Worksheet S-10 - Hospital Uncompensated and Indigent Care Data Questions and Answers

Q1. Courtesy Discount Definition – Request for CMS to clarify the definition of courtesy discounts as some hospitals use this term for self-pay discounts (as opposed to discounts for “friends and family”).

A1. For Medicare purposes, courtesy discounts are not included in the definition of charity care and uninsured discounts on Worksheet S-10.

Q2. Write Off Definition – Request for CMS to clarify the definition of “written-off” as it pertains to bad debt. In many cases bad debt is “written off” a hospital’s general ledger and then sent to a collection agency for attempts to recover patient payment.

A2. Medicare recognizes Medicare bad debt when collection efforts cease and there is no reasonable expectation of recovery. If a hospital writes off bad debt in a general ledger and continues collection, Medicare would not recognize this as a Medicare bad debt. The amount reported for all other non-Medicare bad debts must be net of recovery.

Q3. Coinsurance and Deductible Bad Debt for Insured Patients that do not Qualify for Charity Care – Can CMS provide the reasoning why these amounts are reported on line 26 as the amount “written off”, which are subject to the cost to charge ratio. Furthermore, the cost report definition of bad debt states “charges for health services…” This conflicts with the line 26 instructions to report the amount “written off” to bad debt, as coinsurance and deductible amounts are not written off at charges. Lastly, CMS treats bad debt coinsurance and deductibles for Medicare patients and patients that qualify for charity care differently, by not applying the cost to charge ratio. To be consistent, will CMS consider that all bad debt coinsurance and deductibles should not have the cost to charge ratio applied?

A3. For Medicare Part A and Part B, the bad debt amounts are exclusively deductible and coinsurance; therefore, the CCR is not applied. All other bad debt is included as total facility bad debt on the Medicare cost report and the CCR applies. The CCR is applied for all other bad debt because those amounts are not limited to deductible and coinsurance.

Q4. Coinsurance and Deductibles as Charity Care (Part I) – According to the first 2 examples in the September 29th MLN update, any unpaid amounts related to a coinsurance and deductible, whereby a portion of the coinsurance/deductible was written off to charity care, may be reported to as charity care as opposed to bad debt. Can CMS please clarify that these unpaid patient portions can be reported on line 20 column 2 (no application of the cost to charge ratio)?

A4. Yes. Note that examples 1 and 2 of the MLN Matters Special Edition article SE 17031 assume the following: The hospital has a charity care policy; an insured patient has met the hospital’s charity care criteria; the health service provided was considered allowable and the cost reporting period is on or after October 1, 2016. Thus the amounts written off to charity care for insured patients are reported on line 20, column 2.
Q5. Coinsurance and Deductibles as Charity Care (Part II) – Since instructions state to report the amount written off on line 20 col 2 (and not the patient obligation), it is unlikely that there would be any patient payments reported on line 22, col 2. Can CMS please confirm that is the expectation?

A5. For cost reporting periods beginning on or after October 1, 2016, it is unlikely that providers will report amounts on line 22. In the event that an amount is received, it should be reported on this line.

Q6. Insured Patient Obligation on Remaining Balance after Charity Care – What column of line 20 and what amount should be reported when an insured patient receives charity care on a remaining balance that is not the patient’s coinsurance/deductible. In this case, the insurance plan made a partial payment, and part of the remaining patient obligation was written off to charity care.

A6. The remaining balance can only represent either a deductible, co-insurance or charges for days exceeding a length-of-stay limit for patients enrolled in Medicaid or other indigent care program, and are reported on line 20, column 2. Any other amounts that may be remaining balances following the partial payment from an insurer (i.e., contractual allowances) cannot be reported on line 20, columns 1 or 2.

Q7. State Laws Limiting Amounts Billed to Uninsured Patients – In some cases, hospital financial assistance policies may not specify self-pay discounts because it is a state law that certain discounts are automatically applied. In these cases, can the state regulation be cited as support in place of the hospital’s financial assistance policy?

A7. The state regulation may be cited, but it must also be included in the hospital’s written charity care or financial assistance policy.

Q8. Medicaid Non-Covered Services and Hospital Financial Assistance Policies – Cost report instructions allow Medicaid non-covered charges as uncompensated care provided these non-covered charges are specified in the hospital’s financial assistance policy. However, hospitals cannot request compensation related to non-covered services from Medicaid patients and therefore these amounts are automatically written off as charity care. Because hospitals are not pursuing collections from Medicaid patients, can CMS reconsider the requirement that non-covered Medicaid charges are specified in the financial assistance policy as a requirement for reporting as uncompensated care?

A8. The charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are reported on Worksheet S-10, line 20, column 2 and line 25 in accordance with the hospital’s charity care or financial assistance policy.

Q9. Other indigent care programs – Can CMS provide a list or examples as to what programs qualify as “other indigent care”? Medicaid programs that are “state only” (i.e., no federal match) come to mind, however can CMS clarify if other indigent care programs are eligible (i.e., subsidized plans through the Exchange).
A9. We (CMS) do not have an exclusive list of other indigent care programs as such programs may vary by state or county. The instructions for Worksheet S-10 do not specify which programs qualify as other indigent care programs.

Q10. Insurance Plans that do not have a Contractual Relationship with the Provider – Can CMS please clarify that to report uncompensated care for this group, that these patients also must meet the hospital’s financial assistance policy/criteria? This will help with any confusion whereby some hospitals could be reporting charges for all patients insured by a plan that does not have a contract with the hospital.

A10. Yes, patients that have insurance plans that do not have a contractual relationship with the provider must meet the hospital’s charity care and/or financial assistance policy criteria in order to receive charity care.

Q11. Settled Cost Reports – Some cost reports from FFY 2014 have already been issued a Notice of Program Reimbursement (NPR). Will Medicare Administrative Contractors (MAC) still accept re-opened cost reports so that S-10 revisions can be considered? Some providers are concerned as re-opened cost reports in theory must include an issue of at least $10,000 related to the cost reporting period.

A11. Yes, the MACs shall accept amended cost reports or reopening requests to amend Worksheet S-10 data.

Q12. Are all S-10 changes to be submitted as Amended reports?

A12. Worksheet S-10 changes must be submitted as amended cost reports if no NPR has been issued. If an NPR has been issued, a reopening request with amended S-10 data must be submitted.

Q13. How are reports that have been settled or adjusted by the MACs for Wage Index adjustments to be submitted?

A13. If an NPR has been issued, a reopening request must be submitted with revised Worksheet S-10 data that the MAC will incorporate into the settled or adjusted for wage index cost report.

Q14. What happens to the application of the calculation of the CCR ratio on co-payments if the report is not amended? Will the calculations still be made? (There are concerns that the software would require that every cost report must be reopened to allow the calculation to take place and have it be reflected in the HCRIS files. Apparently there could be a technical hiccup?)

A14. The modified calculations provided in T-11 will be applied to all FY 2014 and FY 2015 cost reports, both amended and not amended; however, if the cost report fails the level 1 edits, the modifications will not be applied and the revised HCRIS files will not be generated. Providers are encouraged to review the level 1 edits and submit amended
or reopening requests to clear the level 1 edits if applicable to ensure they benefit from the calculation modifications.