Medicare Disproportionate Share (DSH) & Uncompensated Care

New York

2025

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U.S. Presence

Leading U.S. Firm

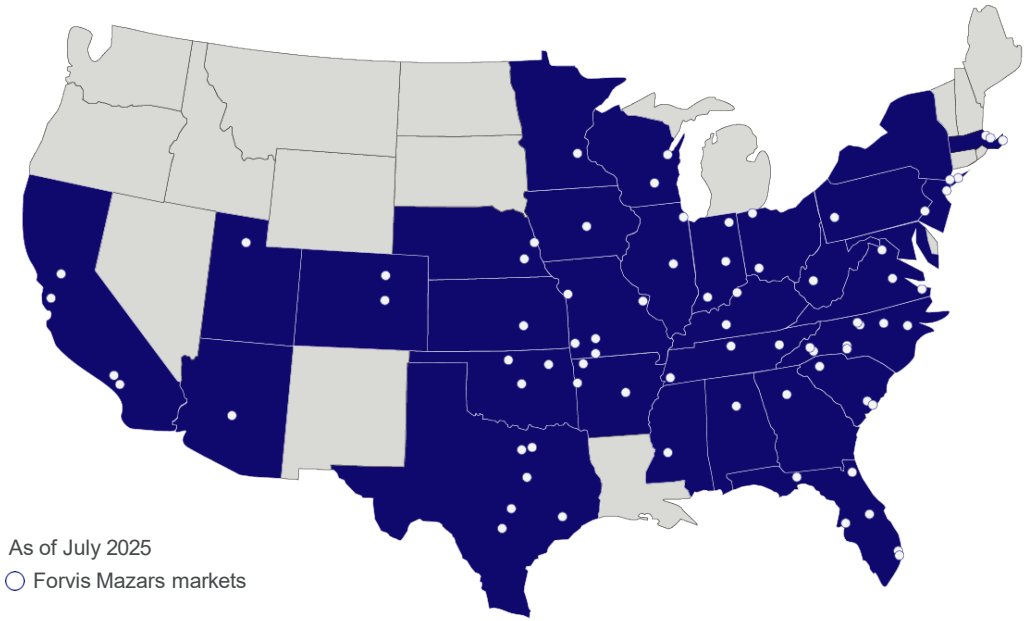
$2.24B
Revenue (FY 2025)*

76
Markets

30
States

600+
Partners & Principals

7,000+
Employees



As of July 2025
◯ Forvis Mazars markets

Alabama
Birmingham

Arizona
Phoenix

Arkansas
Fort Smith
Little Rock
Rogers

California
Irvine
Los Angeles
Sacramento
San Jose

Colorado
Colorado Springs
Denver

Florida
Boca Raton
Fort Lauderdale
Jacksonville
Orlando
Tallahassee
Tampa Bay

Georgia
Atlanta

Illinois
Chicago
Decatur

Indiana
Evansville
Fort Wayne
Indianapolis

Iowa
Des Moines

Kansas
Wichita

Kentucky
Bowling Green
Louisville

Massachusetts
Boston
Brewster
Chestnut Hill

Minnesota
Minneapolis

Mississippi
Jackson

Missouri
Branson
Joplin
Kansas City
Springfield
St. Louis

Nebraska
Lincoln
Omaha

New Jersey
Iselin

New York
Long Island
New York City

North Carolina
Asheville
Charlotte SouthPark
Charlotte Uptown
Greensboro
Greenville
Hendersonville
Raleigh
Winston-Salem

Ohio
Cincinnati
Toledo

Oklahoma
Enid
Oklahoma City
Tulsa

Pennsylvania
Fort Washington
Pittsburgh

South Carolina
Charleston
Greenville
Summerville

Tennessee
Knoxville
Memphis
Nashville

Texas
Austin
Dallas
Fort Worth
Houston
San Antonio
Waco

Utah
Salt Lake City

Virginia
Norfolk
Richmond
Tysons

West Virginia
Charleston

Wisconsin
Appleton
Madison

*FY 2025 revenue: period ending 5/31/25.

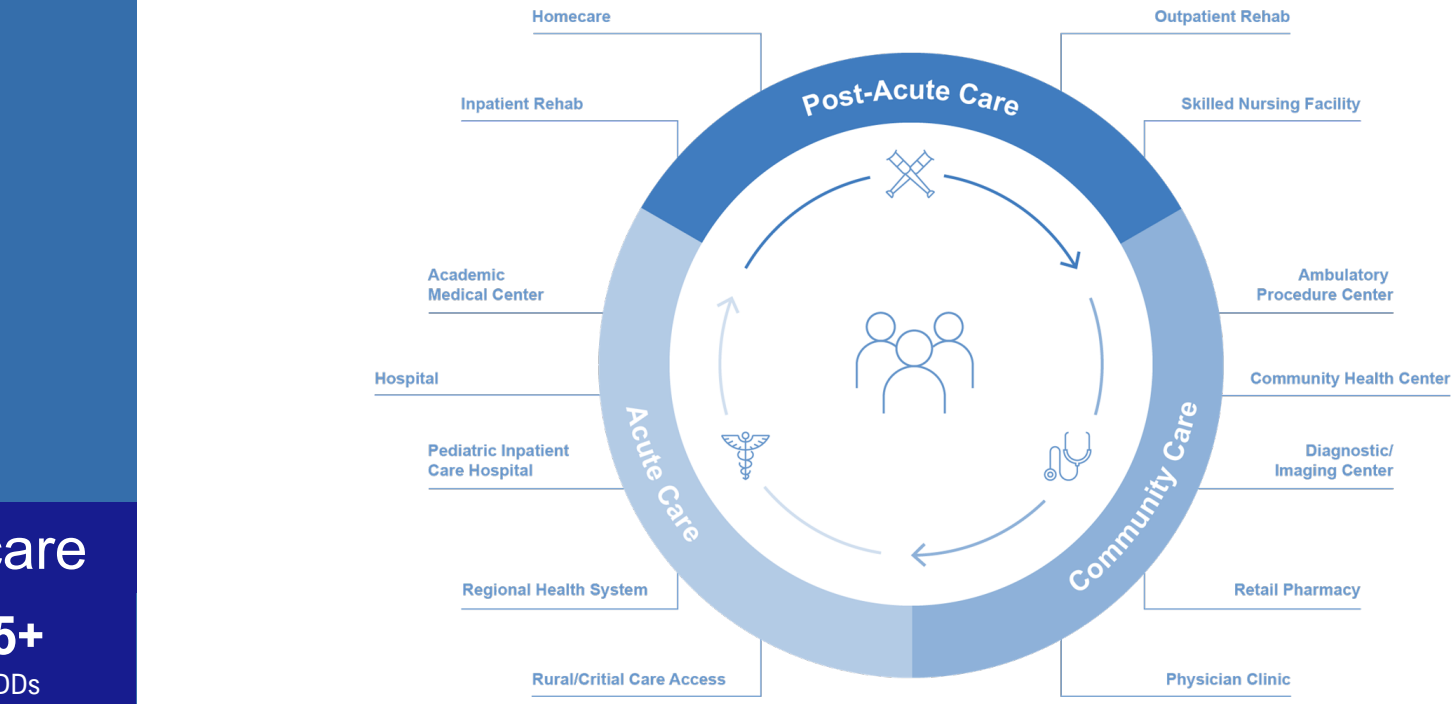
Updated 8/22/2025

Forvis Mazars Healthcare Practice

Forvis Mazars Knows Healthcare

950+	6100+	175+
team members	Healthcare clients	PPMDDs

Serving the Entire Continuum of Care



90	9th	2nd	2nd
Healthcare Net Promoter Score	Modern Healthcare Largest Healthcare Consulting Firm	Largest Healthcare Auditor	Largest Healthcare Tax Preparer

Meet the Presenters

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Agenda

1. A Challenging Environment
2. Medicare DSH
3. Uncompensated Care
4. Medicare Bad Debts

Key Reimbursement Opportunities

New York Totals

1. Medicare Disproportionate Share (DSH)

   ~$290 Million

2. Medicare Bad Debts

   ~$90 Million

3. Uncompensated Care Worksheet S-10

   ~$366 Million

“These programs are not commodities; they are strategic reimbursement opportunities.”

A Challenging Environment

Providers Under Pressure

50% of provider executives rank margin improvement as one of their top priorities over the next three to five years.

40% of hospitals had negative margins in 2024

16 hospitals closed in 2025
25 hospitals closed in 2024

338 rural hospitals at risk of closure

Medicare margin for “efficient hospitals” is **-2%**

78% of physicians employed in 2024

774 nursing homes have closed since 2020

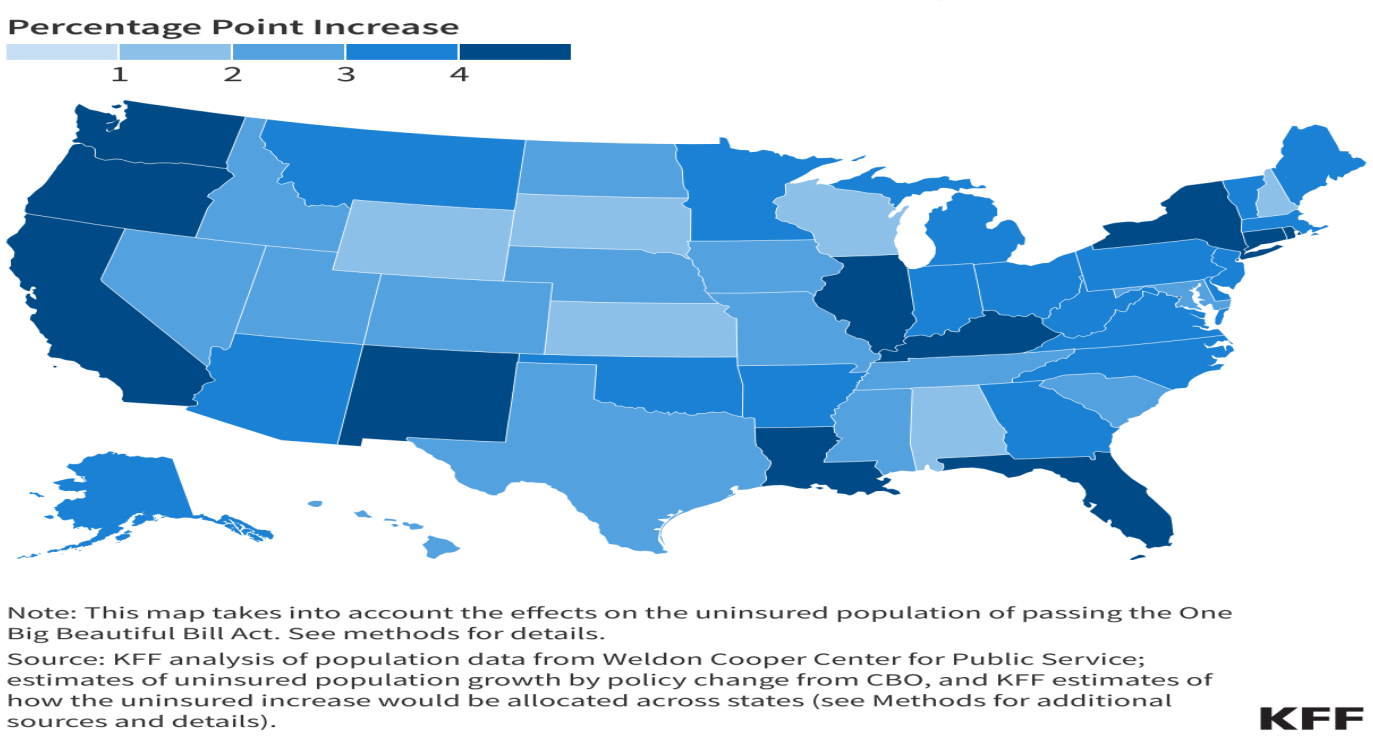
Sources:
1) Mindsets Healthcare Executive Leadership Report,” Forvis Mazars, 2024.
2) https://www.markey.senate.gov/imo/media/doc/letter_on_rural_hospitals.pdf
3) https://www.fitchratings.com/research/us-public-finance/fitch-revises-sector-outlook-for-us-nfp-hospitals-to-neutral-09-12-2024
4) www.medpac.gov/wp-content/uploads/2024/08/Tab-D-Hospital-payment-adequacy-January-2025-SEC.pdf
5) https://www.beckershospitalreview.com/finance/4-hospital-closures-in-2-weeks/?
6) https://www.beckershospitalreview.com/finance/5-hospital-closures-in-2024.html#:~:text=Becker's%20has%20reported%20on%2025,This%20article%20was%20updated%20Dec.
7) https://www.beckershospitalreview.com/finance/10-hospitals-closing-departments-or-ending-services-5.html
8) https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023
9) https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Report-Access-to-Nursing-Home-Care-is-Worsening-.aspx

OBBBA: Coverage Impact

Changes to Medicaid and Exchange eligibility are projected to increase the uninsured by 10 million.

2034 Projected Uninsured Increase

OBBBA Medicaid & Exchange Provisions



Note: This map takes into account the effects on the uninsured population of passing the One Big Beautiful Bill Act. See methods for details.

Source: KFF analysis of population data from Weldon Cooper Center for Public Service; estimates of uninsured population growth by policy change from CBO, and KFF estimates of how the uninsured increase would be allocated across states (see Methods for additional sources and details).

KFF

Source: https://www.kff.org/affordable-care-act/issue-brief/how-will-the-2025-reconciliation-bill-affect-the-uninsured-rate-in-each-state-allocating-cbos-estimates-of-coverage-loss/

Medicaid

- Work requirements for select individuals ($326B)
- Increased redeterminations for expansion population ($62B)
- Reduced retroactive eligibility ($4.2B)

Exchange

- Increased income verification requirements ($37B)
- Limits premium tax credit eligibility for certain SEPs ($39B)
- Restricts premium tax credit eligibility for non-citizens ($120B)

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OBBBA Medicaid Work Requirements

Implementation Provisions

- 🩺 **Begin January 1, 2027; States can apply for an extension until December 2028**
- ⚙️ **80 hours per month for Medicaid beneficiaries aged 19 through 64**
  - **Community service, educational programs, or job training**
- 📋 **Exemptions**
  - **Pregnant woman**
  - **Individuals with disabilities**
  - **Caretakers of children under 14**

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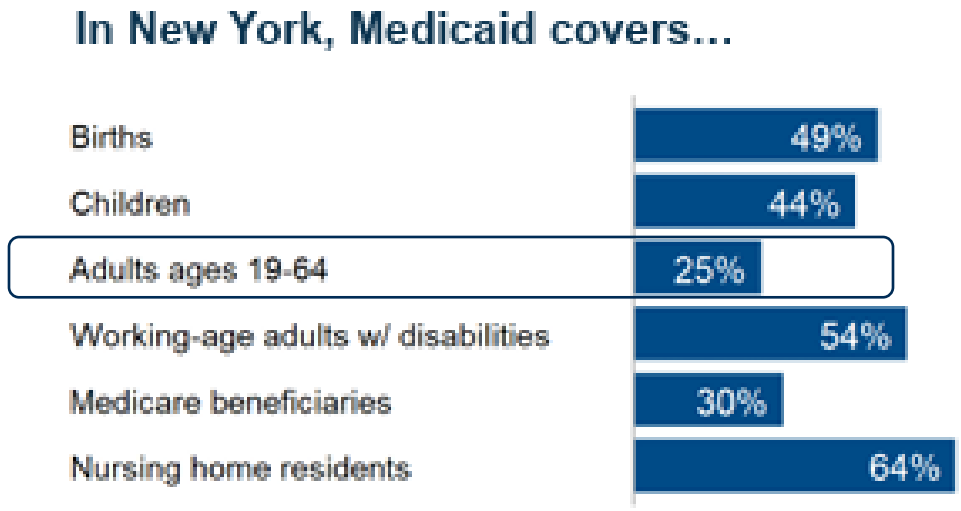
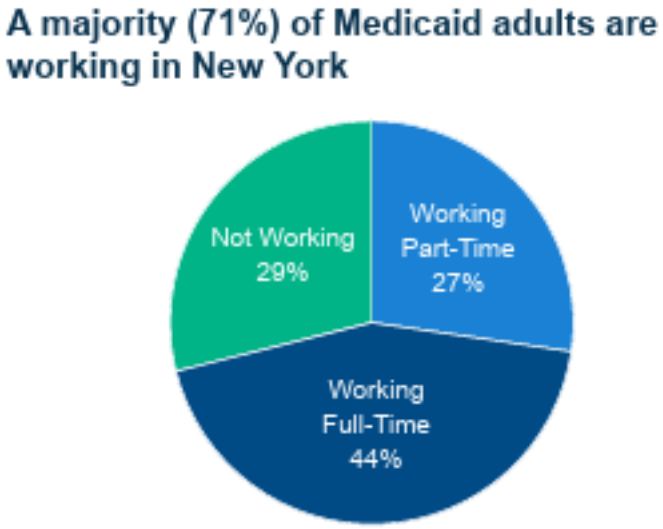
Medicaid Enrollment

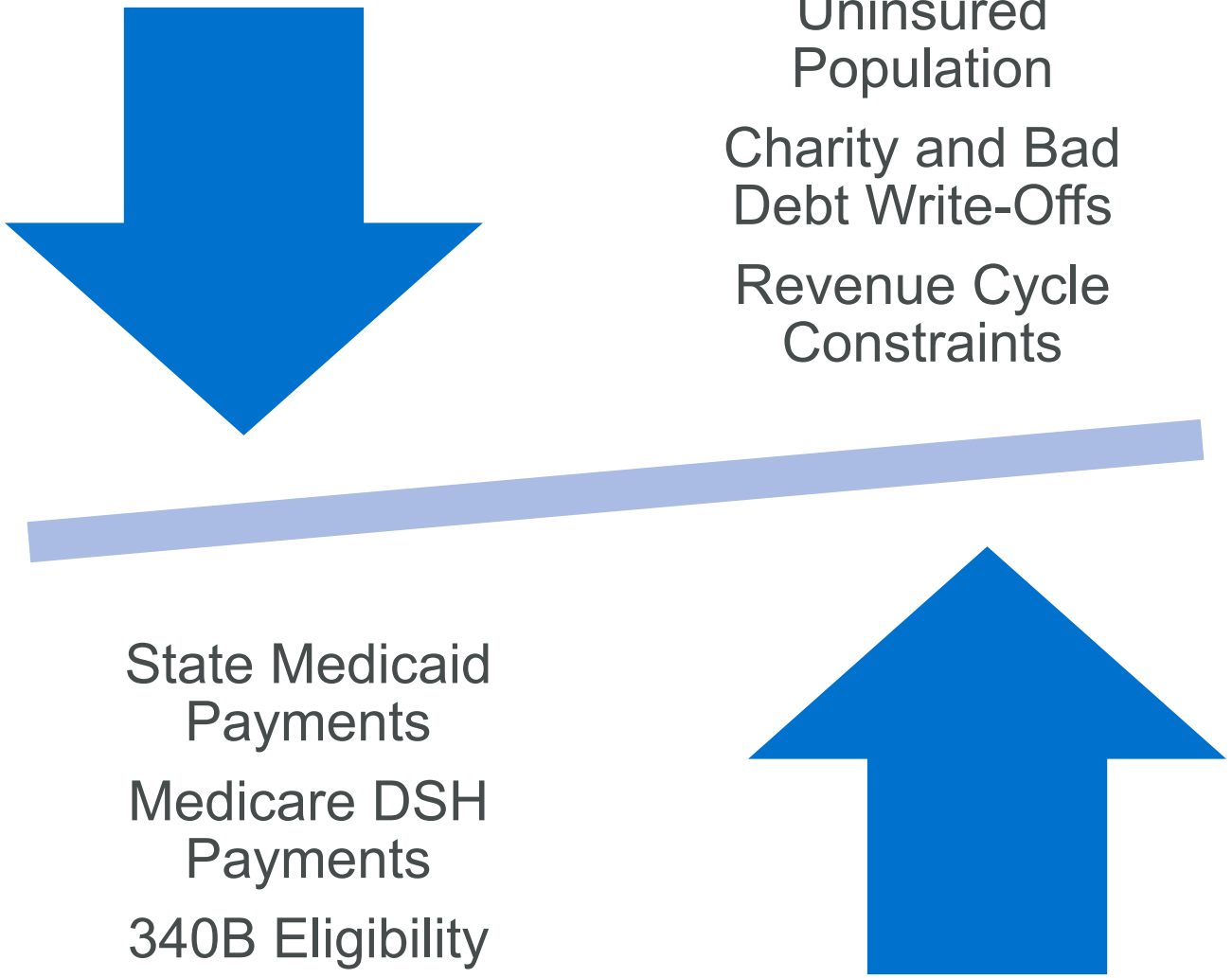
Nearly 7 Million beneficiaries





Source: https://files.kff.org/attachment/fact-sheet-medicaid-state-NY

OBBBA: Hospital Margin Impact



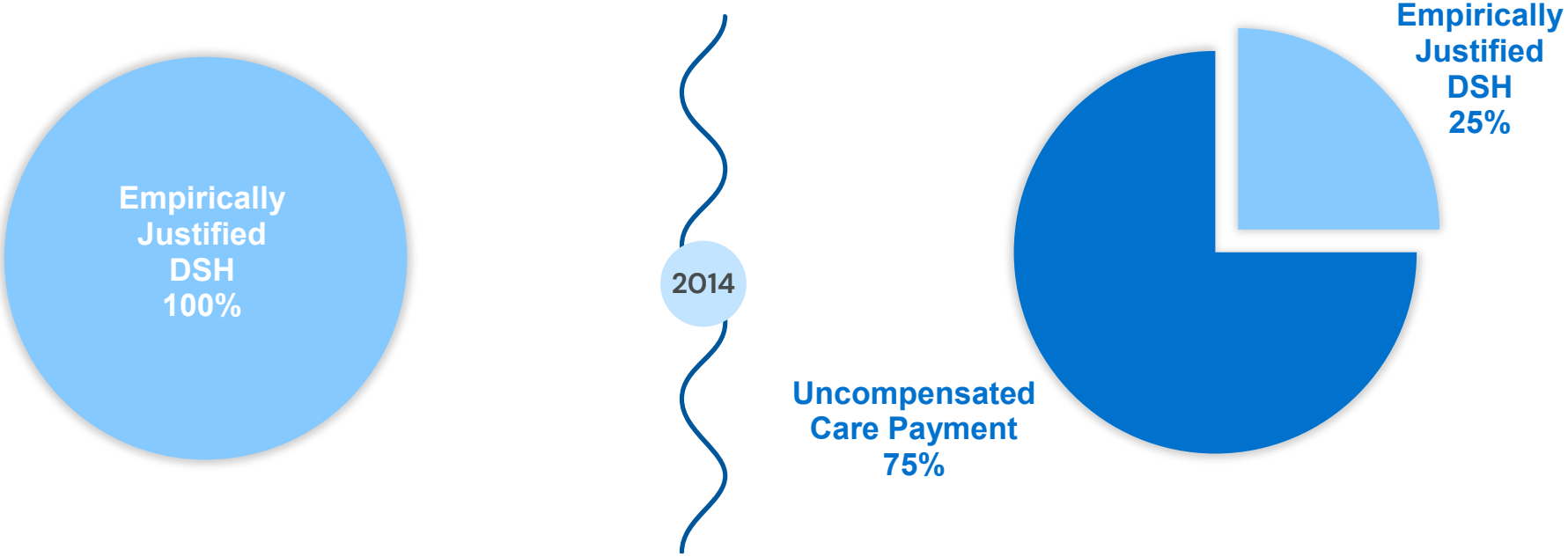
Medicare Disproportionate Share

Disproportionate Share Hospital (DSH) Program

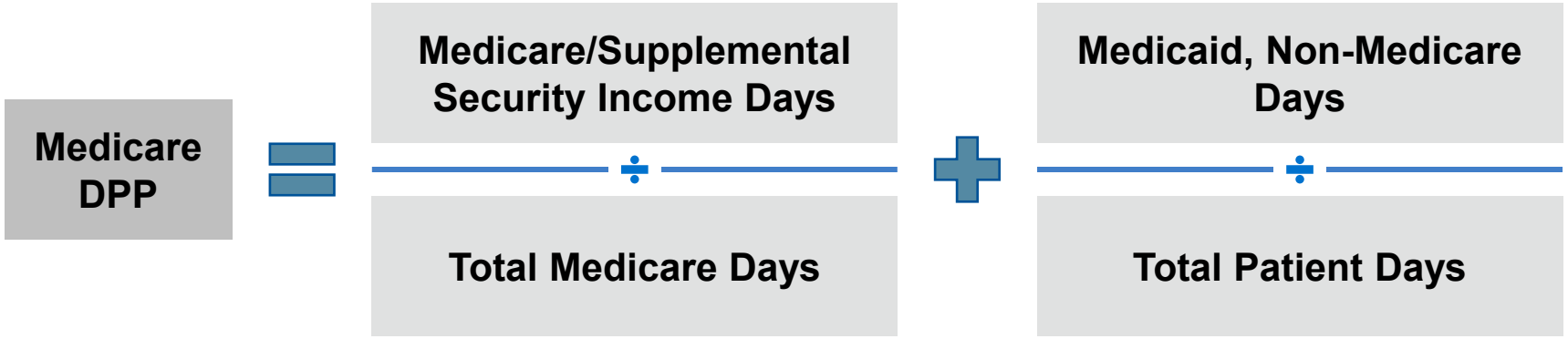
Established by Congress in 1986

Purpose

To provide additional reimbursement for hospitals that serve a disproportionate share of ***low-income*** patients.



Empirically Justified DSH



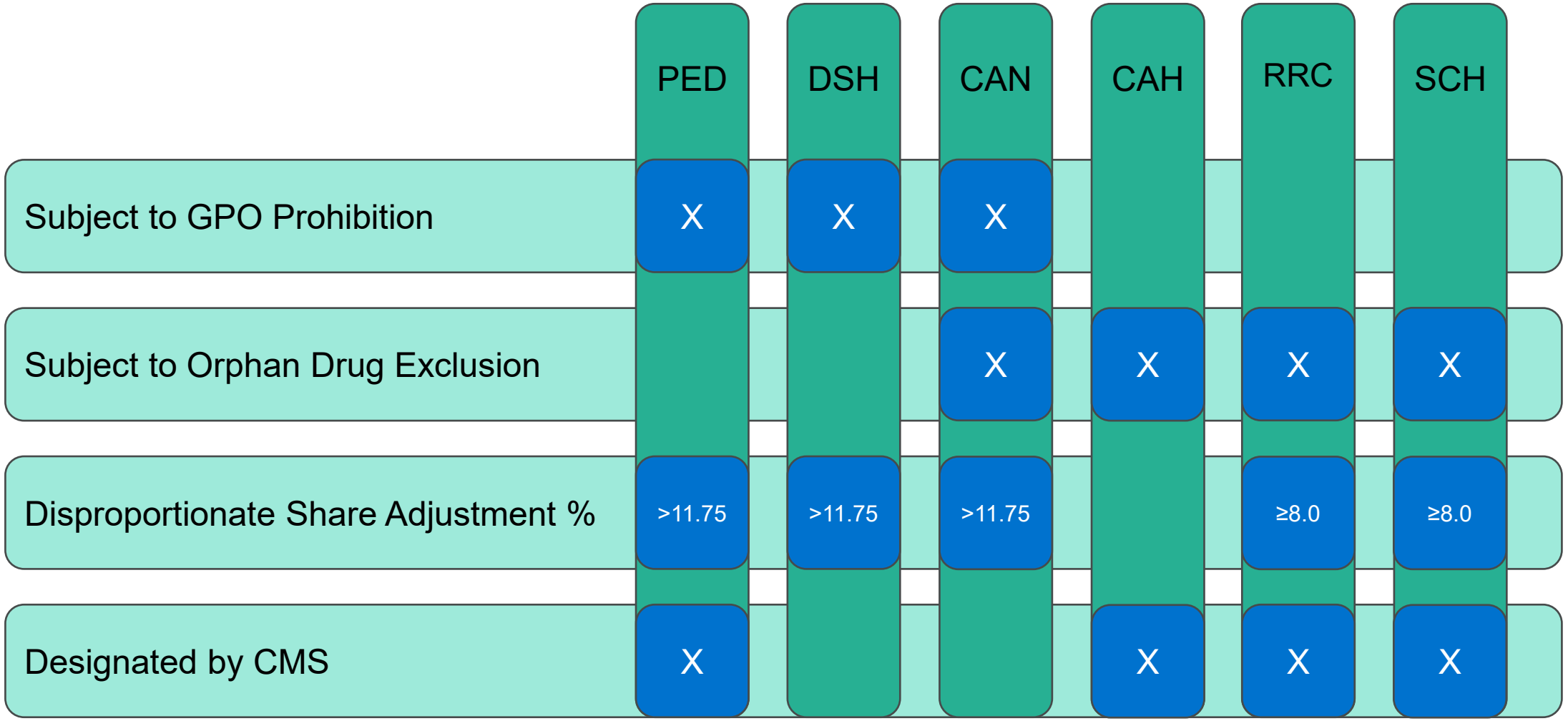
SSI Fraction

- Entitled to both Medicare Part A & C
- Supplemental Security Income (SSI)

Medicaid Fraction

- Medicaid-eligible patient days
- Not covered under Part A
- Not covered under Part C

340B Eligibility



Medicaid Eligibility

Enrollment Trend

📉 Medicaid/CHIP Enrollment Trend

- **United States** Medicaid/CHIP enrollment rose during the pandemic, peaked in 2023, then declined by ~17% in 2025
  - Still ~10% above pre-pandemic levels.
- **New York**, enrollment of ~6 Million pre-pandemic (early 2020), peaked in 2023 to ~8 Million enrollees and now declined to under 7 Million
  - Still 17% above pre-pandemic levels

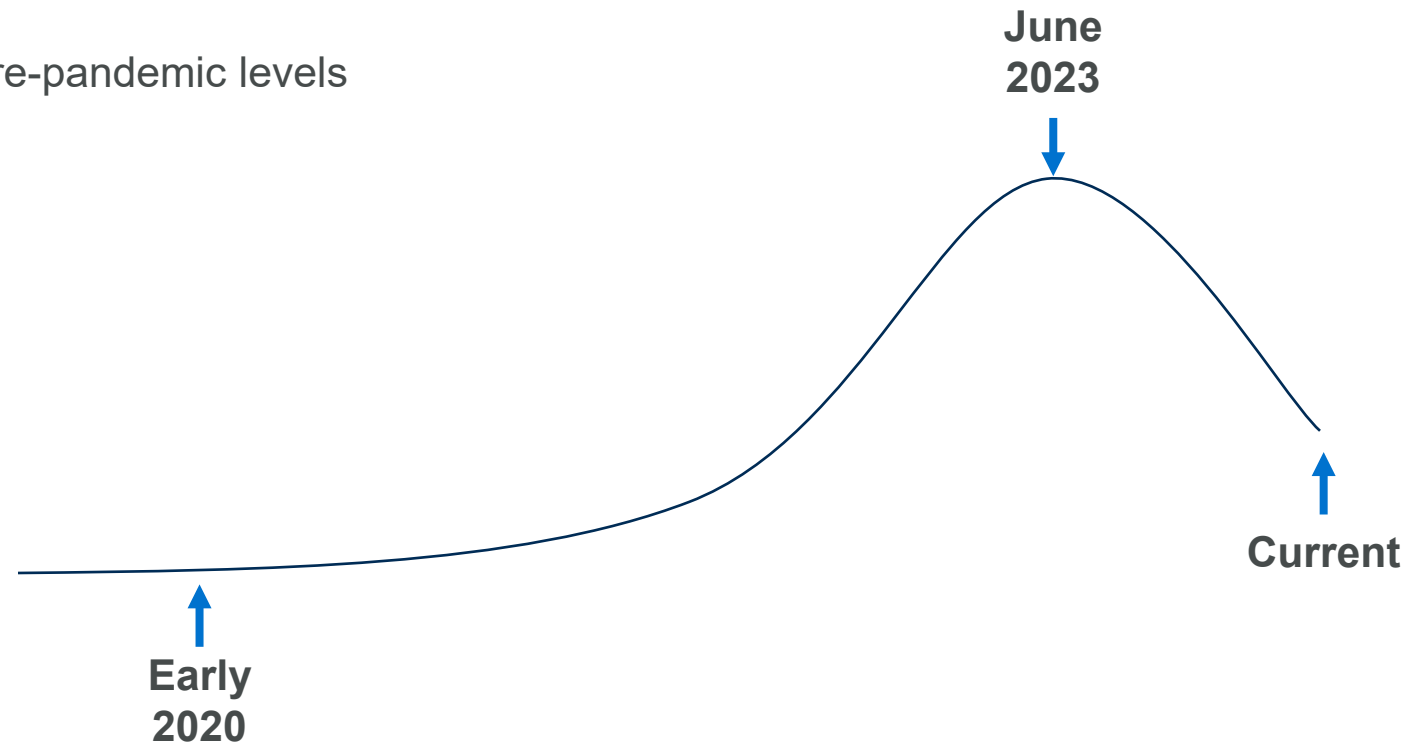


Exhibit 3A – Listing of Medicaid Eligible Days

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							
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

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

Supplemental Security Income

Background

SSI (Supplemental Security Income) is a U.S. government program that provides **monthly financial assistance** to people who have **low income and limited resources**, and who are:

- **Age 65 or older**, or
- **Blind**, or
- **Disabled** (any age, including children)

- **Administered by the Social Security Administration (SSA)**, but **funded by general federal tax revenues**, **not** Social Security taxes.
- **Purpose:** To help pay for basic needs like **food, clothing, and shelter**.
- **Eligibility Requirements:**
  - **Income:** Must be very low (varies by state and living situation).
  - **Resources:** Generally, under **$2,000** for an individual or **$3,000** for a couple (excludes your home and one car).
  - **Residency:** Must live in the U.S. and be a citizen or eligible non-citizen.
  - **Disability:** Must meet SSA's definition of disability, which involves long-term medical conditions that limit your ability to work.
- **SSI vs. SSDI:** SSI is **need-based**, while **SSDI (Social Security Disability Insurance)** is based on your **work history** and payroll tax contributions.

Supplemental Security Income

Litigation Update

Supreme Court Case: *Advocate Christ Medical Center v. Kennedy* (formerly Becerra)

Background
Over 200 hospitals argued that the **Department of Health & Human Services (HHS)** was under-counting low-income Medicare patients by only counting those who **actually received an SSI cash payment** during their hospital stay. They claimed anyone **entitled to SSI**, regardless of monthly cash receipt, should count—potentially increasing DSH funds by ~$1.5 billion annually.

Timeline & Litigation:

1. Hospitals filed in 2017 seeking to redesign DSH calculations.
2. The *Provider Reimbursement Review Board*, CMS, D.C. District Court, and the D.C. Court of Appeals sided with HHS.
3. The Supreme Court granted certiorari (June 2024), heard arguments (Nov 2024), and **ruled 7–2 on April 29, 2025.**

Decision Outcome:
The Court held that **only SSI beneficiaries who receive a cash payment in the month of hospitalization** qualify for inclusion in the Medicare DSH formula.

- **Dissenting View:**
  Justices **Ketanji Brown Jackson and Sonia Sotomayor** argued this interpretation undermines Congress's intent, ignoring non-cash benefits and ongoing entitlement during months without payment.

Medicare Disproportionate Share

Best Practices

Medicaid Identification

- Apply for Medicaid early in the revenue cycle
- Thorough eligibility testing in home state and out-of-states
- Interim Medicaid monitoring
- Many search iterations and capabilities

Total Day reporting

- Ensure accurate reporting of total days
- Reconcile census reports to revenue and usage detail
- Exclude observation and days without room charges

Utilization Review

- Identify trends in Medicaid and non-Medicaid utilization by department, service line, admitting physician, etc.
- Provider number structuring
- Acute vs. exempt units

Appeals & Litigation

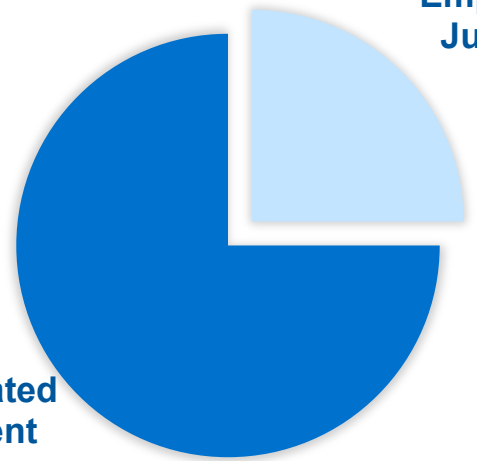
- Stay current on Medicaid day and SSI appeals
- Keep documentation support for audit readiness

Uncompensated Care S-10

Uncompensated Care Costs

Worksheet S-10

Used in the computation of Factor 3 to distribute uncompensated care payments to all eligible hospitals, except Puerto Rico hospitals and Indian Health Service and Tribal hospitals.



- **Charity Care**
- **Total Bad Debt:**
  - **Medicare**
  - **Non-Medicare hospital bad debt**
  - **Non-reimbursable hospital bad debt**

FY 2026 IPPS FINAL RULE

Factor 1 – Estimated DSH (75% of empirical DSH)

- FFY 2024 = $10,015,191,022
- FFY 2025 = $10,509,750,000
- FFY 2026 = $12,412,500,000

Factor 2 – Impacted by estimate of national rate of uninsured

- FFY 2024 = 59.29%
- FFY 2025 = 54.29%
- FFY 2026 = 62.14%

Uncompensated Care Pool – to be distributed

- FFY 2024 = $5,938,006,757
- FFY 2025 = $5,705,743,275
- FFY 2026 = $7,713,127,500

Computing the Uncompensated Care DSH Pool

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FY 2026 IPPS FINAL RULE

Future uncompensated care payments will be based on:

FY2024

Factor 3 = Average of FY2018, FY2019, and FY2020 Reports

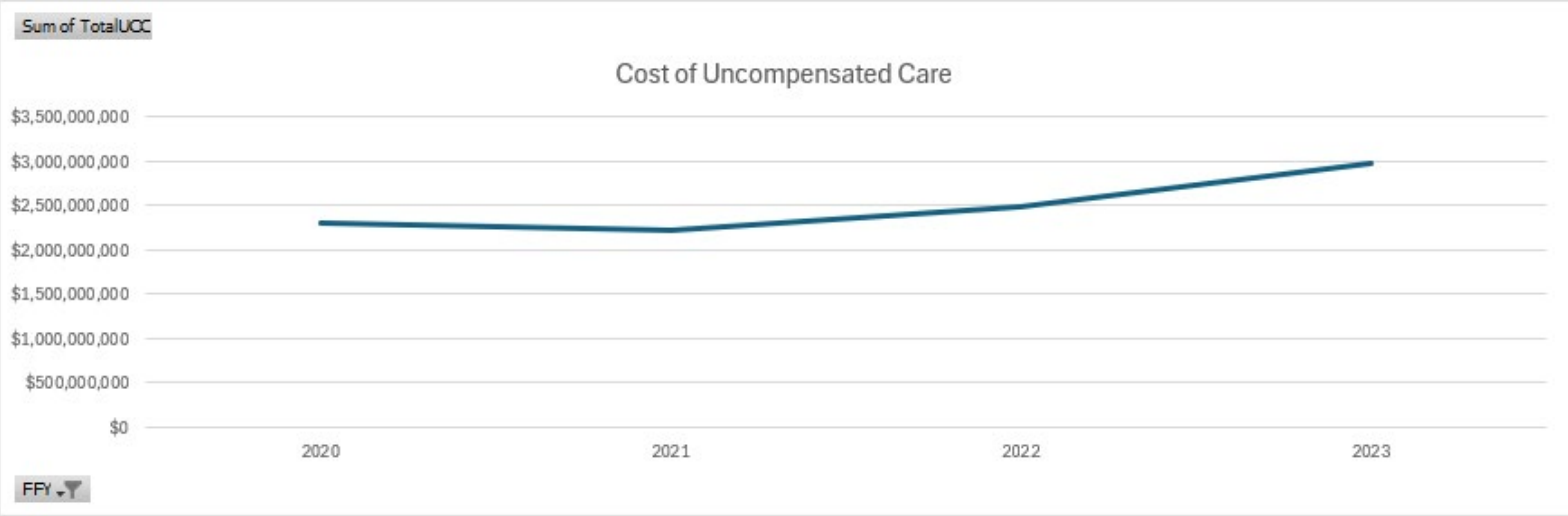
FY2025

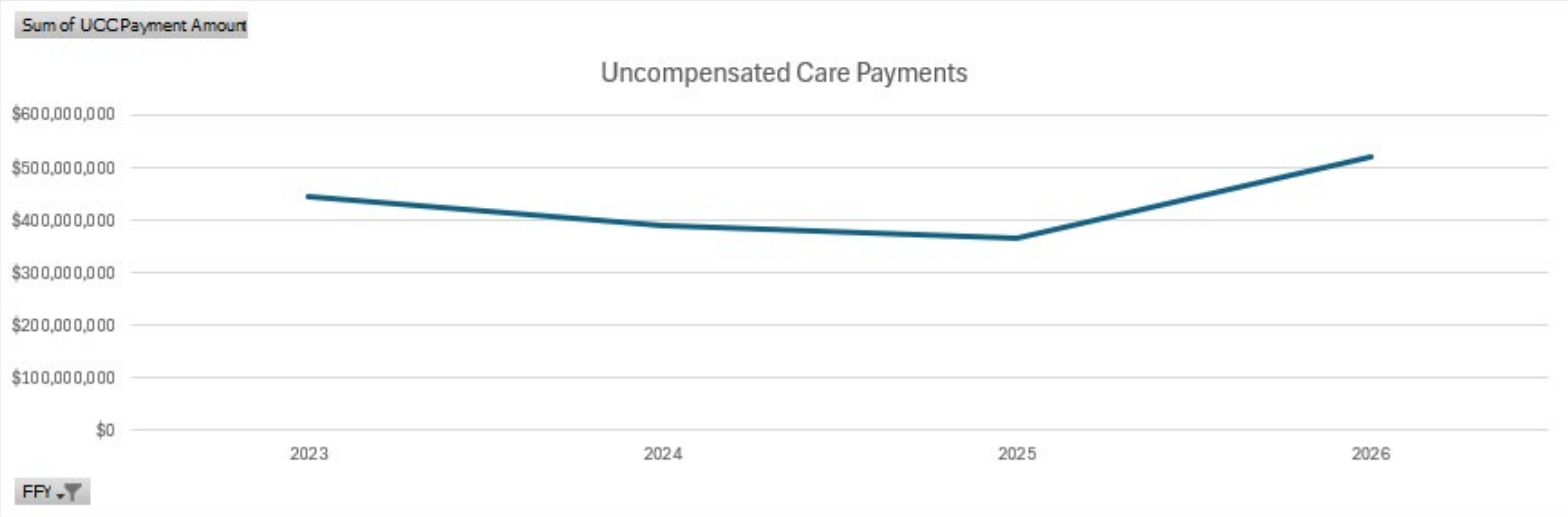
Factor 3 = Average of FY2019, FY2020, and FY2021 Reports

FY2026

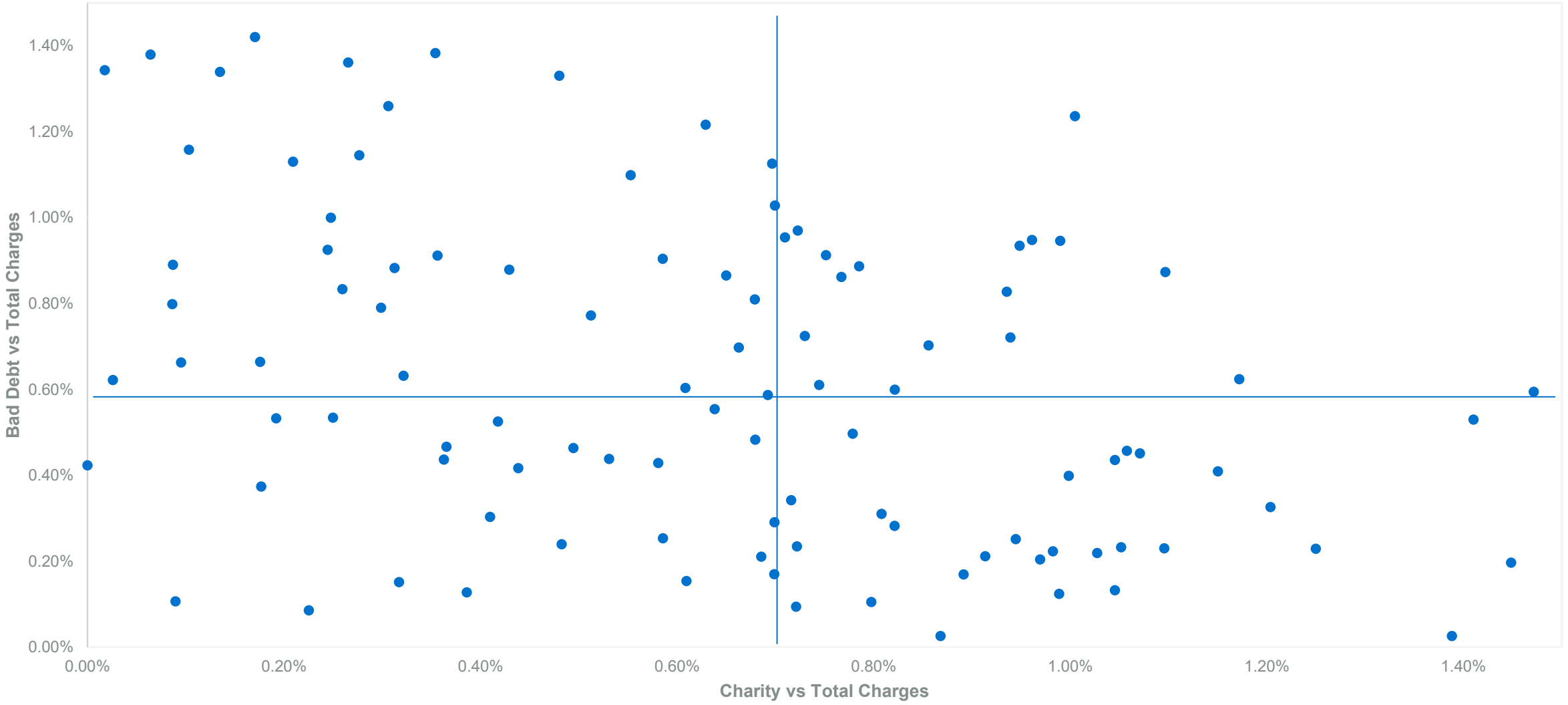
Factor 3 = Average of FY2020, FY2021, and FY2022 Reports

Trending NY Hospital UCC vs Payments





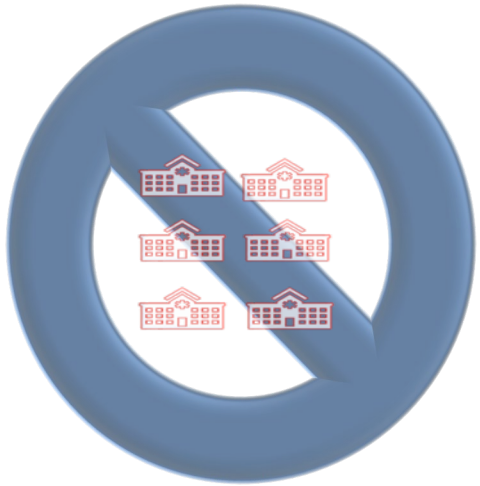
Trending NY Hospitals Charity & Bad Debt



Transmittal 18 – Worksheet S-10

S-10 PART I
Total Hospital Complex

Including Psych Unit, SNF, HHA, etc.



S-10 PART II
Limited to services billed under Hospital Provider number

Exhibit 3B – Worksheet S-10 Charity

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

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

Exhibit 3B – Worksheet S-10 Charity

COLUMN 11 Deduct./Coins./Copay	COLUMN 6 Insurance Status	COLUMN 13 Contractual Allowance Amount	COLUMN 16 Bad Debt Write-Off
• Deductible & coinsurance must be separately identified • This could create issues during data retrieval	• Options are uninsured (1), insured (3), & insured not covered (2) ▪ Includes no contractual relationship, exhausted benefits, non-covered, etc.	• Required only for insured and insured not covered accounts.	• Report amount written-off A/R in the system regardless of the date.

CHARITY CARE CHARGES

- **Uninsured**
  - Reduced to cost
  - Exhausted benefits
- **Insured**
  - Coinsurance, copay, deductible

Worksheet S-10	Included
Charity Care	✓
Courtesy Discounts	✗
Uninsured Discounts	✓
Non-Contract	✓
Presumptive Eligibility	✓
COVID Adjustments	✗

Exhibit 3B

Worksheet S-10 Example

INSURED NOT COVERED CASE STUDY:

- Patient D is insured but has exhausted their benefits. The hospital's financial assistance policy states that patients whose benefits are exhausted are covered under the policy. As such the hospital writes the account off to zero.

1	2	3	4	5	6	7	8	9	10
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 / PROFESSIONAL CHARGES
Doe	Jill	5/1/2023	5/3/2023	123456789	2	ANTHEM	SELF PAY	$24,566.00	$0.00

11	12	13	14	15	16	17	18	19	20
DEDUCTIBLE / COINSURANCE / COPAY AMOUNTS	TOTAL THIRD-PARTY PAYMENTS	INSURED CONTRACTUAL 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
$0.00	$0.00	$17,933.00	$0.00	$0.00	$0.00	$0.00	$6,633.00	$0.00	$6,633.00

Exhibit 3C - Worksheet S-10 Bad Debts

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	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE -TO	PATIENT ACCT NUMBER	INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR
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

NAVIGATING THE AUDIT

POLICY REVIEW

Charity Care

- What is the criteria for approval, and does it reconcile to the data?
  - Automatic 100% adjustment
  - Sliding scale
  - Non-covered Medicaid
  - Non-contracted insurance

Financial Assistance Policy (FAP)

- Applies to patients unable to meet financial obligation
- May apply to uninsured, underinsured, ineligible for government assistance, or unable to pay

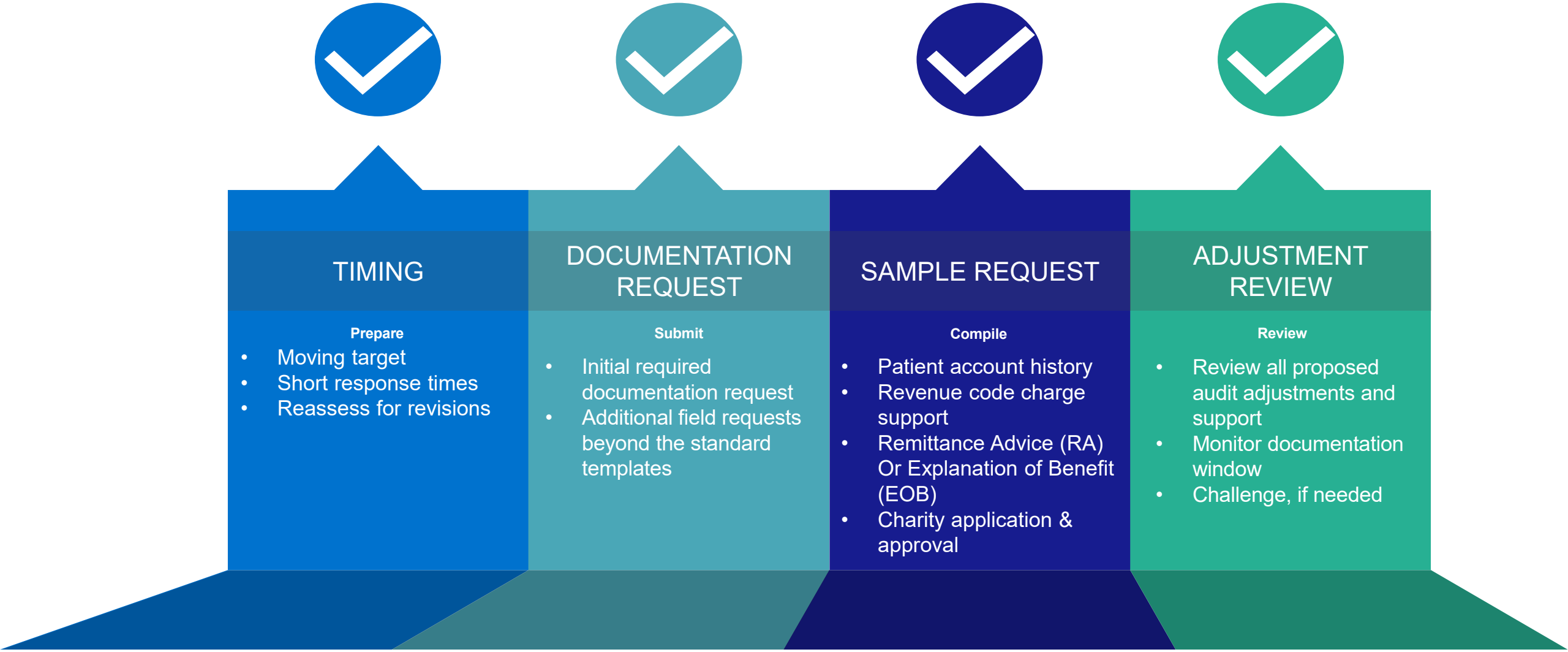
Uninsured Discount

- Confirmation of insurance status
- Is the discount automatic?
- Percent of charges applied
- How does it compare to the AGB%?

Bad Debt

- What criteria is applied
- Medicare policies are also important, but not part of S-10 audit

S-10 AUDIT PREPARATION

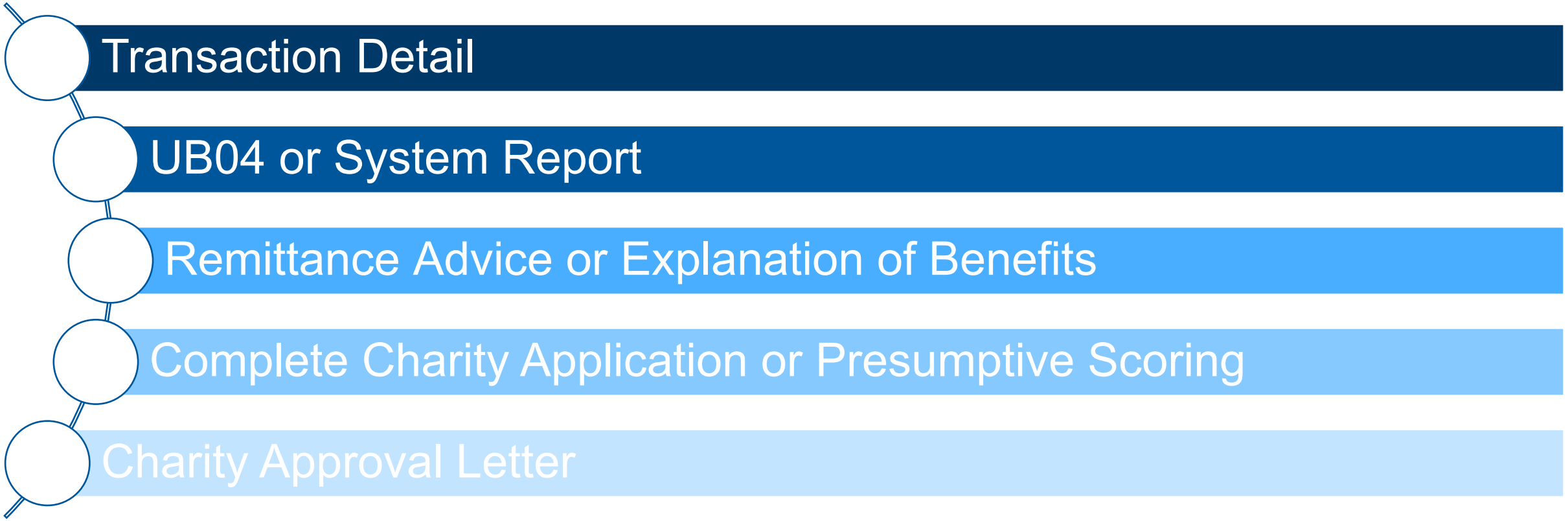


S-10 AUDIT PREPARATION

Typical auditor request includes:

- Charity, FAP, and self-pay discount policies (in force during FY)
- Audited financial statements and working trial balance (may ask for prior-year as well)
- Bad debt reconciliation
- Charity reconciliation
- List of transaction codes with descriptions
- Detailed query logic for lines 20, 22, and 26
- Detailed Charity listing – includes rev code detail (if applicable)
- Detailed Bad Debt listing – includes Medicare crossovers, indigent, and rev code detail (if applicable)
- Query logic methodology questionnaire

S-10 AUDIT SAMPLE DOCUMENTATION REVIEW



Medicare Bad Debts

New York Medicare Bad Debt Trending

Year	Deduct/Coins	Total Bad Debt	Total Crossover
2019	$1,277,012,265	$105,517,125	$65,463,182
2020	$1,123,537,803	$96,200,608	$50,301,361
2021	$1,233,317,859	$81,499,658	$38,354,743
2022	$1,292,252,202	$99,479,300	$53,586,988
2023	$1,354,934,895	$84,432,144	$48,183,622
Grand Total	**$6,281,055,024**	**$467,128,835**	**$255,889,896**

BAD DEBT TYPES

Agency Returned Bad Debts

Non-indigent Medicare beneficiaries

Not Medicaid eligible and not determined indigent by provider's customary methods

Follows the provider's typical collection process outlined in the policy

Crossover Medicare Bad Debts

Dual eligible Medicare beneficiaries, eligible for Medicare and Medicaid

Reasonable collection efforts involve billing the State Medicaid plan, not the patient

Indigent Medicare Bad Debts

Indigent non-dual eligible Medicare beneficiaries

Indigence is determined by the provider, not Medicaid eligible

Follows the provider's financial assistance policy

Excerpt from FY 2021 IPPS Final Rule:

"… we believe that as we clarify and codify these longstanding bad debt policies, it is important to set forth the definition of each of these three beneficiary categories so that it is clear which bad debt collection effort policy applied, and continue to apply, to each."

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Exhibit 2A – Medicare Bad Debts

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

Exhibit 2A – Medicare Bad Debts

ADDITIONAL FIELDS REQUIRED

- Medicaid RA date
- Secondary payer RA date
- A/R write-off date
- Date returned from collection agency
- Collection effort cease date
- Beneficiary responsible amount
- Recovery detail

COLUMN 14
A/R Write-Off Date

- Date in which the account is transferred out of active A/R
- May be difficult to identify in some provider EHR systems

Exhibit 2A

Medicare Bad Debts Example

TRADITIONAL CASE STUDY:

- Patient A has Medicare and owes their $1,408 deductible for the most recent stay at your hospital. The hospital collects on this patient for at least 120 days, deems the account uncollectible, and writes off the account balance to zero on 8/7/2023.

1	2	3	4	5	6	7	8	9	10	11	12
PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN	MEDICAID NUMBER	PROVIDER DEMMED INDIGENT	MEDICARE REMITTANCE ADVICE DATE	MEDICAID REMITTANCE ADVICE DATE	SECONDARY PAYER RA RECEIVED DATE	BENEFICIARY RESPONSIBILITY AMOUNT
Doe	Jane	4/1/2021	4/3/2021	123456789	Z0S55S531		N	4/17/2021			$1,408.00

13	14	15A	15	16	17	18	19	20	21	22	23
DATE FIRST BILL SENT TO BENE	A/R WRITE-OFF DATE	SENT TO COLLECTION AGENCY (Y/N)	RETURN FROM COLLECTION AGENCY DATE	COLLECTION EFFORT CEASED DATE	MEDICARE WRITE-OFF DATE	RECOVERIES ONLY: AMOUNT RECEIVED	RECOVERIES ONLY: MCR FYE DATE	MEDICARE DEDUCTIBLE AMOUNT	MEDICARE COINSURANCE AMOUNT	PAYMENTS RECEIVED PRIOR TO WRITE-OFF	ALLOWABLE BAD DEBTS AMOUNT
5/2/2021	8/30/2021	Y	8/5/2023	8/5/2023	8/7/2023			$1,408.00	$0.00	$200.00	$1,208.00

Exhibit 2A

Medicare Bad Debts Example

CROSSOVER CASE STUDY:

- Patient B has Medicare with Medicaid as a secondary payer. They have a $1,408 deductible for their most recent stay at your hospital. The hospital bills Medicaid for the deductible and Medicaid pays $108. Remaining balance is written-off to an implicit price concession on 8/7/2023.

1	2	3	4	5	6	7	8	9	10	11	12
PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN	MEDICAID NUMBER	PROVIDER DEMMED INDIGENT	MEDICARE REMITTANCE ADVICE DATE	MEDICAID REMITTANCE ADVICE DATE	SECONDARY PAYER RA RECEIVED DATE	BENEFICIARY RESPONSIBILITY AMOUNT
Doe	John	4/1/2023	4/3/2023	123456789	Z0S55S531	ZZZ7894123	N	4/17/2023	5/5/2023		$0.00

13	14	15A	15	16	17	18	19	20	21	22	23
DATE FIRST BILL SENT TO BENE	A/R WRITE-OFF DATE	SENT TO COLLECTION AGENCY (Y/N)	RETURN FROM COLLECTION AGENCY DATE	COLLECTION EFFORT CEASED DATE	MEDICARE WRITE-OFF DATE	RECOVERIES ONLY: AMOUNT RECEIVED	RECOVERIES ONLY: MCR FYE DATE	MEDICARE DEDUCTIBLE AMOUNT	MEDICARE COINSURANCE AMOUNT	PAYMENTS RECEIVED PRIOR TO WRITE-OFF	ALLOWABLE BAD DEBTS AMOUNT
	8/7/2023	N		8/7/2023	8/7/2023			$1,408.00	$0.00	$108.00	$1,300.00

Going Forward
Takeaways

Best Practices

- Data harmony
  - All three projects utilize the same datasets. Keep these teams connected to ensure consistent and accurate reporting
  - Increases efficiencies and lowers cost
- Recurring reimbursement + revenue cycle meetings
  - This should be a strong relationship to reduce opportunities for lost revenue
- Don’t go at it alone
  - Lean on industry experts – these topics continue to evolve and are increasingly scrutinized
- Perform periodic mock audits throughout the year
  - Identify process gaps that can be corrected prior to year-end

Common Pitfalls

- Not aligning practices with policies
- Lack of education between patient access, middle revenue cycle, and reimbursement
- Revising policies for one objective and negatively impacting an unrelated reimbursement item
- Purging documentation, particularly with system conversions
- Assigning responsibility/ownership of compiling listing to staff that are unaware of audit requirements or cost reporting instructions
- Not performing necessary reconciliations
- Doing what has always been done in the past

Questions?

Thank you!

forvis mazars

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