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The Business Office Impact to 501(r), Worksheet S-10 and Medicare Bad Debts

Agenda

- Introductions
- IRC Section 501(r)
- Transmittals
- Worksheet S-10
- Medicare Bad Debts
- Closing

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Presenters

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IRC Section 501(r)

- Overview of 501(r) Regulations
- How 501(r) relates to revenue cycle management and the business office
- How 501(r) impacts policies and procedures

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IRC Section 501(r)

- Affordable Care Act (ACA) Section 9007 created new Section 501(r) in 2010
- Final 501(r) Regulations issued in December of 2014
- Sets forth four requirements for hospitals to maintain tax-exempt, non-profit status
  - Community Health Needs Assessment (CHNA)
  - Financial Assistance Policy (FAP) and Emergency Medical Care policies
  - Limitations on charges
  - Billing and collections

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IRC Section 501(r)

- Section 9007 also requires the IRS to:
  - Review the community benefit activities of each charitable hospital at least once every three years
  - Submit reports to Congress, with the U.S. Department of Health and Human Services, comparing community benefit provided by taxable, tax-exempt, and governmental hospitals

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IRC Section 501(r)

- Financial Assistance Policy (FAP)
  - Requires written policies defining eligibility for financial assistance and how those people will be identified
  - Cannot charge FAP eligible patients more than AGB (amounts generally billed) for medically necessary or emergency care
  - Must make 'reasonable effort' to determine FAP eligibility

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IRC Section 501(r)

- Establishing a Financial Assistance Policy (FAP)
  - Section 501(r)(4) requires exempt hospitals to write and adopt a financial assistance policy
  - Plain Language Summary
  - Make documents publicly available

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Financial Assistance Policy (FAP)

- Your FAP must:
  - State that it applies to all emergency and medically necessary care only
  - List all financial assistance options the hospital offers, as well as eligibility criteria for participating in each
  - Explain how patients can apply for financial assistance
  - Describe how the hospital calculates charges for patients who are eligible for financial assistance
  - Explain assistance-eligible patients cannot be charged more than the AGB

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Financial Assistance Policy (FAP)

- Your FAP must (continued)
  - Describe potential collections steps the hospital will take to collect an overdue bill, including the timeline and processes you will follow
  - List any third-party sources the hospital uses to determine whether a patient is eligible for financial assistance
  - Include a list of providers the FAP covers and does not cover
  - Provide contact information for patients if they need more help understanding or applying for financial assistance
  - Include a complete list of information and documentation patients must provide when they apply for financial assistance

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FAP Plain Language Summary

- The plain language summary version of the FAP is mandatory and must:
  - Be easy to understand by the “lay reader”
  - List the core elements of the FAP
  - Include a direct URL to the website or another location where the full FAP and FAP application can be found
  - Include a physical location and phone number where patients can get more information
  - Direct patients to translated versions of the documents

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IRC Section 501(r) Compliance Challenges

- AGB
  - Establishing that deposit/prepayment amounts for services are less than AGB for that particular service, if the patient is FAP-eligible or the patient’s FAP eligibility has not yet been determined
  - Refunding amounts paid by FAP-eligible patients that exceed amounts that the hospital determines such patients are responsible for paying

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IRC Section 501(r) Compliance Challenges

- Billing and Collections
  - Confirming that agreements with third-party collection agencies require compliance with 501(r) reasonable effort requirements before the third party engages in ECAs
  - Ensuring no ECAs are taken until after expiration of notification period

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IRC Section 501(r) Compliance Challenges

- General
  - Authorized body adoption of FAP, CHNA report, implementation strategy, emergency medical policy and, if applicable, billing and collections policy
  - Developing and implementing procedures for overseeing 501(r) compliance and detecting/correcting/disclosing 501(r) violations
  - Ensuring that each policy clearly names each facility to which the policy applies

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IRC Section 501(r) Compliance Challenges

- General (cont.)
  - Verifying policies and procedures remain up to date
  - Updated policies/reports are not posted timely to website
  - Make sure required FAP-related signage and publications are in hospital facility

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FAP & Emergency Medical Care Policy Operational Checklist

- Check
  - Whether the policies list each hospital facility to which they apply
  - Whether contact information in FAP, plain language summary and FAP application has changed
  - Whether application methods or criteria have changed
  - Whether required documents have been made widely available
  - Whether there may be new or growing limited English proficiency populations that require translations
- Update
  - AGB information
  - Provider list information (at least quarterly)
- Document
  - Approval by authorized body of new versions
  - Availability of Documents

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Limitations on charges and Billing & Collections Operational Checklist

- Recalculate AGB percentage (if using look-back method) or review billing and coding process (if using prospective method)
- Implement new AGB limits, based on recalculation/review
- Check required prepayments and deposits for medically necessary care against updated AGB information
- Check a sample of FAP-eligible patients to determine if both amounts charged and amounts paid were below AGB
- Check whether new types of ECAs are being conducted
- Check whether new collection agencies are being used and, if so, if contracts with those agencies include the required language

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IRC Section 501(r)

- Understand the 501(r) requirements – read the code, talk to your CPA
- Recognize 501(r) compliance challenges and make sure your team has a plan to prevent failures
- Work off the operational checklists provided and ensure your team does a periodic review and/or has your CPA review your policies and procedures

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Agenda

- Introductions
- IRC Section 501(r)
- Transmittals
- Worksheet S-10
- Medicare Bad Debts
- Closing

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S-10 Transmittal

- What is a Medicare Provider Reimbursement Manual Transmittal?
- How many have there been?
- Transmittal 18 was issued December 29, 2022 and is effective for cost reporting periods beginning on or after October 1, 2022.
- Transmittal 18 contains certain revisions requiring additional patient data fields that may require the assistance of the business office. What is a Medicare Provider Reimbursement Manual Transmittal

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Worksheet S-10

- Section 112(b) of the Balanced Budget Refinement Act (BBRA) requires that short-term acute care hospitals (§1886(d) of the Act) submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated.
- Section 1886(r)(2) of the Act, as added by section 3133 of the ACA, requires an additional payment for uncompensated care for 1886(d) DSH eligible hospitals.
- Charity care charges, discounts given to uninsured patients that meet the hospital's written financial assistance policy/uninsured discount policy (hereinafter referred to as "financial assistance policy" or FAP), non-Medicare bad debt, and nonreimbursed Medicare bad debt may be used in the calculation of the UCP.
- **CMS does not mandate the eligibility criteria that a hospital uses under its financial assistance policy.**

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Worksheet S-10

- **Important Definitions**
  - **Charity Care and Uninsured Discounts**
  - **Inferred contractual relationship**
  - **Medicare bad debt**
  - **Nonreimbursable Medicare bad debt**

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Worksheet S-10

- **Charity Care and Uninsured Discounts**
  - Charity care and uninsured discounts result from a hospital's policy to provide all or a portion of medically necessary health care services free of charge to patients who meet the hospital's charity care policy or FAP. Charity care and uninsured discounts can include full or partial discounts. If a patient is not eligible for discounts under the hospital's charity care policy or FAP, then any discounts or reductions given to the standard managed care rate must not be accounted for as charity care or an uninsured discount. Discounts given to patients for prompt payment must not be included as charity care.
  - Hospitals that received HRSA-administered Uninsured Provider Relief Fund (PRF) payments, as authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. 116-136), for services provided to uninsured COVID-19 patients, must not include the patient charges for those services. Under the terms and conditions of the PRF, payments are considered payment in full for such care or treatment.
- **Courtesy Allowances**
  - Courtesy allowances are reductions in charges by a provider in the form of allowances to persons such as physicians, clergy, members of religious orders, and others as may be approved by the governing body of the provider, for services received from the provider. Courtesy allowances also include discounts for prompt payment, friends and family discounts, and employee discounts. Courtesy allowances are not charity care charges, nor are they Medicare bad debts, and must not be included on this worksheet.
- **Inferred contractual relationship**
  - For Worksheet S-10 purposes, a contractual relationship between an insurer and a provider will be inferred where a provider accepts an amount from an insurer as payment, or partial payment, on behalf of an insured patient (for example, payments from workman's compensation funds, payments from an automobile insurer for medical benefits, or payments from an insurer for out-of-network services).
- **Medicare bad debt**
  - When furnishing services to a Medicare beneficiary, a provider incurs costs in furnishing such covered services. A Medicare beneficiary may be responsible for paying a share of those costs as part of their applicable deductible and/or coinsurance amounts. When a Medicare beneficiary, or other responsible party, fails to pay the deductible and/or coinsurance amounts, the provider has incurred costs of furnishing services that are unrecovered. If the unpaid deductible and coinsurance amounts meet the criteria of 42 CFR 413.89, then these amounts may be allowable as Medicare bad debt. Amounts reimbursed as a Medicare bad debt cannot be claimed as charity care. Non-Medicare bad debt--Charges for health services for which a hospital determines the non-Medicare patient has a financial responsibility to pay, but the non-Medicare patient does not pay. These amounts are subject to the cost-to-charge ratio (CCR). (Additional guidance provided in the instructions for lines 28 and 29.)
- **Nonreimbursable Medicare bad debt**
  - The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but not reimbursed by Medicare under the requirements of 42 CFR 413.89(h). (Additional guidance provided in the instructions for lines 27 and 27.01.) Net revenue--Actual payments received or expected to be received from a payer (including coinsurance payments from the patient) for services delivered during this cost reporting period. Net revenue will typically be charges (gross revenue) less contractual allowance. (Applies to lines 2, 9, and 13.) Public Programs--Federal, State, and/or local government programs paying, in full or in part, for health care (e.g., Medicare, Medicaid, CHIP and/or other Federal, State, or locally operated programs). Uncompensated care--Consists of charity care and uninsured discounts, non-Medicare bad debt, and nonreimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances, discounts given to patients that do not meet the hospital's charity care policy, or discounts given to uninsured patients that do not meet the hospital's FAP, or bad debt reimbursed by Medicare. Rev. 18

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Worksheet S-10

12-22 FORM CMS-2552-10 4090 (Cont.)

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET S-10 *PART I*

PART I - HOSPITAL AND HOSPITAL COMPLEX DATA

Uncompensated and Indigent Care *Cost-to-Charge Ratio*			
1	Cost to charge ratio *(see instructions)*		1
Medicaid (see instructions for each line)			
2	Net revenue from Medicaid		2
3	Did you receive DSH or supplemental payments from Medicaid?		3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges		6
7	Medicaid cost (line 1 times line 6)		7
8	Difference between net revenue and costs for Medicaid program *(see instructions)*		8
Children's Health Insurance Program (CHIP) (see instructions for each line)			
9	Net revenue from stand-alone CHIP		9
10	Stand-alone CHIP charges		10
11	Stand-alone CHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone CHIP *(see instructions)*		12
Other state or local government indigent care program (see instructions for each line)			
13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program *(see instructions)*		16
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)			
17	Private grants, donations, or endowment income restricted to funding charity care		17
18	Government grants, appropriations or transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, CHIP, and state and local indigent care programs (sum of lines 8, 12, and 16)		19
Uncompensated *care cost* (see instructions for each line)			

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Worksheet S-10

Uncompensated *care cost* (see instructions for each line)

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured *discounts (see instructions)*				20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)				21
	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (*see instructions*)				23
24	Does the amount on line 20, *col.* 2, include charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program?				24
25	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length-of-stay limit (see instructions)				25
25.01	*Charges for insured patients' liability (see instructions)*				*25.01*
26	*Bad debt amount (see instructions)*				26
27	*Medicare reimbursable bad debts (see instructions)*				27
27.01	*Medicare allowable bad debts (see instructions)*				27.01
28	Non-Medicare bad debt *amount* (see instructions)				28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt *amounts* (see instructions)				29
30	Cost of uncompensated care (line 23, *col.* 3, plus line 29)				30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31

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Worksheet S-10

Examples for the Worksheet S-10, Uncompensated and Indigent Care Data

- Assume the following facts: A hospital has a charity care policy which determines charity care on a “sliding scale” basis and may forgive anywhere from 25% to 100% of the patient’s liability. An insured patient owes the hospital $100 for a deductible on an allowable hospital service. The insured patient applies for charity care and the hospital determines that they qualify for charity care at 25%.

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Worksheet S-10

- **Example 1: Unpaid Insured Patient's Liability**
  - The hospital deems $25 of the patient's $100 liability as charity care and records this $25 on line 20, column 2. The remaining $75 is a patient liability. The $75 remaining patient liability may subsequently be determined by the hospital to be classified as charity care or a hospital bad debt, but not both. (It is generally assumed that insured persons are not eligible for charity care, however an insured person can qualify for charity care for the portion of the charges that represents the patient liability pursuant to the hospital's charity care policy).
- **Example 2: Partial Payment of Insured Patient's Liability**
  - The hospital deems $25 of the patient's $100 liability as charity care and records this $25 on line 20, column 2. The patient pays $35 of the $75 patient liability. The hospital can determine the remaining $40 patient liability to qualify as charity care or a bad debt, but not both. If the $40 is determined to be charity care, it is recorded on line 20, column 2. If it is determined to be a bad debt, it is recorded on line 26 as a hospital bad debt.
- **Example 3: Partial Payment of Insured Patient's Liability, a Medicare Beneficiary**
  - The hospital deems $25 of the patient's $100 liability as charity care and records this $25 on line 20, column 2. The hospital makes reasonable collection efforts to collect the remaining $75 patient liability. The patient pays $35 of the $75 patient liability. The hospital determines the unpaid $40 patient liability to be a Medicare bad debt. The $40 unpaid patient liability would be recorded on line 26 as a hospital bad debt and be reflected on line 27.01 as the Medicare allowable bad debt. The Medicare reimbursable bad debt, $26, would be reflected on line 27 (assuming a 65% bad debt limitation pursuant to 42 CFR 413.89(h)).

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Worksheet S-10

- **Example 4: Uninsured Patient, Sliding Scale Charity Care, Partial Payment of Patient Liability with Remaining Amount of Patient Liability Unpaid**
  - An uninsured patient owes the hospital $1,000 for an allowable hospital service. The patient applies for charity care, and the hospital determines that the uninsured patient qualifies for charity care at 60%.
  - The hospital records the $600 charity care amount on line 20, column 1. The remaining $400 is the patient's liability.
  - The uninsured patient pays $100 toward his liability.
  - If the patient does not pay the remaining $300 and the hospital determines the unpaid patient liability to be a bad debt, the hospital would record the $300 on line 26 as a hospital bad debt.
  - The $100 payment made by the patient does not get recorded anywhere on the Worksheet S-10 because it was not a payment toward the amount deemed charity care; it was a payment toward the noncharity care patient liability.

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Worksheet S-10

- **Example 5: Uninsured Patient Qualifies to Receive an Uninsured Patient Discount Pursuant to Hospital's FAP**
  - An uninsured patient owes the hospital $100 for an allowable hospital service. The uninsured patient does not qualify for charity care. The hospital has a FAP which automatically gives a 30% discount to all uninsured patients who meet the hospital's FAP. The uninsured patient meets the hospital's FAP
  - The hospital writes off $30 as an uninsured discount on line 20, column 1. The remaining $70 is a patient liability.
  - If the $70 patient liability remains uncollected and the hospital determines it to be a bad debt, it is recorded on line 26 as a hospital bad debt.

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Worksheet S-10

12-22 FORM CMS-2552-10 4090 (Cont.)

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1	Cost to charge ratio *(see instructions)*		1
Medicaid (see instructions for each line)			
2	Net revenue from Medicaid		2
3	Did you receive DSH or supplemental payments from Medicaid?		3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges		6
7	Medicaid cost (line 1 times line 6)		7
8	Difference between net revenue and costs for Medicaid program *(see instructions)*		8
Children's Health Insurance Program (CHIP) (see instructions for each line)			
9	Net revenue from stand-alone CHIP		9
10	Stand-alone CHIP charges		10
11	Stand-alone CHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone CHIP *(see instructions)*		12
Other state or local government indigent care program (see instructions for each line)			
13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program *(see instructions)*		16
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)			
17	Private grants, donations, or endowment income restricted to funding charity care		17
18	Government grants, appropriations or transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, CHIP, and state and local indigent care programs (sum of lines 8, 12, and 16)		19
Uncompensated *care cost* (see instructions for each line)			

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Worksheet S-10

	Uncompensated *care cost* (see instructions for each line)	Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured *discounts (see instructions)*				20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)				21
	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (*see instructions*)				23
24	Does the amount on line 20, *col.* 2, include charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program?				24
25	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length-of-stay limit (see instructions)				25
25.01	*Charges for insured patients' liability (see instructions)*				*25.01*
26	*Bad debt amount (see instructions)*				26
27	*Medicare reimbursable bad debts (see instructions)*				27
27.01	*Medicare allowable bad debts (see instructions)*				27.01
28	Non-Medicare bad debt *amount* (see instructions)				28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt *amounts* (see instructions)				29
30	Cost of uncompensated care (line 23, *col.* 3, plus line 29)				30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31

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Worksheet S-10

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | *PROVIDER CCN:* | *PERIOD: FROM ____ TO ____* | *WORKSHEET S-10, PART II*

PART II - HOSPITAL DATA

	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1	*Cost to charge ratio (see instructions)*		*1*
	Medicaid (see instructions for each line)		
2	*Net revenue from Medicaid*		*2*
3	*Did you receive DSH or supplemental payments from Medicaid?*		*3*
4	*If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?*		*4*
5	*If line 4 is no, enter DSH and/or supplemental payments from Medicaid*		*5*
6	*Medicaid charges*		*6*
7	*Medicaid cost (line 1 times line 6)*		*7*
8	*Difference between net revenue and costs for Medicaid program (see instructions)*		*8*
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9	*Net revenue from stand-alone CHIP*		*9*
10	*Stand-alone CHIP charges*		*10*
11	*Stand-alone CHIP cost (line 1 times line 10)*		*11*
12	*Difference between net revenue and costs for stand-alone CHIP (see instructions)*		*12*
	Other state or local government indigent care program (see instructions for each line)		
13	*Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)*		*13*
14	*Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)*		*14*
15	*State or local indigent care program cost (line 1 times line 14)*		*15*
16	*Difference between net revenue and costs for state or local indigent care program (see instructions)*		*16*
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17	*Private grants, donations, or endowment income restricted to funding charity care*		*17*
18	*Government grants, appropriations or transfers for support of hospital operations*		*18*
19	*Total unreimbursed cost for Medicaid, CHIP, and state and local indigent care programs (sum of lines 8, 12, and 16)*		*19*

Uncompensated care cost (see instructions for each line)

		Uninsured	Insured	Total	

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Worksheet S-10

Uncompensated care cost (see instructions for each line)

		Uninsured Patients	Insured Patients	Total (col. 1 + col. 2)
		1	2	3
20	Charity care charges and uninsured discounts (see instructions)			
21	Cost of patients approved for charity care and uninsured discounts (see instructions)			
22	Payments received from patients for amounts previously written off as charity care			
23	Cost of charity care (see instructions)			
24	Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program?			
25	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length-of-stay limit (see instructions)			
25.01	Charges for insured patients' liability (see instructions)			
26	Bad debt amount (see instructions)			
27	Medicare reimbursable bad debts (see instructions)			
27.01	Medicare allowable bad debts (see instructions)			
28	Non-Medicare bad debt amount (see instructions)			
29	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			
30	Cost of uncompensated care (line 23, col. 3, plus line 29)			
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			

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Medicare Bad Debts

Allowable bad debts (see instructions)
Adjusted reimbursable bad debts (see instructions)
Allowable bad debts for dual eligible beneficiaries (see instructions)
Subtotal (line 61 plus line 65 minus lines 62 and 63)

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Medicare Bad Debts

- **Reasonable collection efforts**
  - Providers must issue the first bill within 120 days of the latter:
    - Medicare remittance.
    - Remittance advice from the beneficiary's secondary payer.
    - Notification that the beneficiary's secondary payer.
  - Bad debt billing outside the above timeframe could result in adjustments disallowing bad debts.

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Medicare Bad Debts

- **Bad debt log checklist**
  - Nonduplicated accounts not previously claimed deductible and coinsurance only
  - Bad debt is net of any payments received from the beneficiary or other third-party payers
  - Coinsurance related to physician Part B professional services or outpatient fee-based services is not included
  - For inpatient dual eligible bad debts, ensure that Medicaid is billed timely and a remittance advice showing payment, or a valid rejection is available for our review.
  - Indigent bad debt claims are fully
  - Non-indigent, non-dual eligible accounts ensure that collection activity is documented in the file
  - Deceased patients, ensure that the determination that there was no estate available is fully documented

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Medicare Bad Debts

4004.2 (Cont.) FORM CMS-2552-10 12-22

EXHIBIT 2

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER NAME _____ PREPARED BY _____
CCN _____ DATE PREPARED _____
FYE _____ INPATIENT ____ OUTPATIENT _____

(1) Patient Name	(2) HICN / MBI	(3) DATES OF SERVICE FROM	TO	(4) INDIGENCY & MEDICAID BENEFICIARY (CK IF APPL) YES	MEDICAID NUMBER	(5) DATE FIRST BILL SENT TO BENE-FICIARY	(6) DATE COLLECTION EFFORTS CEASED	(7) MEDICARE REMITTANCE ADVICE DATES	(8)* DEDUCT	(9)* CO-INS	(10) TOTAL

* THESES AMOUNTS MUST NOT BE CLAIMED UNLESS THE PROVIDER BILLS FOR THESE SERVICES WITH THE INTENTION OF PAYMENT. SEE INSTRUCTIONS FOR COLUMN 4 - INDIGENCY/MEDICAID BENEFICIARY, FOR POSSIBLE EXCEPTION.

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Medicare Bad Debts

EXHIBIT 2A

TITLE	*MEDICARE BAD DEBTS*
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 23	
TOTAL DUAL ELIGIBLE	

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/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*

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Medicare Bad Debts & S-10 variation

- **Reimbursable Medicare bad debt guidance**
  - The CFR at 42 CFR 413.89(f) requires that the uncollectible Medicare deductible and coinsurance be charged off as bad debts in the accounting period when the bad debt is determined to be worthless. For example, a bad debt that is properly written off the providers books as a bad debt after the providers current Medicare Fiscal Year End Cost Report must be claimed on the next Medicare cost report even if the provider has not filed their most recent cost report because it is not yet due.
  - Before claiming the unpaid amounts as a Medicare bad debt, cease all collection efforts, including the collection agency efforts, and ensure that the collection accounts have been returned to the provider from the agency.
- **Bad debt guidance for S-10**
  - enter the amount of bad debts (Medicare bad debts and non-Medicare bad debts), net of recoveries, written off during this cost reporting period on balances owed by patients for the entire facility regardless of the date of service.

- Complete a separate exhibit for the hospital and each component of the hospital complex (each CCN) and, on each listing, report only the data related to inpatient and outpatient services billed under that CCN. The sum of the amounts in column 17 for all the CCNs of the hospital complex bad debt listings must correspond to the amount reported on Worksheet S-10, Part I, line 26. The sum of the amounts in column 17 for the hospital CCN bad debt listing must correspond to the amount reported on Worksheet S-10, Part II, line 26. The bad debt of a Medicare beneficiary may be included on this listing even when their unpaid deductible and coinsurance amounts do not meet the Medicare bad debt criteria for inclusion on the Medicare bad debt listing (not included on Worksheet E, Parts A or B) for this cost reporting period.

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