Medicare Uncompensated Care Worksheet S10 Reporting & Audits

Soup to Nuts
What did we learn and what’s next?

Fred Fisher, Senior Director
Toyon Associates, Inc.

Notable Recent Events

- MAC Review of 2015 S10 -600 (25%) DSH Hospitals (Fall ’18 - Winter ’19)
- CMS Reversal of 2015 “Expected Payment” Adjustment (Winter ’19)
- Hospitals Notified of Potential Aberrant 2017 S10 Data (Spring ’19)
- MAC Review of 2017 S10 (Summer ’19 – Winter ’19)
- Updated HCRIS Data Published By CMS (July 2019)
- CMS Proposes 2015 or 2017 S10 for Federal Year 2020 UC Payments (Spring ’19)
- Updated HCRIS Data Published By CMS (July 2019)

2015 S10 Audits

- Resubmitted S10 Data Was Accepted
  - Total charges by date of service (DOS)
  - Non-covered Medicaid
  - Repayment of bad debt and charity
- Variations in Review Process Materialized
  - "Expected vs. actual" payments
  - Charity co-payments with charity co-insurance and deductibles (C+D)
  - Interpretation of Financial Assistance Policy (FAP) language
- Large Data Requires Advanced Skills
  - Data request includes superfluous fields
  - Data requested in separate Excel tabs
  - Challenges analyzing supporting detail
2015 S10 Reporting

Common Adjustments to Uninsured and Insured Charity Cost in 2015

Uninsured Charity Care
- Include self-pay discounts per FAP
- Amend to report charity care charges by DOS (however, in 2017 charity is reported by write-off date)
- Report non-covered Medicaid per FAP

Insured Charity Care
- Remove/reclassify amounts not related to charity C+D or charges from Medicaid days exceeding LOS limit*
- Adjustments to remove non-covered Medicaid from "insured" and report as "uninsured"

*Changes are also reported on WS S10 Line 25 Col. 1 to ensure amounts are reduced to cost

Since September 2017, National 2015 UC Cost has Decreased by $4.2bn*

$3.9bn Decrease in Charity | $337m Decrease in Bad Debt

*Changes comparing September 2017 HCRIS to June 2019 HCRIS (S10 Line 30 Col. 1)

Top 5 Increases by State

<table>
<thead>
<tr>
<th>State/Province</th>
<th>Top 5 Increase in Charity Cost ($10.000)</th>
<th>Top 5 Decreases in Charity Cost ($10.000)</th>
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<tbody>
<tr>
<td>WA</td>
<td>$5.612,217</td>
<td>$127,249,297</td>
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<tr>
<td>CA</td>
<td>$5.212,608</td>
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National Charity Charge Increase of $15.3bn — $3.9bn Reduction in Charity Cost

Due to Adjustments on WS S10 Line 20, Col. 2

*Changes comparing September 2017 HCRIS to June 2019 HCRIS **Line 20 = Charges $22.0bn -$6.7bn $15.3bn

Line 21 = Cost of Patients $1.3bn -$6.7bn -$5.4bn

Line 22 = Patient Payments ***$459.0m -$199.0m $260.0m

Line 23 = Net Cost $2.6bn -$6.5bn -$3.9bn

*Changes comparing September 2017 HCRIS to June 2019 HCRIS
Variations During Review Process

Actual vs. Expected Patient Payment

Cost Report Instruction Interpretation

Financial Assistance Policy Interpretation

Requested Supporting Documentation

2015 S10 Audits

Variations During Review Process

Actual vs. Expected Patient Payment

Cost Report Instruction Interpretation

Financial Assistance Policy Interpretation

Requested Supporting Documentation

Actual vs. Expected Payment Example

- Total Hospital Charges on Line 20: $10,000
- Uninsured Cost on Line 21: $2,000
- Payment on Line 22: $0
- Cost % of the Total Charity Care Charges (D/A): 20%
- Bad Debt on Line 26: $0
- Bad Debt Cost as % of Bad Debt Charges (G/F): 0%
- Grand Total Amount of UC Cost (D+G): $2,000
- Recognized Percentage of UC Cost (I/A): 20%

March 2019 Update:
CMS Clarified that actual payments, not expected payments, are to be reported
Revisions will be reflected in a later HCRIS file (e.g., June 2019 HCRIS)

Cost Report Instruction Interpretation

Charity Co-payments
- Cost report instructions state: "Enter in column 2, the deductible and coinsurance payments... which the provider has a contractual relationship that were written off to charity care"
- Some MACs are not allowing charity care co-payments due to a literal interpretation of "deductible and coinsurance" terminology
- FAP Tip: Consider covering eligibility for co-insurance, co-pay and deductible amounts for insured patients

Non-Covered Medicaid
- Cost report instructions state: "Enter in column 1, charges for non-covered services provided to patients eligible for Medicaid..."
- Some MACs are evaluating each non-covered Medicaid transaction and determining which are "covered"
- FAP Tip: Consider discussing Medicaid encounter/transaction types that are considered non-covered by the hospital and eligible for charity care

All FAP tips are focused on policy language as it relates to reporting uncompensated care on the Medicare cost report. All other regulations (e.g., 501r) must also be considered when crafting FAP language.
2015 S10 Audits

FAP Interpretation

Charity Care Eligibility
- Varying review determinations in allowing charity; some cases relate to verbiage used in the FAP
- FAP Tip: Ensure language in the FAP matches the hospital’s process and available supporting documentation; sample large and random claims

Presumptive Charity Care
- Varying determinations allowing presumptive charity care; some cases related to expected documentation not readily available
- Reporting Tip: Consider maintaining a log of all presumptive charity care and ensure the supporting detail matches what is articulated in the FAP

All FAP tips are focused on policy language as it relates to reporting uncompensated care on the Medicare cost report. All other regulations (i.e., 501r) must also be considered when crafting FAP language.

2015 S10 Audits

Requested Support
- Patient account detail
- Revenue code detail if hospital bills for professional services
- Charity and bad debt detail requested separately

Sampled Claims
- No or very few samples
- Pilot testing
- Large sampling (100 or more accounts)
- Hospitals were requested to provide support under short order

Extrapolation
- In many cases, hospitals were able to resubmit data with very little effects of extrapolated adjustments
- In some cases, MACs applied findings of sampled claims to an extrapolated result

S10 Trend: 2015 - 2017

Comparing June ‘19 HCRIS to CMS FY 20 IPPS Proposed Rule
- $1.2bn increase to national 2015 UC Cost
- $318m increase to national 2017 UC Cost

California:
- $32.4m increase to 2015 UC Cost
- -$81.0m decrease to 2017 UC Cost
S10 Trend: 2015 - 2017
Comparing June '19 HCRIS to CMS Proposed Rule

Notable Range of Cost Change

<table>
<thead>
<tr>
<th>Notable Range of Cost Change</th>
<th>Number of DSH Hospitals</th>
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<tr>
<td>$100M+</td>
<td>1</td>
</tr>
<tr>
<td>$50M to $99M</td>
<td>2</td>
</tr>
<tr>
<td>$1M to $5M</td>
<td>27</td>
</tr>
<tr>
<td>$500K to $999K</td>
<td>28</td>
</tr>
<tr>
<td>-$1M to -$999K</td>
<td>18</td>
</tr>
<tr>
<td>-$1M to -$5M</td>
<td>58</td>
</tr>
<tr>
<td>-$10M to -$99M</td>
<td>8</td>
</tr>
</tbody>
</table>

*Initial Observations from June 2019 HCRIS – IF CMS USES 2015 FOR DSH PAYMENTS – WITH UPDATED HCRIS DATA – IN FFY 2020

Updated HCRIS Data Impacts Budget Neutrality to the $8.5bn UC Fund*

*Initial Observations Comparing June 2019 HCRIS UC Cost to UC Cost as Published by CMS in the FFY 2020 IPPS Proposed Rule
The national average of Charity C+D to total charges is ~15%*.

In 2015, calculated from the June HCRIS file, 457 DSH hospitals reported C+D greater than 25% total charity charges.

Decrease of 63 hospitals (as compared to 520) flagged for over-reporting C+D in the FFY 2020 IPPS Proposed Rule.

*When weighted for hospital size (UC cost), this percentage is ~8%

2017 S10 data shows improvement with 438 DSH hospitals with C+D greater than 25% total charity charges.

Some hospitals received a notice of aberrant data from CMS and/or are under a review of 2017 S10.

S10 Reporting

Differences in 2015 & 2017 UC Reporting

Federal Year 2015:
- Charity by DOS | Bad debt by write-off date
- Report charity by total hospital charges | Bad debt by write-off amount
- Report actual payments related to charity DOS during 2015

Federal Year 2017:
- Charity and bad debt by write-off date
- Report discounted charges (write-off amount)
- Report payments received in 2017 related to charity dose and reports before 10/1/16 (likely small amounts)
S10 Reporting

2017 Audits

- MACs contact selected hospitals for S10 audits
- Trend of same hospitals selected for 2017 S10 audits also selected for 2015 S10 audits

July 2019

- Hospitals have audit kick-off meetings with MACs and provide initial requested data
- Toyon observation: The MACs all appear to be working from the same S-10 standard request excel template

December 31, 2019

- Deadline for MACs to submit 2017 audit findings to CMS
- Toyon observation: Regardless of the data used for FY 2020, based on audit activity, it appears CMS is looking to use 2017 S10 for UC DSH funding in future years

S10 Reporting

2017 Audit Data Request

- MACs allow hospitals to add columns to the data request
- Toyon recommends columns are added for cases when:
  - Reported charity care does not come from the transaction amount
  - Charity care or bad debt needs to be reclassified to another category

Charges for Non-covered Medicaid

- Ensure the discounted charge is reported as opposed to the expected payment amount
- Column for any reclassified amounts (e.g., from insured charity on line 20 col. 2 to uninsured charity on line 20 col. 1)

Reclassify UC Amounts

- "For an insured patient who receives charity that is not the patient's C+D, the remaining patient balance following payment from an insurer…must be reported on column 1 and is subject to the CCR"

Non-covered Medicaid

- What are non-covered services?
  - The term "non-covered" has different meanings across the healthcare industry
  - Non-Covered Per Contract vs. Non-Billable / Denials
  - Non-Covered example: lab-work for observation care
  - Non-Billable / Denials example: TAMO Medical Necessity, Billing (Emergency Billing, etc.)

- What guidance is provided on non-covered services?
  - CMS has not defined "non-covered" for purposes of uncompensated care reporting

Data Sources

- Patient transaction details
- Medicaid 835 Remittance Advice (TPS)
- Revenue Codes, Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARCs)

Non-Covered Per Contract vs. Non-Billable / Denials

- Non-Covered example: lab-work for observation care
- Non-Billable / Denials example: TAMO Medical Necessity, Billing (Emergency Billing, etc.)
S10 Reporting

FAP Language Considerations

Presumptive Eligibility

- Is there ideal presumptive eligibility language that hospitals should include in their FAPs?
- What support will CMS find sufficient for claims approved for charity care under presumptive eligibility?

Definition of Non-Covered

- What is the definition of “specified” regarding non-covered Medicaid services in a hospital’s FAP?
- CMS does not define “non-covered” services in S-10 instructions. No current S-10 distinction between non-covered and non-billable services.

Non-Contractual Relationship

- Why is this UC category separate from any other charity care qualification?
- If charges related to patients with insurance not under contract with the hospital may be reported, can hospitals also report charges related to non-covered services provided to insured patients?

Revenue Recognition Accounting Standards

“FASB Topic 606”

<table>
<thead>
<tr>
<th>Intent</th>
<th>Effective Date</th>
<th>Impact on Financial Reports</th>
<th>Impact on WS S-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus is on implied performance obligations</td>
<td>Fiscal Periods Beginning After 12/15/17</td>
<td>Hospital reporting of bad debts will decrease</td>
<td>CMS clarification may be needed for reporting consistency</td>
</tr>
</tbody>
</table>

- A performance obligation can be explicit in a contract or it can be implied.
- Amounts not historically collected are considered an implicit promise of service (implicit price concession).

Est. Impact to Financial Reports

- Hospitals may reclassify amounts previously written off as bad debt to charity.
- This may involve determining the likelihood of collecting on accounts.
- Amounts historically not collected could then be deemed charity for UC reporting.

Impact on WS S-10

- CMS clarification may be needed for reporting consistency.

Charity Care and Revenue Recognition

- FAPs are public facing for qualification.
- Top of S10 is an accounting definition related to charity qualifications.
- Without clarification from CMS, providers may record S10 transactions as a form of patient financial assistance (charity).
- The existence of internal charity accounting policies could open “Pandora’s box” causing additional variation in hospital UC reporting.

Insight:
- Many bad debts are C+D. If reported as charity care, this would result in large variations in cost.
- When reported as bad debt, C+D are reduced by the CCR.
- When reported as charity, C+D are not reduced by the CCR.
• Build system out for:
  o Audit data request elements
  o Reference of supporting detail
  o Changes to Medicare cost reporting instructions
  o Other Governmental programs

• Standard reports to respond to inquiries and audits
• Benchmarking and measurements
  o Relationship of charity, Medicaid and bad debt
  o UC by month, quarter, year, etc.

• Determine the best tool and skillset, with the ability to tailor reports based on varying and evolving program instructions
• Meet with a multi-disciplined staff to discuss what is truly uncompensated care
• If certain amounts are not allowable for reporting, quantify and maintain these costs to articulate the whole story

### Data Source Purpose

| Transaction Code Report - Charity Care, Uninsured Discounts and Bad Debt | To determine the transaction codes and appropriate amounts to report as uncompensated care considering the value that each transaction represents (charge vs. expected payment) and account reversals. |
| Hospital Policies: Financial Assistance, Charity Care and Bad Debt | To identify allowable uncompensated care amounts and determine which transaction codes (above) match each FAP category. |
| Patient Transaction and Remittance Detail | To report charges and payments associated with transaction and revenue codes allowable for UC cost reporting. |
| Listing of Non-Contracted Insurance Plans | To determine potential claims eligible as uncompensated care whereby the entity does not have a contracted relationship with the provider. |

### Data Source Purpose

| Bad Debt Accounting Process | To understand the accounting of hospital bad debts, specifically when/how accounts are written off as bad debt including how research and estimates are recognized. |
| Detailed listing of Medicare Bad Debt totaling for the respective cost reporting year | To ensure the Medicare bad debts reported on the cost report are included in the amount of total reported bad debt (Line 26). |
| Sample of Accounts Reported on S10 FY: Sample accounts with large amount, transactions spanning multiple fiscal years, as well as other random accounts. | To sample and test accounts for audit support. Account support may include, but is not limited to:
  o All Patient Transaction Detail
  o All Revenue Codes and Associated Revenue Code Charges
  o Completed patient eligibility forms for FAP/charity care
  o Remittance Advice and Patient Notes/Screen Shots |
## S10 Reporting

### 2017 Audit Data Request

<table>
<thead>
<tr>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Status (Insured or Uninsured)</td>
<td>Total Patient Payments for Services Provided</td>
</tr>
<tr>
<td>Primary Payor Plan</td>
<td>Total Third/Party Payments for Services Provided</td>
</tr>
<tr>
<td>Secondary Payor Plan</td>
<td>Patient Charity Contractual Amount</td>
</tr>
<tr>
<td>Payment Transaction Code</td>
<td>Other Contractual Amount (insurance write-off, courtesy discount)</td>
</tr>
<tr>
<td>Patient Identification Number (ODN)</td>
<td>Non-Covered SCL Charges for Days Exceeding LOS Limit</td>
</tr>
<tr>
<td>Patient Name</td>
<td>Date of Collection (patient payment)</td>
</tr>
<tr>
<td>Patient Risk Due</td>
<td>Amount of Cash Collection (patient payment)</td>
</tr>
<tr>
<td>Social Security Number</td>
<td>Patient Liability on Claim (patient payment)</td>
</tr>
<tr>
<td>Patient Gender</td>
<td>Total Hospital Charges for Services Provided (patient payment)</td>
</tr>
<tr>
<td>Admission Date</td>
<td>Cost Report Year Claimed on W/S S-10 Line 20 (patient payment)</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>Patient Liability on Claim (patient payment)</td>
</tr>
<tr>
<td>Service Indicator Dependent Hospital (Inpatient / Outpatient)</td>
<td>Bad Debt Amount Written Off as Claim (patient payment)</td>
</tr>
<tr>
<td>Revenue Code*</td>
<td>Date of Write Off to Bad Debt</td>
</tr>
<tr>
<td>Revenue Code Total Charges for the Claim*</td>
<td>Patient Bad Debt Write-Off Amount</td>
</tr>
</tbody>
</table>

*If your hospital tracks professional fees/physician charges in a separate system from your hospital charges, and therefore, professional fees and physician charges would have to be queried separately in order to be included in your patient detail listings, you do NOT have to provide revenue code detail.

## S10 Resources

### Source

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<td>FY 2019 IPPS Final Rule and Correction Notice</td>
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### Questions?

Raise your hand or submit a question at [www.menti.com](https://www.menti.com) and enter code 29 15 36
Fred Fisher
Senior Director
Toyon Associates, Inc
Uncompensated Care Recognition Services
dfred.fisher@toyonassociates.com
888.514.9312