Navigating Medicare Reporting Requirements for Bad Debt, DSH, and Uncompensated Care

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BerryDunn

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Presenters

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Learning objectives

- Gain a clear understanding of the four new Exhibits (2A, 3A, 3B, and 3C) and their specific data requirements.
- Explore common problems encountered in gathering the necessary data and discover practical solutions to overcome these challenges.
- Develop strategies for efficient and accurate data collection to help ensure compliance with the new Medicare reporting requirements, reducing the risk of audit issues.

Transmittal 18 FY23 Cost Report Changes: New Exhibits

Effective for cost reporting periods beginning on or after October 1, 2022.
Instructions updated in Transmittal 22 issued Feb. 29, 2024

Exhibit 3A
Medicaid Eligible Days

New required fields

Changes in how newborn days must be reported

Exhibit 3B
Charity Care (S-10)

21 fields; confusion on how to interpret some fields

Exhibit 3C
Total Bad Debt (S-10)

17 fields; more confusion…

Exhibit 2A
Medicare Bad Debts

24 required fields instead of 10, some fields now mandatory

Electronic versions of templates can be found on the CMS website at:
https://www.cms.gov/medicare/audits-compliance/part-cost-report-audit/electronic-cost-report-exhibit-templates

Which provider types are impacted?

DSH-Eligible PPS Hospitals

Required at time of filing for cost report acceptance:

Exhibit 3A: Medicaid-Eligible Days

Exhibit 3B: Charity Care

Exhibit 3C: Total Bad Debt

Exhibit 2A: Medicare Bad Debts, if claiming for reimbursement

Critical Access Hospitals

Required at time of filing for cost report acceptance:

Exhibit 2A: Medicare Bad Debts, if claiming for reimbursement

Not required for cost report acceptance, but support completion of Worksheet S-10:

Exhibit 3B: Charity Care

Exhibit 3C: Total Bad Debt

DSH & Uncompensated Care Payments

Supported by Exhibits 3A – 3C

Quick Refresher

DSH/Uncompensated Care Payments

Empirical Disproportionate Share Payment (Requires Medicaid-eligible days listing, Exhibit 3A)

DSH-eligible hospitals will receive **25%** of the amount they previously would have received under the statutory formula for Medicare **Empirical DSH payments**.

DSH Patient Percent (DPP) = (Medicare SSI Days / Total Medicare Part A Days) + (Medicaid-eligible, Non-Medicare Part A&C Days / Total Patient Days)

Uncompensated Care Payment (Requires Charity Care & Bad Debt listings, Exhibits 3B & 3C)

The remainder, equal to **75%** of what otherwise would have been paid as Medicare DSH, will become available to hospitals in the form of **Uncompensated Care payments** after the amount is reduced for changes in the percentage of individuals that are uninsured.

Medicaid-Eligible Days for DSH % Calculation

Reported in Worksheet S-2 Part I, Lines 24 & 25. Supported by detailed listing, Exhibit 3A

- Start with patient-level detail of all inpatient days and match data against State Medicaid eligibility data
  - Avoid relying solely on paid claims data
  - Understand the state's specific matching criteria and format and if there is more than one match process
  - Consider matching in border states and Medicare PS&R detail and/or Common Working File
  - Review individual eligibility for Medicaid patients who didn't match with your State's batch results
- Understand which Medicaid programs and/or patient populations are not eligible for inclusion
- Monitor data at least quarterly particularly if you're close to the 340B eligibility threshold
- Perform retrospective review and consider amending

Exhibit 3A: Medicaid-Eligible Days

Required for cost reporting periods beginning on or after October 1, 2022

PATIENT CLAIM INFORMATION							
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER	MEDICAID NUMBER	STATE ELIGIBILITY CODE	PATIENT POPU-LATION CODE
1	2	3	4	5	6	7	8
		A				B	C

MEDICAID DAYS						MEDICARE ELIGIBILITY			
WKST S-2, PART I COLUMN NUMBER	ELIGIBLE DAYS	LABOR & DELIVERY ROOM DAYS	NEWBORN BABY DAYS	INSURANCE OR OTHER PAYER NAME		A/B INDICATOR	START DATE	END DATE	COMMENTS
				PRIMARY	SECONDARY				
9	10	11	12	13	14	15	16	17	18
D	E	F	G	H		I	J		

Exhibit 3A: Medicaid-Eligible Days, columns 1 – 8

	Column			
A	1 2 3	4 5 6	Patient Claim information and **Medicaid ID** Number	The Medicaid beneficiary's name, dates of service, patient account number, and Medicaid ID. For a newborn of a Medicaid-eligible mother, enter the mother's Medicaid identification number
B	7		**State Eligibility Code**	Enter the applicable State plan eligibility code number, if available. To report more than one code, report the additional State plan eligibility codes in column 18 Comments
C	8		**Patient Population Code**	Unique patient population code to identify a restricted (R#) or unrestricted (U#) day: R1: pregnancy/labor and delivery services R2: emergency services R3 – R9: user-defined, description in comments U1: generally unrestricted U2 – U9: user-defined, description in comments

Exhibit 3A: Medicaid-Eligible Days, columns 9 – 12

	Column		
D	9	Worksheet S-2, Part I, column number	1 – In-State Medicaid paid days 2 – In-State Medicaid eligible unpaid days 3 – Out of State Medicaid paid days 4 – Out of State Medicaid eligible unpaid days 5 – Medicaid HMO days 6 – Other Medicaid days
E	10	**Eligible Days**	Include the number of days for a newborn baby remaining in the hospital after the Medicaid eligible mother's discharge. **S-2pl Col 1 – 5 = Exhibit 3A Col 10 + Col 12**
F	11	Labor & Delivery Room Days	Days a maternity patient is in the L&D room ancillary area at time of midnight census and was subsequently admitted as inpatient during the same stay. **= S-2pl Col 6**
G	12	**Newborn Baby Days**	Occurring prior to Medicaid-eligible mom's discharge and reported in addition to mom's days in col 10. If baby remained in hospital after mom's discharge, report days separately in col 10.

Exhibit 3A: Medicaid-Eligible Days, columns 13 – 17

	Column		
H	13 14	Insurance or Other Payer Name – Primary and Secondary	Name of the insurance company or other payer with primary responsibility for paying the claim and with secondary responsibility, if applicable
I	15	**Medicare Eligibility A/B Indicator**	If the patient was eligible for Medicare, enter “A” or “B” as follows: • Only Medicare Part A, enter “A” • Both Part A and Part B, enter “A” • Only Medicare Part B, enter “B”
J	16 17	Medicare Eligibility **Start and End Date**	Enter the dates that the patient’s Medicare eligibility started and ended, if applicable. Medicare Part A & C are not to be included in the listing. These fields can relay if Part A eligibility ended prior to the days reported as Medicaid-eligible.

Uncompensated Care

Reported in Worksheet S-10. Supported by detailed listings, Exhibit 3B (charity) & 3C (bad debt).

75% of what otherwise would have been paid as Medicare DSH is comprised of uncompensated care payments, which are the product of three factors:

1

75% of the estimated DSH payments that would otherwise be made under the old DSH methodology (section (d)(5)(F) of the Social Security Act)

2

1 minus the percent change in the percent of individuals under the age of 65 who are uninsured (minus 0.2 percentage points for FYs 2018 and 2019, no additional reduction for FY 2020 and after)

3

A hospital's amount of uncompensated care relative to the amount of uncompensated care for all DSH hospitals expressed as a percentage

Each hospital wants to optimize its UCC to gain as large a piece of the DSH pie as possible!

Uncompensated Care

Continued

Worksheet S-10 data is audited regularly and used in the DSH uncompensated care payment calculation (Factor 3).

- Uncompensated Care does not include:
  - Bad debt reimbursed by Medicare
  - Courtesy allowances
  - Discounts given to patients that are not included in the Hospitals Charity Care Policy
  - Professional fees
- Charity Care Charges are the actual charge amounts except for physician and other professional services.
  - Written off during the cost reporting period
  - Charges for non-covered services can be included if allowable per the Charity Care Policy
  - Policy follows CMS Pub 15-1 §312 for determining a patient indigence

Exhibit 3B: Charity Care Charges

Required for cost reporting periods beginning on or after October 1, 2022

PATIENT CLAIM INFORMATION										
PATIENT NAME - LAST	PATIENT NAME - FIRST	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER	INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR	TOTAL CHARGES FOR CLAIM	PHYSICIAN / PROFES-SIONAL CHARGES	DEDUCT-IBLE / COINSUR / COPAY AMOUNTS
1	2	3	4	5	6	7	8	9	10	11
A					B	C		D		E

TOTAL THIRD PARTY PAYMENTS	INSURED CONTRAC-TUAL ALLOWANCE AMOUNT	OTHER NON-ALLOWABLE AMOUNTS	TOTAL PATIENT PAYMENTS	AMOUNTS WRITTEN OFF AS BAD DEBT	UNINSURED DISCOUNT AMOUNTS	CHARITY CARE NON-COVERED CHARGES	OTHER CHARITY CARE CHARGES	AMOUNTS WRITTEN OFF TO CHARITY CARE AND UNINSURED DISCOUNTS	WRITE OFF DATE
12	13	14	15	16	17	18	19	20	21
F		G	H	I	J	K	L	M	N

Exhibit 3B: Charity Care Charges, columns 1 – 8

	Column			
A	1 2 3	4 5	Patient Claim information	The patient's name, dates of service, and patient account or other identification number
B	6		**Insurance Status**	Indicate the patient's insurance status at the time services were provided, as follows: 1: Uninsured 2: Insured but not covered 3: Insured S-10 Uninsured Col 1 = Sum of Status Code 1 + 2 S-10 Insured Col 2 = Sum of Status Code 3
C	7 8		Primary and Secondary Payor	Enter the name of the primary and secondar payor, as applicable, regardless of whether you have a contractual (or inferred contractual) relationship with the insurer.

Exhibit 3B: Charity Care Charges, columns 9 – 16

	Column		
D	9 10	Total Charges and **Professional Charges**	If total charges include amounts for physician/ professional charges, enter those amounts in Col 10. Professional charges should not be included in UC.
E	11	Deductible, Coinsurance, Copay Amounts	Cost-sharing amounts owed by the patient according to their medical insurance coverage, if applicable.
F	12 13	Third-Party Payments Insured Contractual Allowance	Payments received from third-party payors and any contractual allowance(s) for insured patients (difference between billed charges and insurer allowed amounts).
G	14	Other **Non-allowable Amounts**	Other unpaid non-allowable amounts including non-covered charges for medically necessary services NOT included in the written charity care policy, non-covered charges for services not medically necessary, courtesy discounts, administrative adjustments, and denials.
H	15	Total Patient Payments	All payments received from patients, or individuals responsible for payment.
I	16	Amounts Written off as Bad Debt	Written off as a bad debt, regardless of the date.

Total Charity Care & Uninsured Discounts should = Columns 9 less 10, 12, 13, 14, 15, & 16

Exhibit 3B: Charity Care Charges, columns 17 – 21

	Column		
J	17	Uninsured Discounts	Amount of the uninsured discount given to an uninsured patient per the written charity care policy. Do not complete for insured patients.
K	18	**Charity Care Non-Covered Charges**	For insured patients, the medically necessary non-covered charges, if covered under the written charity care policy, as follows: • Non-covered services provided to Medicaid-eligible patient (or other indigent care program) • Non-covered days exceeding length-of-stay limit for Medicaid-eligible patients • When the patient has exhausted their benefits
L	19	Other Charity Care Charges	Any other allowable charges (not reported in column 17 or column 18) and written off as charity care pursuant to the provider's written charity care policy.
M	20	Amounts Written Off to Charity Care and Uninsured Discounts	Sum of columns 17 through 19 Should also equal Columns 9 less 10, 12, 13, 14, 15, & 16 Report Sum of Status Code 1 + 2 in S-10 Col 1, Uninsured Report Sum of Status Code 3 in S-10 Col 2, Insured
N	21	Write-off Date	Can often be multiple write-off dates. No written guidance on how to handle that. Recommend using most recent write-off date **within the reporting period**.

Exhibit 3C: Total Bad Debt

Required for cost reporting periods beginning on or after October 1, 2022

PATIENT CLAIM INFORMATION					INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCT NUMBER			
1	2	3	4	5	6	7	8

SERVICE INDICATOR (IP / OP)	TOTAL CHARGES	TOTAL PHYS-ICIAN / PROFES-SIONAL CHGS	TOTAL PATIENT PAYMENTS	TOTAL THIRD PARTY PAYMENTS	PATIENT CHARITY CARE AMOUNT	CONTRACTUAL ALLOWANCE / OTHER AMOUNT	A/R WRITE OFF DATE	PATIENT BAD DEBT WRITE OFF AMOUNT
9	10	11	12	13	14	15	16	17

A B C D

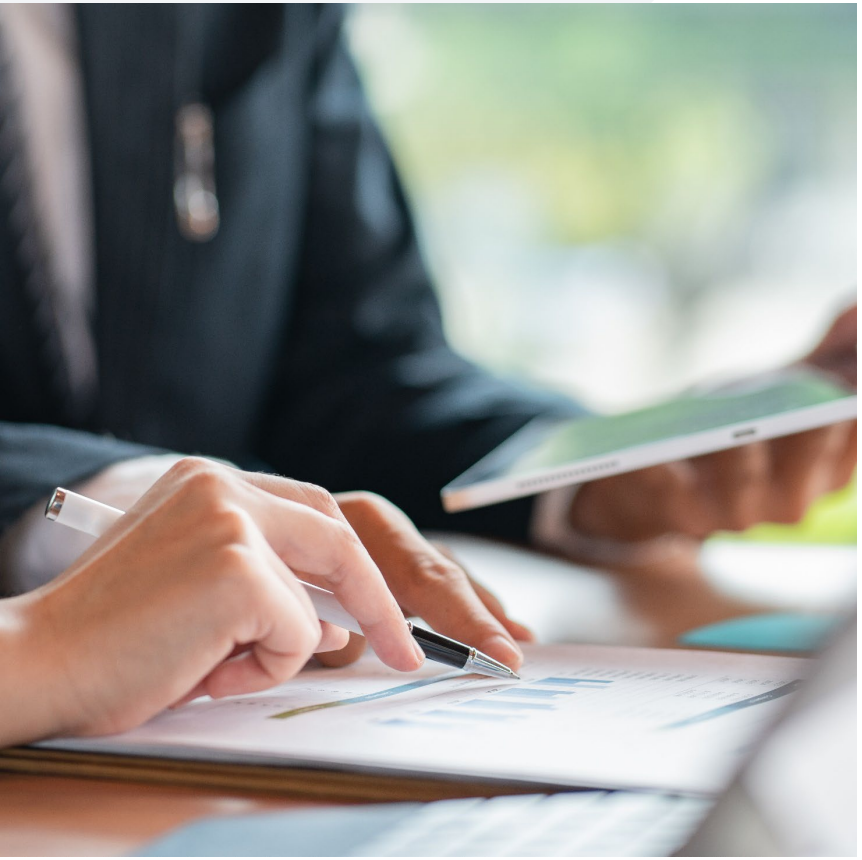
Exhibit 3C: Total Bad Debt, columns of note

	Column		
A	9 10	**Total Charges and Professional Charges**	Unlike the option in the Charity Care listing, the total bad debt listing should not include any professional charges in the Total Charges field in Column 9. Report any professional charges only in column 10. These amounts will be used to prorate the bad debt write-offs to report on the portion related to hospital charges in Uncompensated Care.
B	12	Total Patient Payments	Bad debt reported should be **net of any recoveries**, but there is no separate field to report recoveries. Include these in with total patient payments, regardless of date of transaction.
C	16	A/R Write-off Date	Written off during the cost reporting period, regardless of date of service.
D	17	Patient Bad Debt Write-off Amount	Calculate the net patient bad debt amount by computing the ratio of total charges to total charges plus physician/professional charges (column 10 divided by the sum of columns 10 and 11). Apply the ratio to the total payments, discounts, and allowances (columns 12 through 15) and subtract the resulting amount from total charges (column 10). Total reported in S-10 Line 26

Medicare Bad Debts Reimbursement

OIG Audit of Medicare Bad Debts

OIG December 2022 Audit Report Results



- **Audited 67 cost reports** totaling $13.9M in Medicare reimbursable bad debt
- **14.8% of Medicare bad debts paid** when reimbursement should have been denied
- Medicare Administrator Contractors (MAC) did not meet their responsibility for ensuring proper collection efforts for Medicare bad debts
- Recommended that CMS consider issuing instructions or guidance to the MACs that require more review of Medicare bad debts claimed

See the full report at:
https://oig.hhs.gov/oas/reports/region7/72002825.pdf

Allowable Medicare Bad Debts

Medicare bad debt is allowable if:

1. Traditional Medicare only bad debts
2. Uncollectible Medicare deductibles and coinsurance for covered services
3. Exclude professional fees billed under Part B
4. Timely billing of date of first bill
5. Reasonable collection efforts made and all efforts exhausted
6. Write-off occurred during the cost reporting period
7. Write-off when returned from agency
8. Recoveries of bad debts previously claimed

Allowable Medicare Bad Debts, continued

Medicare bad debt may be claimed without collection efforts if:

1. Medicare/Medicaid crossover claim—must bill to Medicaid and receive a paid remittance advice in order to claim bad debt
2. Indigent patients with supporting proof of indigence
3. Deceased patients with no estate

Medicare Bad Debts, Documentation

Documentation required to support bad debt amount claimed:

- Medicare bad debts listing is required at the time of filing for cost reporting
- Paid remittance advice from Medicare and any supplementary insurance, including Medicaid if applicable
- Copies of bills sent to the patient
- Documentation of collection efforts
- Documentation to support write-off to bad debt account and accounts receivable balance to $0

Exhibit 2A: Medicare Bad Debt Log

Complete separate exhibit for each CCN/Subunit, effective on or after October 1, 2022

14 new required columns on hospital Medicare bad debt template

PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN	MEDI-CAID NUMBER	PROVIDER DEEMED INDI-GENT	MEDI-CARE REMIT-TANCE ADVICE DATE	MEDI-CAID REMIT-TANCE ADVICE DATE	SEC-ONDARY PAYER RA RE-CEIVED DATE	BENE-FICIARY RESPON-SIBILITY AMOUNT	DATE FIRST BILL SENT TO BENE
1	2	3	4	5	6	7	8	9	10	11	12	13
		A				B	C	D	E	F	G	H

A/R WRITE OFF DATE	SENT TO COLLEC-TION AGENCY (Y/N)	RETURN FROM COLLEC-TION AGENCY DATE	COLLEC-TION EFFORT CEASED DATE	MEDI-CARE WRITE OFF DATE	RECOVER-IES ONLY: AMOUNT RECEIVED	RECOVER-IES ONLY: MCR FYE DATE	MEDI-CARE DE-DUCTIBLE AMOUNT	MEDI-CARE CO-INSUR-ANCE AMOUNT	PAYMENTS RECEIVED PRIOR TO WRITE-OFF	ALLOW-ABLE BAD DEBTS AMOUNT	COMMENTS
14	15A	15	16	17	18	19	20	21	22	23	24
I	J		K	L	M			N		O	P

Exhibit 2A: Medicare Bad Debt Log, columns 1 – 11

	Column			
A	1 2 3	4 5 6	Patient identification information	The Medicare beneficiary's name, dates of service, (**new**) patient account or identification number, and MBI or HICN.
B	7		Medicaid Number	Enter the Medicare beneficiary's Medicaid number if the beneficiary was dually eligible.
C	8		Provider **Deemed Indigent**	**New** – Enter "Y" for yes if the provider deemed the patient indigent and Medicare beneficiary was not eligible for Medicaid.
D	9		Medicare Remittance Advice Date	Enter the Medicare remittance advice date
E	10		Medicaid Remittance Advice Date	**New** – Enter the Medicaid remittance advice date.
F	11		Secondary Payer RA Received Date	**New** – Enter the date a remittance advice was received from a secondary payer, if applicable.

Exhibit 2A: Medicare Bad Debt Log, columns 12 – 14

	Column		
G	12	Beneficiary Responsibility Amount	**New** – Enter the amount of coinsurance and deductible for which the Medicare beneficiary is responsible. For a Medicare beneficiary deemed indigent by the provider (column 8 is “Y”), enter zero.
H	13	Date First Bill Sent to Beneficiary	Enter the date that the first bill was sent to the Medicare beneficiary.
I	14	A/R Write-off Date	**New** – Enter the date the Medicare beneficiary’s liability was written off of the accounts receivable (A/R) in the provider’s financial accounting system.

Exhibit 2A: Medicare Bad Debt Log, columns 15 – 17

	Column		
J	15A 15B	Collection Agency sent (Y/N) and Date Returned	**New** – If a collection agency is used, the beneficiary's A/R is to be reduced by the gross amount collected. Accounts sent to a collection agency must be closed and returned to the provider before being claimed as a bad debt.
K	16	Collection Effort Ceased Date	Enter the date all collection efforts ceased. This may be the same date as entered in Col 15.
L	17	Medicare Write-off Date	**New** – The date that the provider or collection agency efforts ceased, and the bad debt was written off (within the reporting period).

Exhibit 2A: Medicare Bad Debt Log, columns 18–24

	Column		
M	18 19	Recoveries	**New** – Only include recoveries received after a bad debt has been written off.
N	20 21 22	Medicare Deductibles Medicare Coinsurance Payments Received Prior to Write-off	Report deductibles and coinsurance amounts from the Medicare RA prior to adjustment by any party. **New** – Any patient payments for these amounts received prior to write-off will be reported in column 22.
O	23	Allowable Bad Debts	**New** – Medicare Deductibles (column 20) + Medicare Coinsurance (column 21) – Patient payments prior to write-off (column 22) – Recoveries (column 18).
P	24	Comments	**New** – Use for information purposes.

Questions?

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