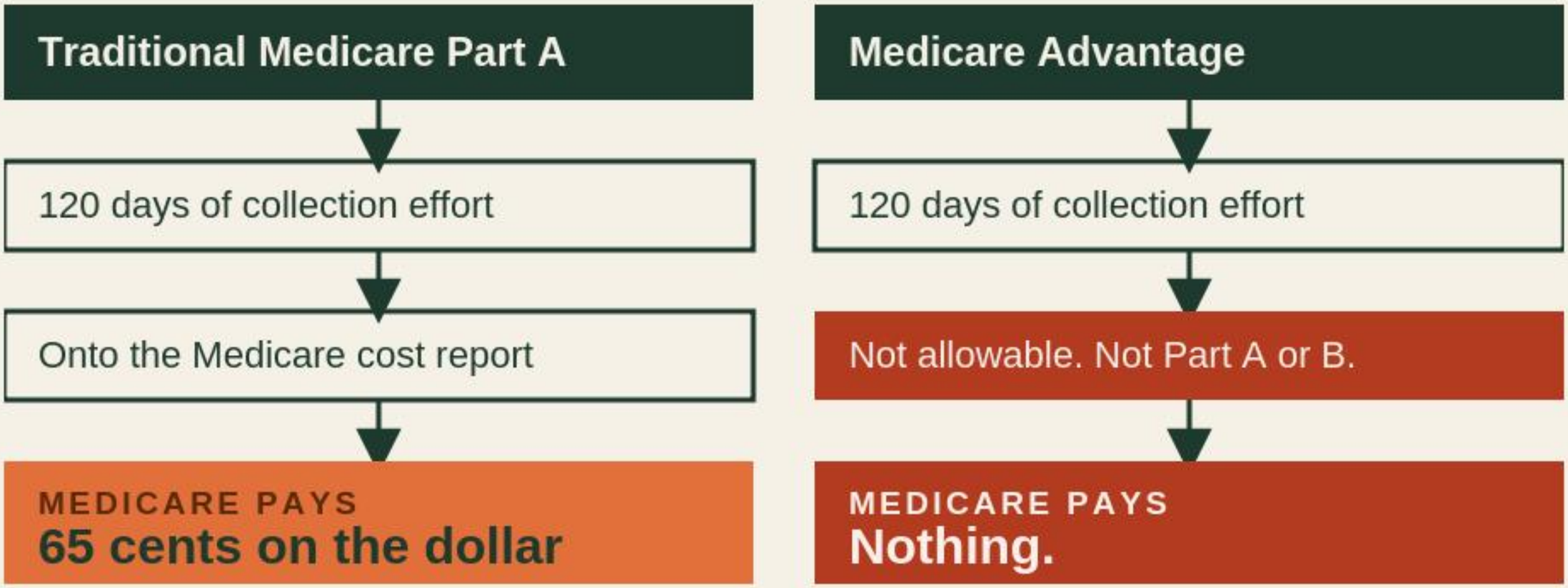
65 cents. Or zero.

The same unpaid coinsurance, from the same resident, in the same bed.

One of them lands on your cost report. The other lands on you.

TWO PATHS, ONE OUTCOME EACH

SAME RESIDENT. SAME CARE. SAME UNPAID COINSURANCE.



Your only recourse on the right side is the contract you signed with the plan.

WHAT THE RULE ACTUALLY SAYS

Part A and Part B. Nothing else.

Under 42 CFR 413.89 and Chapter 3 of the Provider Reimbursement Manual, allowable Medicare bad debt is limited to deductible and coinsurance amounts under traditional Medicare.

Reimbursement is 65 percent, after documented reasonable collection effort running at least 120 days from the original bill.

THE EXCLUSION IS EXPLICIT

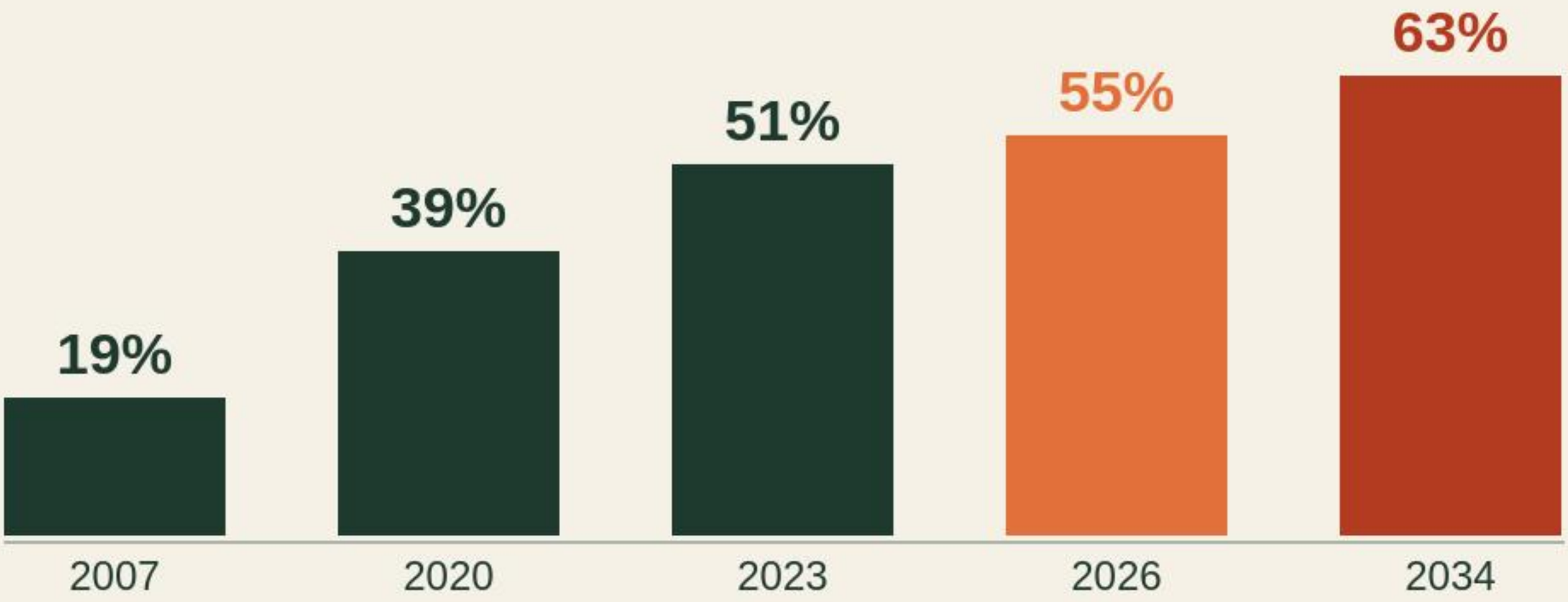
Bad debt logs are restricted to Part A and Part B. Managed care cost sharing does not qualify, no matter how thorough your collection file is.

CMS pays the plan a capitated rate and hands over the risk.

Traditional Medicare reimburses providers against allowable cost and backstops unpaid beneficiary cost sharing under statute.

A Medicare Advantage organization receives a set payment to cover the member. What happens between you and that plan is private and contractual. The federal program is not a party to it.

More than half your Medicare census already has no backstop.



Share of eligible Medicare beneficiaries enrolled in Medicare Advantage. 2034 is a CBO projection.

Roughly 35 million people. In 2007 it was 8 million.

Authorization denials are the visible problem.

Everyone in this industry can tell you about a plan cutting a stay at day fourteen on a resident who clearly needed thirty. We track those. We appeal them. We complain about them at conferences.

Bad debt is the quiet one. It never generates a denial letter. There is nothing to appeal. It simply never appears on a cost report that would have paid 65 percent of it under traditional Medicare.

One problem announces itself. The other just shows up as a smaller margin, and gets blamed on collections.

Every point of MA penetration moves money off the cost report.

This is not a loophole anyone is exploiting. It is how the program was designed.

But the practical effect is that a federal backstop which still exists for traditional Medicare has quietly disappeared for a growing share of your Medicare census, and nobody at the plan has to lift a finger for it to happen.

We treat this as a collections problem. It is a contracting problem.

Your revenue cycle people know exactly which plans generate uncollectible balances, and roughly how much.

They are almost never in the room when the agreement is signed.

Put them there. That is the entire fix.

THREE THINGS TO ASK FOR

01 **A wrap-around provision.** The plan covers a defined share of uncollectible member cost sharing where you can document exhaustive collection effort.

02 **Crossover language.** Spell out exactly how dual eligible balances are routed to Medicaid, and what the plan does when the state pays nothing under its lesser-of policy.

03 **A rate adjustment instead.** If the plan refuses both, negotiate the base rate upward. You are pricing in a cost they have declined to share.

A refusal is not the end of the conversation. It is a number.

You cannot balance bill a QMB.

Federal law prohibits billing a Qualified Medicare Beneficiary for Medicare cost sharing, and that prohibition applies inside Medicare Advantage.

If your dual is a QMB, aggressive collection is not merely unproductive. It is not permitted.

Identify your QMB population before you build any collections push around this.

THE DATA PLAY

Run the must-bill process anyway.

On traditional Medicare, CMS has required a processed state Medicaid remittance advice before dual eligible bad debt is allowable, for cost reporting periods beginning January 1, 2004 forward. That holds even when the state owes nothing under its lesser-of policy.

You cannot put that on the cost report for an MA resident. You can put it on the table.

WHAT IT BECOMES

A clean, defensible record of exactly how much uncollectible cost sharing a specific plan's contract generates in your building. That is leverage at renewal.

WHO NEEDS TO BE IN THE ROOM

01 **Business office and revenue cycle.** They hold the actual uncollectible numbers by plan. Nobody else does.

02 **Whoever signs the contract.** Usually not the person who lives with its consequences.

03 **Admissions.** Knows the plan mix walking in the door, and how it is shifting.

04 **Finance.** Has to be able to model the rate uplift that replaces a refused wrap-around.

Your people have skin in the game. A vendor does not.

The person who has chased these balances for six years knows which plans pay, which stall, and which never intended to. That knowledge is not for sale, and it is already on your payroll.

What is usually missing is not expertise. It is that nobody asked them before the contract was signed.

THE POINT

Track it as if you could claim it. Then spend it as leverage.

You will not recover managed care bad debt through the cost report. That door is closed and it is not opening.

The door that is open is the one you walk through every time a contract comes up for renewal, and most of us walk through it without the numbers in hand.

Sources: 42 CFR 413.89; CMS Provider Reimbursement Manual 15-1, Chapter 3; CMS requirement for processed state Medicaid remittance advice on dual eligible bad debt for cost reporting periods beginning January 1, 2004. Not legal or reimbursement advice.