August 25, 2026

# Medicare Bad Debt, Worksheet S-10, and DSH in Practice

# Agenda

Introduction

In practice: MBD, Worksheet S-10 & DSH

Worksheet S-12

Recap

Introduction

# Meet the presenter

Emily
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R1 Government Navigation

Julie
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Vice President,
R1 Government Navigation

# Introduction

Introduction

# Medicare cost report timeline

## 2025

Fiscal year end 12/31/2025

## 2026

- Medicare cost report typically due 5/31/2026

  Payable due 100% with filing / receivable fully or partially paid at tentative settlement

Tentative settlement typically completed/paid within ~90 days of filing

- Request amendment any time up to when the MAC desk review/audit begins

## 2028

MAC desk review/audit generally 1-3 years after filing (could be longer)

Issues Notice of Program Reimbursement (NPR) / Final settlement occurs

## 2028-2031

- Re-opening window is 3 years from the date of the NPR, SSI redeterminations currently excluded

MAC accepts/denies re-opening request

MAC or CMS can re-open with no time limit for alleged fraud/abuse

## 2032-2033

MAC desk reviews/audits re-opening and issues a Revised NPR (RNPR)

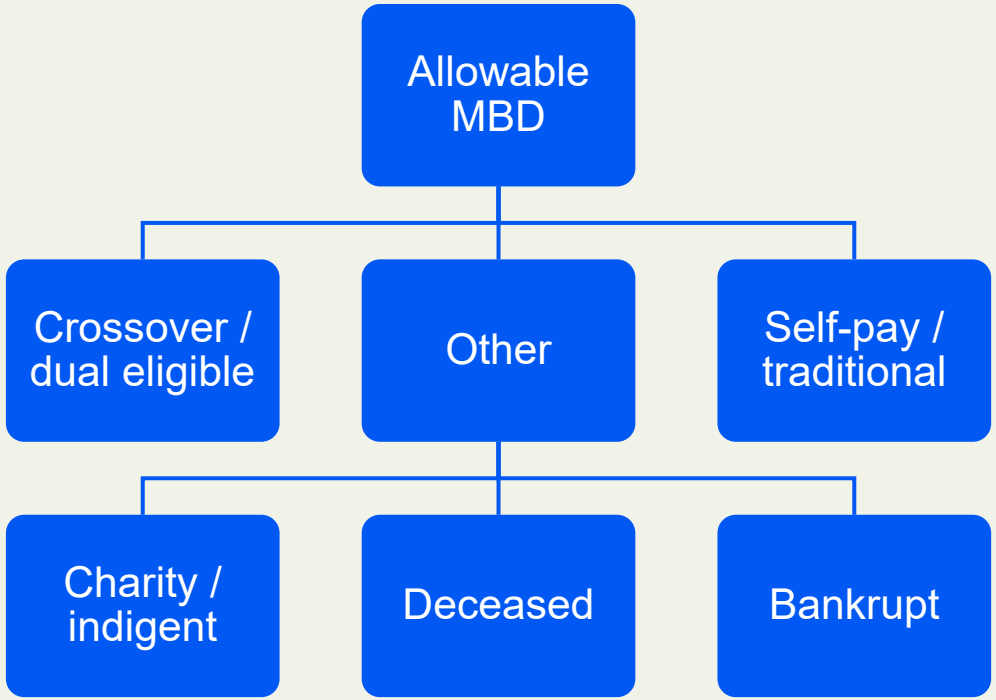
**Review opportunities** ◆ Prospective reviews ◆ Retrospective reviews

# In practice: Medicare Bad Debt

Introduction

# Medicare bad debt (MBD)

**Definition:** Medicare deductible and coinsurance (D&C) amounts that are *unpaid* and *uncollectible* from a patient will be reimbursed to the hospital by Medicare at 65% as a **cost report settlement**




## General criteria for allowable MBD:

- Debt must be related to Medicare covered services and derived from Medicare D&C amounts
- The provider must be able to establish that reasonable and genuine collection efforts were made
- The debt was actually uncollectible when deemed worthless
- Sound business judgment establishes that there is no likelihood of recovery in the future

However, there are many nuances in the allowable Medicare bad debt criteria based on types and circumstances.

In practice

# Allowable crossover – dual eligible

## Criteria - attributes

1. Crossovers can be claimed for both traditional Medicare and Medicare HMO's
   - Traditional MBD is claimed on the cost report
   - Medicare HMO contracts will determine if they will pay for bad debts; normally have varying criteria for what is allowable
2. Account must be Medicare primary ***and*** Medicaid/Medicaid HMO secondary to include on the cost report
3. For Medicare HMO accounts – must be Medicare HMO primary/Medicaid/Medicaid HMO secondary
4. Remittance must have a status code of 2 or 3 (Paid or Tertiary)
   - Status code 4 is denied and not allowable
   - CARCs 23 or 45 are allowable
     - Caid HMO CARC's vary
5. Only transactions mapped to Net Reduction of Revenue/Implicit Price Concession are allowable
   - Contractual W/O codes are not allowable

In practice

# Allowable crossover – dual eligible

## Revenue cycle importance

1. Ensuring Medicaid/Medicaid HMO is billed timely after Medicare
   - Any issues with the billing is followed up on timely
2. Account is reviewed for applicable CARC codes that are allowable for MBD
   - Non-allowable CARC codes on remits will be adjusted at audit
3. At write off, the correct transaction code (NOT CONTRACTUAL) is used
   - Any accounts found with a contractual write off will be adjusted but could also be extrapolated to the full population, resulting in a larger adjustment

In practice

# Allowable traditional self-pay

## Criteria - attributes

1. Accounts that are Medicare primary and self-pay secondary (can include commercial secondary)
   - *Medicare and Non-Medicare have to be treated the same*

2. Typically sent to a collection agency for collection efforts

3. Accounts that have followed the self-pay policies and adhere to Medicare regulations are allowable
   - Per Medicare regulations, the account has to be timely billed within 120 days of the last Medicare remit
   - A reasonable collection effort has to be made on the account; 120 days at a minimum
   - Hospitals typically have their own set of policies and procedures for collecting on these accounts
     - Medicare HMO contracts will determine if they will pay for bad debts; normally have varying criteria for what is allowable

4. Can only be claimed on the cost report when they are returned from the agency

In practice

# Allowable traditional self-pay

## Revenue cycle importance

1. Work with your teams on timely billing to ensure accounts are allowable for MBD
   - Whether in house collection efforts or using an early out
2. Know your collection agencies and contract
   - Ensure the agencies are following your policies and procedures
     - Keeping accounts for allotted time and returning timely
3. Perform periodic reconciliations with collection agencies to ensure accounts are not being kept longer than necessary, or not staying at the agency long enough to adhere to your policies
4. When accounts are closed and returned, ensure the write off or note within the system is entered timely
   - MAC auditors will review to ensure it is within a reasonable amount of time; and does not cross over FY's

In practice

# Indigent – charity / financial assistance

## Criteria - attributes

1. Accounts that are Medicare primary and qualify for the hospital's Charity / Financial Assistance Polices

2. Hospitals can claim traditional charity / financial assistance only if they have the following support:
   - A complete charity / financial assistance application that includes:
     - Asset test and income verification, at a minimum
     - Applicable dates of acceptance
       - Includes the level/percentage of charity approval
     - Signature and dates, from both patient and hospital representative

3. Presumptive charity is NOT allowable to claim as MBD

In practice

# Indigent – charity / financial assistance

## Revenue cycle importance

1. Gathering necessary COMPLETED documentation per FA policy
   - Asset test (bank statements) have to be a part of the FA policy in order to allowable for MBD
   - If patient does not have bank account, having a signed attestation from client and signatures from patient and hospital representative, may be allowable
2. Important to house scanned documents and make them available during audit
   - Incomplete support will result in adjustments during audit
3. Important to treat patient as self-pay prior to establishing indigency and send statements to patient
4. Presumptive charity is NOT allowable

In practice

# Indigent – deceased

## Criteria - attributes

1. Hospitals can claim deceased patients only if they have the following support:
   - Verification of no probate / estate near the date of write off
   - Support must be auditable
     - Print screen from online source; support from probate vendor
   - A note in the account is no longer acceptable
2. If account was sent to collection agency and returned as deceased, probate still has to be checked in order to be allowable

In practice

# Indigent – deceased

## Revenue cycle importance

1. Ensure there are internal policies and procedures for handling deceased patients
   - A separate transaction code should be created for deceased accounts
   - Write off to deceased needs to be done timely with estate search

2. Policies should address probate and estate searches
   - If done in house, support must be scanned and auditable
   - If using a vendor, they should be able to provide the support

In practice

# Indigent – bankruptcy

## Criteria - attributes

1. Hospitals can claim patients that have filed for bankruptcy and they have had their debt discharged
   - The debt has to be discharged and patient hasn't just filed for bankruptcy
   - Support must be auditable
     - A court document showing the debtor discharge
     - A printout from Pacer.gov
       - Both must list the hospital as a creditor
2. If account was sent to collection agency and returned as bankrupt, discharge of debt still has to be checked in order to be allowable

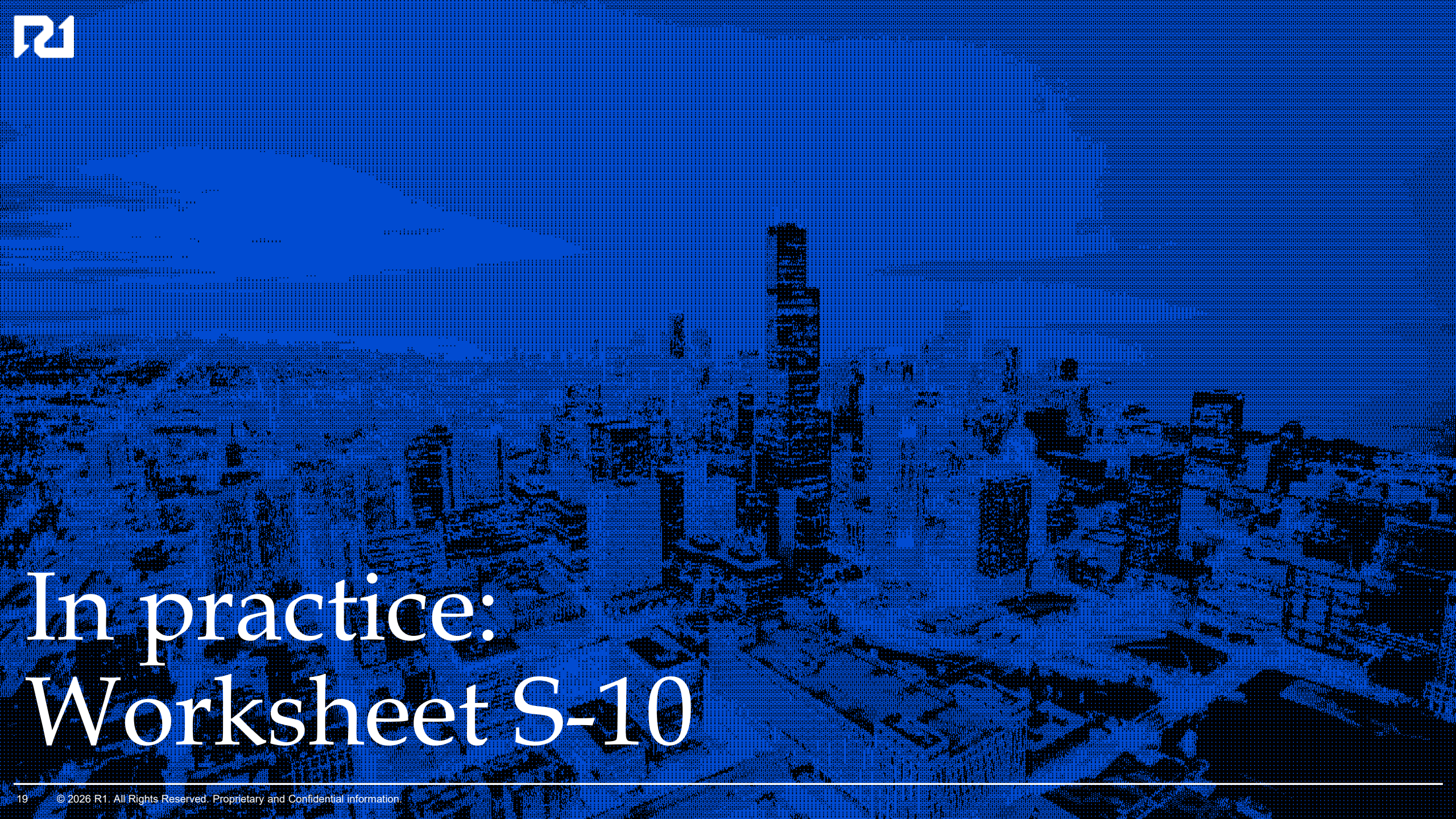
In practice

# Indigent – bankruptcy

## Revenue cycle importance

1. While the volume of the bankruptcy accounts are not usually material, every dollar counts!

2. Ensure there are internal policies and procedures for handling bankruptcy patients
   - A separate transaction code should be created for bankruptcy accounts
   - Write off to bankruptcy needs to be done timely with discharge of debt



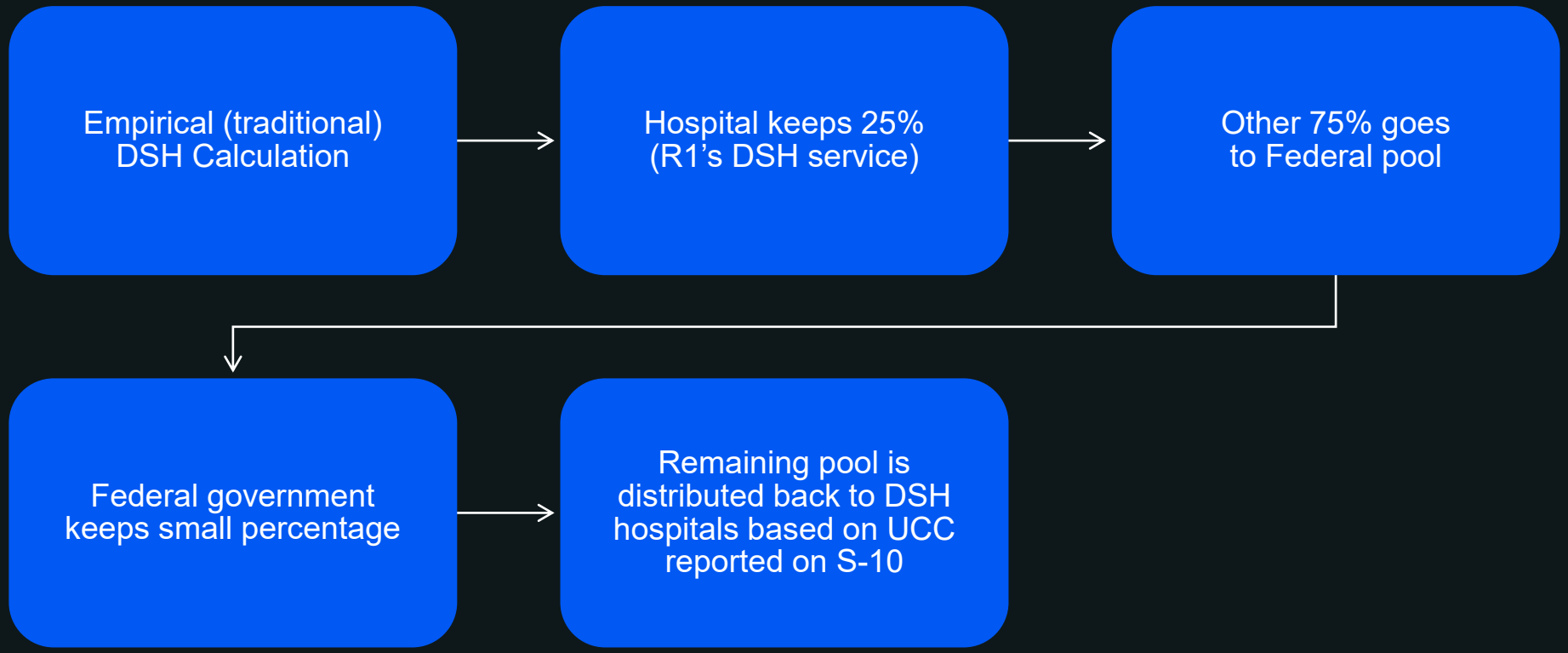
# In practice: Worksheet S-10

Introduction

# What is S-10?

- All hospitals are required to report Uncompensated Care on Worksheet S-10 of the Medicare Cost Report
  - Uncompensated care = total charity care + total bad debt (all payers)
  - Should reconcile to the hospital's audited financial statements (within a reasonable percentage variance < 5%)
- Non-DSH hospitals – Worksheet S-10 is informational only
- Disproportionate Share Hospitals (DSH) – Worksheet S-10 matters!

# S-10 determines 75% of total overall DSH payments for DSH hospitals



Introduction

# Worksheet S-10 timeline

## 2024

Fiscal year end 12/31/2024

## 2025

- Worksheet S-10 typically due 5/31/2025

## 2026

**January / February:**
MAC audit letters typically sent to providers

**March / April:**
MAC sending questions; samples selected and support sent

**December 31:**
All audits have to be completed by end of the year

## 2028*

Uncompensated care payment date effective 10/1/2027*

Will be used for 3 or more years on a rolling basis*

**Review opportunities**

- Prospective reviews




*Estimate based on historical CMS decisions; subject to changes on the base cost report years for future rulemaking

In practice

# Charity care – insured

## Criteria - attributes

1. Patient has a primary insurance but qualifies for the hospital's charity/financial assistance for their remaining portion of responsibility
2. Third party payment and/or contractual adjustment is present in the patient account detail
3. Remittance advice clearly states the patient's financial responsibility
   - Coinsurance, deductible or co-pay amounts
4. Account must balance on Exhibit 3B
   - Total charges – payments/adjustments >/= write off amount
5. Unlike MBD – Presumptive Charity is allowed!
   - Language regarding presumptive charity must be included in the policies and procedures

In practice

# Charity care – insured

## Revenue cycle importance

1. Ensuring charity and financial assistance policies are current and up to date
   - Be specific to include language if patients with insurance are eligible for charity care
2. Verify before writing off the account that the amount is attributed to only the patient responsibility
   - If amount is greater and does not match remit amounts, could be an error at audit
3. If presumptive charity is approved for patient, ensure the write off is to a separate presumptive charity write off code
4. Perform periodic checks of charity policies to ensure they are updated to reflect any current regulatory updates and ensure the teams are following the policies and procedures

In practice

# Charity care – uninsured

## Criteria - attributes

1. Patient has no primary insurance and is truly self-pay
   - Qualifies for the hospital's charity/financial assistance using their criteria for indigency
2. Any uninsured discount for uninsured patients is addressed in the policy
3. Account should not have any insurance payments
   - Patient payments can be made on these accounts
4. Account must balance on Exhibit 3B
   - Total charges – payments/adjustments >/= write off amount
5. Unlike MBD – Presumptive Charity is allowed!
   - Language regarding presumptive charity must be included in the policies and procedures

In practice

# Charity care – uninsured

## Revenue cycle importance

1. Verify no other payors before deeming as uninsured

2. Ensure the write off reconciles to the agreed upon percentage and adheres to your policies
   - If there is a sliding scale, or AGB (Amount Generally Billed) applied, ensure the write off is not exceeding these agreed upon amounts

3. If presumptive charity is approved for patient, ensure the write off is to a separate presumptive charity write off code

4. Perform periodic checks of charity policies to ensure they are updated to reflect any current regulatory updates and ensure the teams are following the policies and procedures

In practice

# Total hospital bad debt

## Criteria – attributes

1. Accounts that are both insured and uninsured are included in total bad debts and go on line 26

2. Amounts claimed are the patient responsibility.  This can include:
   - Deductible, coinsurance, co-pays, noncovered charges and lapse of coverage

3. Accounts are claimed when they are sent to bad debt – AR to BD
   - Unlike MBD, when the account is claimed when returned from the collection agency

4. Includes not only traditional self-pay bad debt but also includes the crossover accounts
   - No contractual write offs should be included

5. Recoveries from the current and prior years' bad debts claimed need to be netted against the total

In practice

# Total hospital bad debt

## Revenue cycle importance

1. Verify all insurances and ensure they are properly billed
2. Verify that all payments are posted correctly and at an account level
   - This helps to ensure proper recoveries in the current year, as well as for accounts claimed in prior years
3. Clearly support the write off date and amount that is going to the collection agency
4. Work with your teams to ensure the proper bad debt policies and procedures are being followed
   - This will help to reduce any potential errors noted during audit
5. Perform periodic checks of collection policies to ensure they are updated to reflect any current regulatory updates and ensure the teams are following the policies and procedures

# In practice: DSH

Introduction

# Disproportionate Share Hospital (DSH) payments

Definition: DSH is an add-on payment for qualifying hospitals that provide services to a ‘disproportionate share’ of low-income patients

**Supplemental Security Income (SSI) fraction / Medicare fraction**

$$\frac{\text{Medicare SSI days}}{\text{Total Medicare days}}$$

+

**Medicaid fraction**

$$\frac{\text{Medicaid eligible (non-Medicare) days}}{\text{Total patient days}}$$

=

**Must equal 15% or more**

DSH patient percentage

- Once a hospital reaches the qualifying 15% threshold, the allowable DSH payment is calculated through a series of complex formulas
- Pre-Affordable Care Act (ACA) – hospitals kept 100% of their DSH payment
- Post-ACA – 10/1/2013 – hospital keep 25% of their DSH payment

But DSH eligibility impacts qualification of **other reimbursement programs** like 340B and Worksheet S-10

Introduction

# 340B eligibility - Hospital

**To qualify for the 340B Drug Discount Program, you must:**

- Be a private nonprofit or public hospital (for-profit hospitals not eligible)
- Have a disproportionate share adjustment percentage for the most-recently filed cost report based on the hospital's CMS classification status (see table below):

Note:

- **Not all 340B qualifications are the same!** (e.g., 340B qualifications via RRC, SCH, CAH, and freestanding cancer hospital pathways are prohibited from purchasing orphan drugs at 340B discounted prices).
- Once a hospital is eligible, 340B registration occurs on a quarterly basis (e.g., register January 1-15 effective April 1st)
- Recertification of 340B eligibility occurs annually

| DSH | Rural Referral Center (RRC) | Sole Community Hospital (SCH) | Critical Access Hospital (CAH) | Children's Hospital* | Freestanding Cancer Hospital* |
|---|---|---|---|---|---|
| > 11.75% | ≥8% | ≥8% | Not applicable | > 11.75% | > 11.75% |

An amended Medicare cost report may be used prospectively for 340B eligibility if it is the most recently filed report accepted by CMS; **it cannot be applied retroactively.**




*Also subject to a separate indigent care calculation

In practice

# Covenant Medical Center v. Kennedy

## (District Court, Northern District of Texas)

**Ruling Date**: 7/27/2026

**Topic:** Exclusion Rule promulgated in the 2024 IPPS Final Rule.  It was a regulation that excluded inpatient days covered by an uncompensated care funding pool when counting Medicaid Days in the DSH payment calculation.

**Winner:** Hospitals.  Specifically in Florida, Kansas, Massachusetts, New Mexico, Tennessee, and Texas

**Ruling:** Once the U.S. Department of Health and Human Services Secretary approves a 1115 demonstration project, the resulting patient days must be counted in the Medicaid Fraction's numerator. The Secretary cannot, by subsequent rulemaking, retroactively withdraw the approval's payment consequences.

"No take-backs".

**Result:** Vacatur applies nationwide. Hospitals should re-evaluate cost report protest positions, appeal recent settlements, and amend open cost reports.

In practice

# Strategies around SSI percentage

## SSI

1. What is the guidance for cost report filing?
   - Most recently released SSI
     - This frequently is an SSI from the previous fiscal year but is the most recently released value
       - Example: Filing your 12/31/2025 cost report with the FFY 2024 SSI

2. SSI realignment
   - You can request to change your SSI to match your cost report fiscal year rather than the federal fiscal year
   - This strategy is meaningful for benefitting your overall DSH reimbursement but will not occur timely for 340B registration

In practice

# Strategies around total days

## Total day review

1. Total day criteria
   - Apply same method used for counting Medicaid days
   - Admit, discharge or census

2. Inpatient stay rebilled as outpatient
   - Insurance denied claim and hospital agrees stay did not warrant inpatient care

3. Only inpatient acute days
   - Remove subacute (psych, rehab, other)

In practice

# Filing early or mid-year review

## Different view of filing

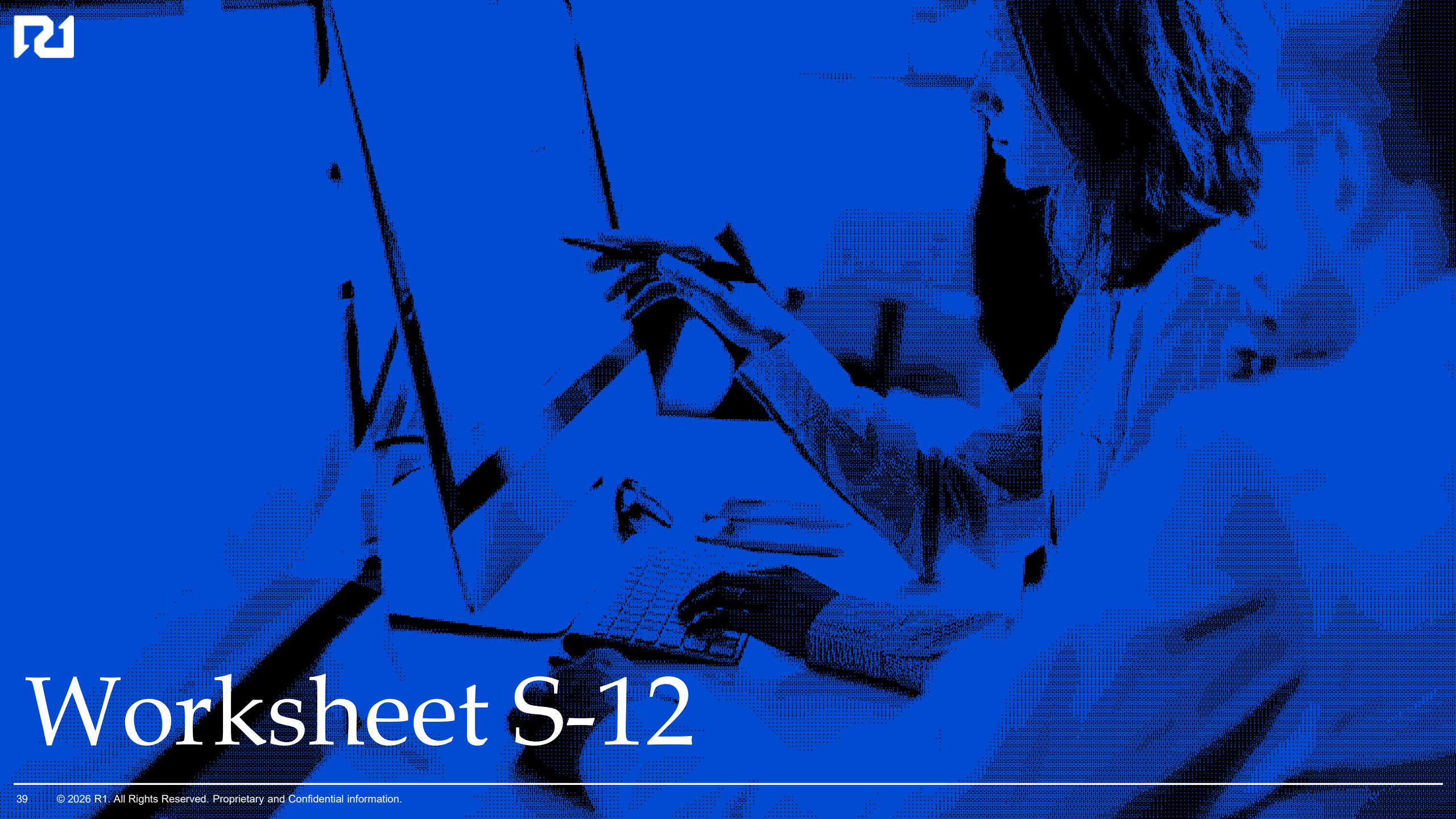
1. File early
   - If your hospital qualifies using most recently filed SSI
2. If filing early, be careful
   - Possibility of missing retroactive Medicaid eligible days
3. Mid-year review
   - Six- or nine-month review for peace of mind

In practice

# Working together

## The perfect Medicaid fraction

1. Capture items that maximize eligibility results
   - Medicaid IDs
   - SSN
2. Pay closer attention to total IP acute days
   - Review denominator to ensure no observation or outpatient days
3. Every possible Title XIX day
   - Home state, surrounding states, all states
4. Following the regulations
   - Rules around newborns
5. Double check revenue codes
   - Patient stays can include both subacute and acute units



# Worksheet S-12

# Worksheet S-12: A new cost reporting requirement

## What it requires

- New filing for cost reporting periods ending on or after January 1, 2026
- First new S worksheet since 2016
- Combines Medicare cost reporting with price transparency and claims data
- Reports the weighted median negotiated charge per Medicare Advantage plan for each MS-DRG
- CMS estimates about 20 hours to complete

## Why CMS requires it

- Today, IPPS weights come from hospital charges and cost-to-charge ratios
- CMS is shifting to a market-based approach
- From FY 2029, this charge data helps recalibrate MS-DRG weights
- IPPS stays budget-neutral, but payments redistribute across MS-DRGs over time

## Who must file

- General acute care hospitals subject to IPPS (i.e., Subsection (d) hospitals)
- Incomplete worksheet means the cost report is rejected

**Exempt from filing:**

- Critical access and rural emergency hospitals
- Hospitals paid only non-negotiated rates (e.g., Indian Health Service, Maryland Total Cost of Care Model)

Worksheet S-12

# Preparing for Worksheet S-12

## The process and data sources

- Pull MS-DRG negotiated charges from the MRF
- Count MA discharges by plan and MS-DRG
- Take the median charge, weighted by discharges

Draws on several sources:

- Machine Readable File (MRF)
- Patient accounting or claims systems
- MA contract information
- MS-DRG assignment data

## Common challenges

Pressure-test the MRF before relying on it:

- Is the MRF current and 2026-compliant?
- Are all contracted MA plans listed?
- Do 835 remit files support the percentiles?
- Do MAO names match across systems?

Be ready to defend your data and methods.

## What hospitals can do now

Start now — it's cross-functional:

- Confirm applicability and get organized
- Validate the MRF against 2026 rules
- Run dry-run calculations for reasonableness
- Confirm alignment across MRF, cost report, and claims
- Document assumptions and methods

# Worksheet S-12

| Provider CCN: | Period: From: To: | Run Date Time: 8/13/2026 12:21 pm MCRIF32 Version: **2552-10** 26.1.181.1 |
|---|---|---|

WEIGHTED MEDIAN MEDICARE ADVANTAGE ORGANIZATION PAYER-SPECIFIC NEGOTIATED CHARGE DATA

**Worksheet S-12**

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORTING PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-1486
EXPIRES 01-31-2029

| | MS-DRG | MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) TITLE | CHARGE | |
|---|---|---|---|---|
| | | | 1.00 | |
| 1.00 | 001 | HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITH MCC | 1.00 | 1.00 |
| 2.00 | 002 | HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITHOUT MCC | 1.00 | 2.00 |
| 3.00 | 003 | ECMO OR TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCEPT FACE, MOUTH AND NECK WITH MAJOR O.R. PROCEDURES | 1.00 | 3.00 |
| 4.00 | 004 | TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCEPT FACE, MOUTH AND NECK WITHOUT MAJOR O.R. PROCEDURES | 1.00 | 4.00 |
| 5.00 | 005 | LIVER TRANSPLANT WITH MCC OR INTESTINAL TRANSPLANT | 1.00 | 5.00 |
| 6.00 | 006 | LIVER TRANSPLANT WITHOUT MCC | 1.00 | 6.00 |
| 7.00 | 007 | LUNG TRANSPLANT | 1.00 | 7.00 |
| 8.00 | 008 | SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT | 1.00 | 8.00 |
| 10.00 | 010 | PANCREAS TRANSPLANT | 1.00 | 10.00 |
| 11.00 | 011 | TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITH MCC | 1.00 | 11.00 |
| 12.00 | 012 | TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITH CC | 1.00 | 12.00 |
| 13.00 | 013 | TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY WITHOUT CC/MCC | 1.00 | 13.00 |
| 14.00 | 014 | ALLOGENEIC BONE MARROW TRANSPLANT | 1.00 | 14.00 |
| 16.00 | 016 | AUTOLOGOUS BONE MARROW TRANSPLANT WITH CC/MCC | 1.00 | 16.00 |
| 17.00 | 017 | AUTOLOGOUS BONE MARROW TRANSPLANT WITHOUT CC/MCC | 1.00 | 17.00 |
| 18.00 | 018 | CHIMERIC ANTIGEN RECEPTOR (CAR) T-CELL AND OTHER IMMUNOTHERAPIES | 1.00 | 18.00 |
| 19.00 | 019 | SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT WITH HEMODIALYSIS | 1.00 | 19.00 |
| 20.00 | 020 | INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITH MCC | 1.00 | 20.00 |
| 21.00 | 021 | INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITH CC | 1.00 | 21.00 |
| 22.00 | 022 | INTRACRANIAL VASCULAR PROCEDURES WITH PRINCIPAL DIAGNOSIS HEMORRHAGE WITHOUT CC/MCC | 1.00 | 22.00 |

# Worksheet S-12

| Provider CCN: | Period: From: To: | Run Date Time: 8/13/2026 12:21 pm MCRIF32 **2552-10** Version: 26.1.181.1 |
|---|---|---|

WEIGHTED MEDIAN MEDICARE ADVANTAGE ORGANIZATION PAYER-SPECIFIC NEGOTIATED CHARGE DATA

**Worksheet S-12**

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORTING PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-1486
EXPIRES 01-31-2029

| | MS-DRG | MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) TITLE | CHARGE | |
|---|---|---|---|---|
| | | | 1.00 | |
| 947.00 | 947 | SIGNS AND SYMPTOMS WITH MCC | 1.00 | 947.00 |
| 948.00 | 948 | SIGNS AND SYMPTOMS WITHOUT MCC | 1.00 | 948.00 |
| 949.00 | 949 | AFTERCARE WITH CC/MCC | 1.00 | 949.00 |
| 950.00 | 950 | AFTERCARE WITHOUT CC/MCC | 1.00 | 950.00 |
| 951.00 | 951 | OTHER FACTORS INFLUENCING HEALTH STATUS | 1.00 | 951.00 |
| 955.00 | 955 | CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA | 1.00 | 955.00 |
| 956.00 | 956 | LIMB REATTACHMENT, HIP AND FEMUR PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA | 1.00 | 956.00 |
| 957.00 | 957 | OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITH MCC | 1.00 | 957.00 |
| 958.00 | 958 | OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITH CC | 1.00 | 958.00 |
| 959.00 | 959 | OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITHOUT CC/MCC | 1.00 | 959.00 |
| 963.00 | 963 | OTHER MULTIPLE SIGNIFICANT TRAUMA WITH MCC | 1.00 | 963.00 |
| 964.00 | 964 | OTHER MULTIPLE SIGNIFICANT TRAUMA WITH CC | 1.00 | 964.00 |
| 965.00 | 965 | OTHER MULTIPLE SIGNIFICANT TRAUMA WITHOUT CC/MCC | 1.00 | 965.00 |
| 969.00 | 969 | HIV WITH EXTENSIVE O.R. PROCEDURES WITH MCC | 1.00 | 969.00 |
| 970.00 | 970 | HIV WITH EXTENSIVE O.R. PROCEDURES WITHOUT MCC | 1.00 | 970.00 |
| 974.00 | 974 | HIV WITH MAJOR RELATED CONDITION WITH MCC | 1.00 | 974.00 |
| 975.00 | 975 | HIV WITH MAJOR RELATED CONDITION WITH CC | 1.00 | 975.00 |
| 976.00 | 976 | HIV WITH MAJOR RELATED CONDITION WITHOUT CC/MCC | 1.00 | 976.00 |
| 977.00 | 977 | HIV WITH OR WITHOUT OTHER RELATED CONDITION | 1.00 | 977.00 |
| 981.00 | 981 | EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC | 1.00 | 981.00 |
| 982.00 | 982 | EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC | 1.00 | 982.00 |
| 983.00 | 983 | EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITHOUT CC/MCC | 1.00 | 983.00 |
| 987.00 | 987 | NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC | 1.00 | 987.00 |
| 988.00 | 988 | NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC | 1.00 | 988.00 |
| 989.00 | 989 | NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITHOUT CC/MCC | 1.00 | 989.00 |

# Recap

Recap

# MBD Takeaways

## In practice!

Can you answer the following questions?

- Am I working with the reimbursement department on any regulatory changes and/or policy and procedure changes needed at a patient level?
- Are our dual eligibles being written off properly and not to a contractual allowance?
- Are our policies for bad debt and indigent accounts up to date?
- Are our collection agencies following their contract obligations?
- Do we house our support needed for remits, charity applications, etc. for audit and is it easily retrievable?

Recap

# S-10 Takeaways

## In practice!

Can you answer the following questions?

- Am I working with the reimbursement department on any regulatory changes and/or policy and procedure changes needed at a patient level?
- Are our dual eligibles being written off properly and not to a contractual allowance?
- Are our policies for bad debt and indigent accounts up to date?
- Are our insured charity amounts related to Deductible/Coinsurance/ Co-pay?  If not, are we reporting the values on line 25.01?
- Do we house our support needed for remits, charity applications, etc. for audit and is it easily retrievable?
- Are we capturing our self pay discount on line 20 column 1?

Recap

# DSH Takeaways

## In practice!

Can you answer the following questions?

- Are we using the most recently released SSI?
- Should we consider filing our cost report early?
- Have any of our Inpatient days been rebilled as Outpatient?
- Do we have the best matching criteria to send to the State Medicaid Eligibility program?
- Do we want to do a mid-year DSH review?
- Are we capturing every Title XIX day?

# Contact information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# Thank You

# Appendix

Introduction

# Cost report exhibit for Medicare bad debt (on or after October 1, 2022)

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 |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |




Source: Noridian JF

Introduction

# Medicare cost report worksheet S-10

| | | | | | |
|---|---|---|---|---|---|
| | Uncompensated care cost (see instructions for each line) | | | | |
| 20.00 | Charity care charges and uninsured discounts (see instructions) | 0 | 0 | 0 | 20.00 |
| 21.00 | Cost of patients approved for charity care and uninsured discounts (see instructions) | 0 | 0 | 0 | 21.00 |
| 22.00 | Payments received from patients for amounts previously written off as charity care | 0 | 0 | 0 | 22.00 |
| 23.00 | Cost of charity care (see instructions) | 0 | 0 | 0 | 23.00 |
| | | | | | |
| | | | | 1.00 | |
| 24.00 | 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? | | | | 24.00 |
| 25.00 | If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit | | | 0 | 25.00 |
| 25.01 | Charges for insured patients' liability (see instructions) | | | 0 | 25.01 |
| 26.00 | Bad debt amount (see instructions) | | | 0 | 26.00 |
| 27.00 | Medicare reimbursable bad debts (see instructions) | | | 0 | 27.00 |
| 27.01 | Medicare allowable bad debts (see instructions) | | | 0 | 27.01 |
| 28.00 | Non-Medicare bad debt amount (see instructions) | | | 0 | 28.00 |
| 29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions) | | | 0 | 29.00 |
| 30.00 | Cost of uncompensated care (line 23, col. 3, plus line 29) | | | 0 | 30.00 |
| 31.00 | Total unreimbursed and uncompensated care cost (line 19 plus line 30) | | | 0 | 31.00 |

Line 30 (Cost of uncompensated care) is used for DSH UCP Factor calculation.
Line 30 = Line 23 (charity care) + Line 29 (bad debt)

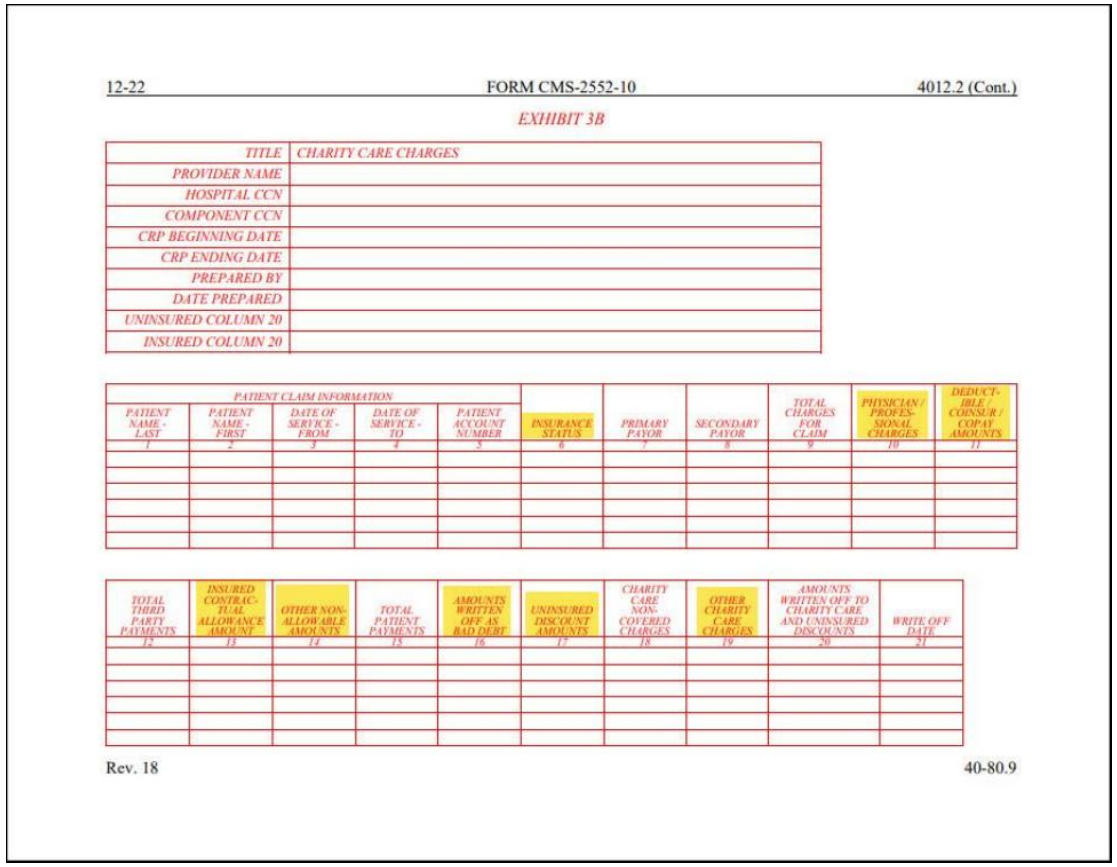


Source: WPS

Regulatory updates and impact

# Cost report exhibits for Worksheet S-10 (on or after October 1, 2022)

## Exhibit 3B – Charity Care Charges



12-22 FORM CMS-2552-10 4012.2 (Cont.)

EXHIBIT 3B

| | |
|---|---|
| TITLE | CHARITY CARE CHARGES |
| PROVIDER NAME | |
| HOSPITAL CCN | |
| COMPONENT CCN | |
| CRP BEGINNING DATE | |
| CRP ENDING DATE | |
| PREPARED BY | |
| DATE PREPARED | |
| UNINSURED COLUMN 20 | |
| INSURED COLUMN 20 | |

| PATIENT CLAIM INFORMATION | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| PATIENT NAME - LAST 1 | PATIENT NAME - FIRST 2 | DATE OF SERVICE - FROM 3 | DATE OF SERVICE - TO 4 | PATIENT ACCOUNT NUMBER 5 | INSURANCE STATUS 6 | PRIMARY PAYOR 7 | SECONDARY PAYOR 8 | TOTAL CHARGES FOR CLAIM 9 | PHYSICIAN / PROFESSIONAL CHARGES 10 | DEDUCTIBLE / COINSUR / COPAY AMOUNTS 11 |
| | | | | | | | | | | |

| TOTAL THIRD PARTY PAYMENTS 12 | INSURED CONTRACTUAL ALLOWANCE AMOUNT 13 | OTHER NON-ALLOWABLE AMOUNTS 14 | TOTAL PATIENT PAYMENTS 15 | AMOUNTS WRITTEN OFF AS BAD DEBT 16 | UNINSURED DISCOUNT AMOUNTS 17 | CHARITY CARE NON-COVERED CHARGES 18 | OTHER CHARITY CARE CHARGES 19 | AMOUNTS WRITTEN OFF TO CHARITY CARE AND UNINSURED DISCOUNTS 20 | WRITE OFF DATE 21 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

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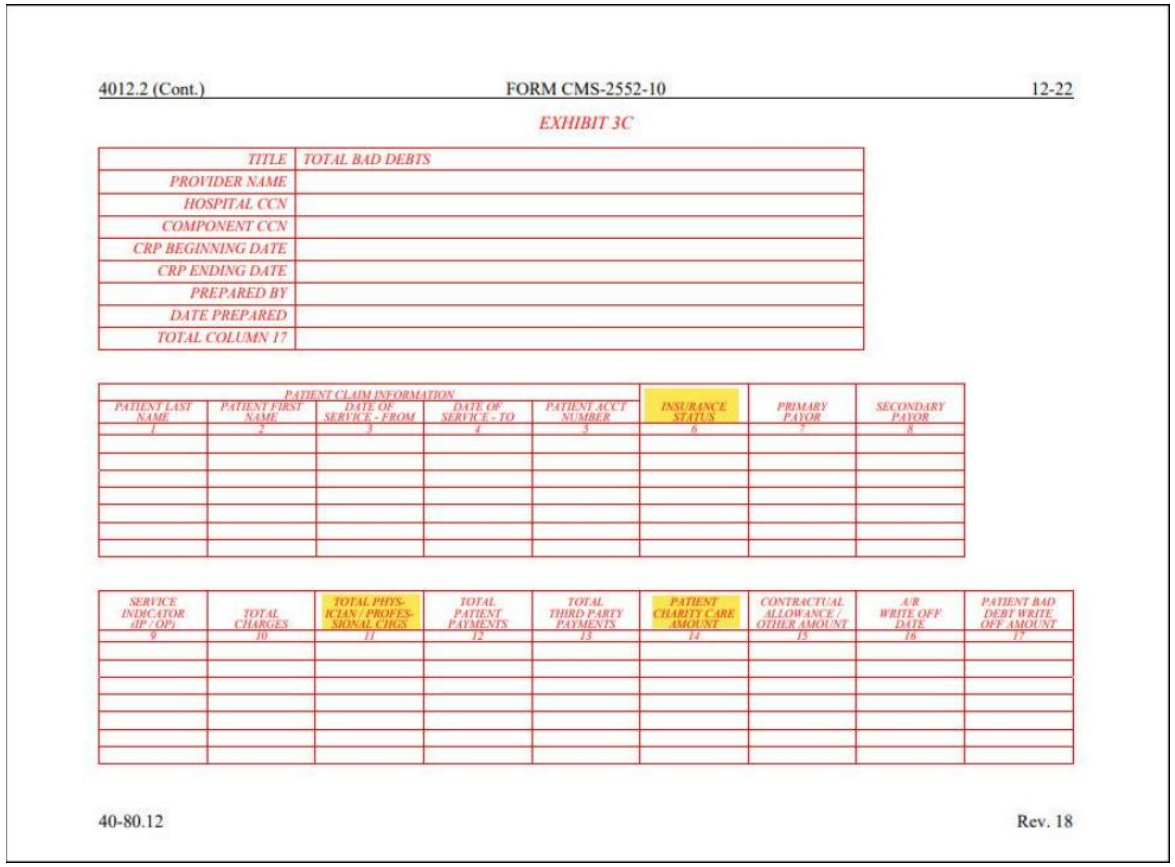
## Exhibit 3C – Total Bad Debts



4012.2 (Cont.) FORM CMS-2552-10 12-22

EXHIBIT 3C

| | |
|---|---|
| TITLE | TOTAL BAD DEBTS |
| PROVIDER NAME | |
| HOSPITAL CCN | |
| COMPONENT CCN | |
| CRP BEGINNING DATE | |
| CRP ENDING DATE | |
| PREPARED BY | |
| DATE PREPARED | |
| TOTAL COLUMN 17 | |

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

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

40-80.12 Rev. 18




Source: Noridian JF

Regulatory updates and impact

# Cost report exhibit for DSH (on or after October 1, 2022)

*EXHIBIT 3A*

| | |
|---|---|
| TITLE | MEDICAID ELIGIBLE DAYS FOR A DSH ELIGIBLE HOSPITAL |
| PROVIDER NAME | |
| CCN | |
| CRP BEGINNING DATE | |
| CRP ENDING DATE | |
| WS S-2, PT. I, LINE # | |
| PREPARED BY | |
| DATE PREPARED | |
| TOTAL COLUMNS 10 &12 | |
| TOTAL COLUMN 11 | |

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

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

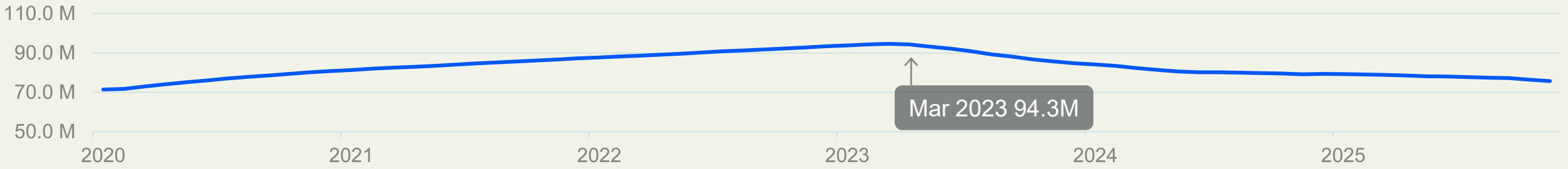



Source: CMS

Regulatory updates and impact

# Medicaid unwinding

**National enrollment in Medicaid/CHIP** Feb 20 to Dec 25




| State | Feb 2020<br>Pre-pandemic baseline | Mar 2023<br>Unwinding baseline | Dec 2025 | % Change<br>Feb 20-Mar 23 | % Change<br>Mar 23-Dec 25<br>Unwinding effect | % Change<br>Feb 20-Dec 25 |
|---|---|---|---|---|---|---|
| **US total** | **71.4 M** | **94.3 M** | **75.7 M** | **32.1%** | **-19.7%** | **6.0%** |
| California | 11.6 M | 14.3 M | 12.6 M | 23.3% | -11.5% | 9.1% |
| New York | 6.0 M | 7.5 M | 6.5 M | 25.6% | -13.3% | 8.8% |
| Texas | 4.2 M | 5.9 M | 4.1 M | 41.0% | -31.0% | -2.7% |
| Florida | 3.6 M | 5.1 M | 3.6 M | 41.3% | -29.4% | -0.2% |
| Illinois | 2.9 M | 3.8 M | 3.0 M | 29.8% | -21.6% | 1.8% |




Source: KFF Medicaid Enrollment and Unwinding Tracker

Regulatory updates and impact

# SSI ratio impact

| | All IPPS hospitals | | | | IPPS hospitals participating in the 340B program as of 4/14/26 | | | |
|---|---|---|---|---|---|---|---|---|
| | FY 2024 | FY 2023 | Variance | % Change FY23-24 | FY 2024 | FY 2023 | Variance | % Change FY23-24 |
| Average | 7.11% | 7.28% | -0.12% | -10.98% | 8.61% | 8.74% | -0.13% | -6.19% |
| Highest | 100.00% | 66.67% | 100.00% | 100.00% | 54.35% | 57.16% | 19.83% | 100.00% |
| 75th | 8.78% | 9.01% | 0.62% | 10.82% | 10.23% | 10.53% | 0.58% | 7.31% |
| Median | 5.67% | 5.79% | -0.08% | -1.60% | 7.14% | 7.31% | -0.14% | -1.63% |
| 25th | 3.52% | 3.55% | -0.82% | -16.10% | 5.07% | 5.23% | -0.92% | -13.21% |
| Lowest | 0.00% | 0.00% | -66.67% | -2168.75% | 0.00% | 0.00% | -7.37% | -616.22% |

- CMS publishes annual SSI ratios with FY24 data being released on March 17, 2026
- SSI ratio = Medicare SSI Days / Total Medicare Days = SSI Fraction or Medicare Fraction
- By default, SSI ratios published by CMS are based on the federal fiscal year (FFY) ending September 30
- Hospital can request its SSI ratio be recalculated based on the hospital's cost reporting period when it is different from the federal fiscal year

SSI ratios should be carefully examined each year to determine your 340B eligibility.




Sources: CMS, 340B OPAIS