WORKSHEET S-10: KEY POINTS AND CONSIDERATIONS FOR CALCULATING HOSPITAL UNCOMPENSATED CARE
OUTLINE

• Overview of FY 2019 IPPS Final Rule
• Uncompensated Care Data Analysis and Trends
• Brief Overview of Waiver Extension
• S-10 Definitions and Instructions
• Charity Care Policy Review
• CMS Audits
• Appeals Consideration
• Approaches & Next Steps
• Questions
UNCOMPENSATED CARE UNDER ACA

- Starting with FFY 2014, qualifying Medicare DSH providers receive an empirically justified DSH payment, which is calculated at 25% of the traditional DSH formula.
- Remaining 75% DSH reimbursement is distributed to all qualifying providers under an uncompensated care reimbursement formula.
- Fixed UC pool divided among providers based on their percentage of uncompensated care costs
- FY 2018 – CMS first began using blend of UC data from Worksheet S-10 and low income days
UC FACTOR 1

- Medicare DSH Estimate: difference between CMS’ estimate of what DSH payments would have been in 2019 absent the passage of the Affordable Care Act and the 25% empirically justified amount
  - FFY 2019 Estimate = $16.339B
  - About 5% yearly average increase
    - 25% empirically justified reduced = $4.085B
    - Resulting Factor 1 for FFY 2019 = $12.254B
      - $589 Million more compared to FFY 2018 final rule
UC FACTOR 2 – REDUCTION FACTOR

- Reduces Factor 1 based on the change in the national uninsured rate
  - CMS Office of the Actuary report as part of development of the National Health Expenditures Account (NHEA)...continues in FY 2019
- 2019 Final Factor 2 = 67.51%
- 2019 Gross Pool from Factor 1 = $12.254 Billion
- 2019 Final Factor 2 = $8.273 Billion
  - Distributed to 2,485 hospitals projected to qualify for DSH in FY2019
  - Increase of ≈$1.5 Billion (22.26%) from FFY 2018
UC POOL TRENDS

FFY 2014: $9,032,997,000
FFY 2015: $7,647,644,885
FFY 2016: $6,406,145,534
FFY 2017: $5,977,483,147
FFY 2018: $6,766,695,163
FFY 2019: $8,272,872,447
UC FACTOR 3 – FFY 2019

• FFY 2019 IPPS Final Rule Factor 3:
  ➢ A blend of low-income days and UC costs per worksheet S-10
  • FY 2013 Medicaid days + 2016 SSI days
  • FY 2014 Uncompensated care cost per S-10
  • FY 2015 Uncompensated care cost per S-10
• Finalizing again the use of uncompensated care costs for purposes of calculating Factor 3 from Line 30
  ➢ Cost of charity care – Line 23
  ➢ Cost of non-Medicare bad debt – Line 29
**FEDERAL UC REIMBURSEMENT SHIFT - STATES**

### Largest Gains By Dollars - 2018 UC vs 2019 UC

<table>
<thead>
<tr>
<th>State</th>
<th>Providers</th>
<th>2018 UC Payment</th>
<th>2019 UC Payment</th>
<th>Variance</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>199</td>
<td>730,655,269</td>
<td>1,134,362,359</td>
<td>403,707,090</td>
<td>55.25%</td>
</tr>
<tr>
<td>FL</td>
<td>132</td>
<td>593,668,674</td>
<td>788,072,441</td>
<td>194,403,766</td>
<td>32.75%</td>
</tr>
<tr>
<td>GA</td>
<td>86</td>
<td>247,624,240</td>
<td>352,724,410</td>
<td>105,100,169</td>
<td>42.44%</td>
</tr>
<tr>
<td>NC</td>
<td>69</td>
<td>241,716,249</td>
<td>306,289,970</td>
<td>64,573,722</td>
<td>26.71%</td>
</tr>
<tr>
<td>IL</td>
<td>104</td>
<td>266,434,720</td>
<td>330,607,411</td>
<td>64,172,691</td>
<td>24.09%</td>
</tr>
</tbody>
</table>

### Largest Gains by Dollars - 2019 UC to S-10 Only UC

<table>
<thead>
<tr>
<th>State</th>
<th>Providers</th>
<th>2019 UC Payment</th>
<th>Future UC Payment</th>
<th>Variance</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>199</td>
<td>1,134,362,359</td>
<td>1,414,825,964</td>
<td>280,463,605</td>
<td>24.72%</td>
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<tr>
<td>FL</td>
<td>132</td>
<td>788,072,441</td>
<td>874,034,582</td>
<td>85,962,141</td>
<td>10.91%</td>
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<tr>
<td>GA</td>
<td>86</td>
<td>352,724,410</td>
<td>411,057,013</td>
<td>58,332,603</td>
<td>16.54%</td>
</tr>
<tr>
<td>VA</td>
<td>49</td>
<td>182,684,295</td>
<td>219,718,809</td>
<td>37,034,515</td>
<td>20.27%</td>
</tr>
<tr>
<td>SC</td>
<td>35</td>
<td>161,468,807</td>
<td>188,994,161</td>
<td>27,525,354</td>
<td>17.05%</td>
</tr>
</tbody>
</table>
## FEDERAL S-10 NATIONAL VS. TEXAS (CHARITY)

<table>
<thead>
<tr>
<th></th>
<th>FFY 2014 Nation</th>
<th>FFY 2014 TX</th>
<th>FFY 2015 Nation</th>
<th>FFY 2015 TX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualify for DSH</td>
<td>2,375</td>
<td>198</td>
<td>2,375</td>
<td>201</td>
</tr>
<tr>
<td>Cost Reports:</td>
<td>1,494</td>
<td>139</td>
<td>1,480</td>
<td>143</td>
</tr>
<tr>
<td>Governmental</td>
<td>153</td>
<td>16</td>
<td>130</td>
<td>14</td>
</tr>
<tr>
<td>Proprietary</td>
<td>440</td>
<td>62</td>
<td>434</td>
<td>64</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>901</td>
<td>61</td>
<td>916</td>
<td>65</td>
</tr>
</tbody>
</table>

### Charity:

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<tr>
<th></th>
<th>FFY 2014</th>
<th>FFY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Reports</td>
<td>1,428</td>
<td>1,409</td>
</tr>
<tr>
<td>Increased by</td>
<td>26.43%</td>
<td>28.40%</td>
</tr>
<tr>
<td>Average</td>
<td>63,371,674,273 to 80,122,648,791</td>
<td>61,899,253,107 to 79,478,498,778</td>
</tr>
<tr>
<td>Median</td>
<td>11,730,374</td>
<td>12,476,399</td>
</tr>
<tr>
<td>Average Decreased</td>
<td>(14,947,653)</td>
<td>(16,667,336)</td>
</tr>
</tbody>
</table>
| Over 50% of the increase in charity charges nationwide is due to 42 providers while over 50% is due to 10 providers in Texas. | Over 50% of the increase in charity charges nationwide is due to 40 providers while over 50% is due to 11 providers in Texas.
## FEDERAL S-10 NATIONAL VS. TEXAS (BAD DEBT)

<table>
<thead>
<tr>
<th></th>
<th>FFY 2014</th>
<th></th>
<th>FFY 2015</th>
<th></th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Nation</td>
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<td>Nonprofit</td>
<td>901</td>
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### Bad Debt:

<table>
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<th></th>
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<td>TX</td>
<td>Nation</td>
<td>TX</td>
</tr>
<tr>
<td>Cost Reports</td>
<td>1,133</td>
<td>128</td>
<td>1,153</td>
<td>130</td>
</tr>
<tr>
<td>Increased by</td>
<td>3.33%</td>
<td>-20.87%</td>
<td>-0.39%</td>
<td>-8.04%</td>
</tr>
<tr>
<td></td>
<td>48,462,048,797 to 50,073,980,216</td>
<td>8,239,303,477 to 6,519,384,423</td>
<td>48,169,182,402 to 47,980,408,052</td>
<td>7,672,601,474 to 7,055,992,031</td>
</tr>
<tr>
<td>Average</td>
<td>1,422,711</td>
<td>(13,436,868)</td>
<td>(163,725)</td>
<td>(4,743,150)</td>
</tr>
<tr>
<td>Median</td>
<td>1,120,804</td>
<td>815,965</td>
<td>164,061</td>
<td>471,735</td>
</tr>
<tr>
<td>Decreased</td>
<td>358</td>
<td>53</td>
<td>497</td>
<td>59</td>
</tr>
<tr>
<td>Average</td>
<td>(14,969,332)</td>
<td>(56,221,036)</td>
<td>(10,514,763)</td>
<td>(26,066,290)</td>
</tr>
</tbody>
</table>

77% of the decrease in bad debt in Texas is due to 1 provider.

46% of the decrease in bad debt in Texas is due to 1 provider in Texas.
WORKSHEET S-10 ANOMALIES (TX)

• FFY 2014 & FFY 2015
  ➢ 19 reported 0 total charity
  ➢ 1 reported 0 uninsured charity
  ➢ 51 reported 0 insured charity
  ➢ 7 reported negative amounts on line 22
  ➢ 8 reported insured charity amounts greater than uninsured charity

• FFY 2016
  ➢ 10 reported 0 total charity
  ➢ 26 reported 0 insured charity
  ➢ 3 reported negative amounts on line 22
  ➢ 9 reported insured charity amounts greater than uninsured charity
WAIVER EXTENSION

- 5-year extension approved by CMS on December 21, 2017
- Methodology must conform to nationally applied federal policies
- Gravitate towards charity care
- Precise definition of uncompensated charity care costs
  - Consistent with Medicare cost reporting principles
WAIVER EXTENSION (CONT’D.)

• First 2 years
  ➢ Pool size approx. $3.1B

• Years 3-5
  ➢ Resize the pool using charity care data from Medicare cost reports beginning in calendar year 2017
    ➢ Amend cost report if needed
  ➢ Resize by September 2019
    ➢ If not, placeholder data will be used
  ➢ Reconciliation for actual payment period
  ➢ S-10 will be used for resizing and throughout demonstration period
UC PROTOCOL – S-10 USE

• Several time periods S-10 will be used
  ➢ Pool resizing
  ➢ Payment determination
  ➢ Reconciliation
WORKSHEET S-10 DEFINITIONS & INSTRUCTIONS

• CMS charity care definition – charity care and uninsured discounts that result from a hospital’s policy to provide all or a portion of services free of charge to patients who meet the hospital’s charity care policy or financial assistance policy. Charity care and uninsured discounts can include full or partial discounts. Prompt pay or courtesy discounts excluded from S-10.

• Charity care reporting requirements:
  ➢ Before 10/1/16, charity charges claimed by service dates of patient within fiscal year.
  ➢ After 10/1/16, charity charges claimed by actual write-off dates occurring within fiscal year, regardless of service dates of patient.
WORKSHEET S-10 DEFINITIONS & INSTRUCTIONS (CONT’D.)

• Line 20 instructions:
  “Enter the actual charge amounts for the entire facility (except physician and other professional services) of uninsured patients who were given full or partial discounts that were: (1) determined in accordance with the hospital’s charity care criteria/policy or FAP, and (2) written off during this cost reporting period, regardless of when the services were provided.”

• Review procedures at the patient level. Policy only as good as the procedures put in place to follow that policy.

• Professional fees must be excluded from Worksheet S-10
Line 20 instructions (cont’d.):

“Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital’s charity care policy and the patient meets the hospital’s charity care criteria.”

Review policy to make sure these are included and patient financial system can capture these charges.
WORKSHEET S-10 DEFINITIONS & INSTRUCTIONS (CONT’D.)

• Self-pay / Uninsured discounts:

➢ Do you have a written policy for these self pay discounts?

➢ Have you reviewed the language of your self pay discount policy to make sure it is in compliance with S-10 instructions?

➢ Are you including these discounts currently in Worksheet S-10?

• Significant impact to a hospital’s total charity charges
CMS AUDITS: S-10

• Began this Fall
• S-10 audit data request letter received
  ➢ 18 items requested
    1. A copy of the hospital’s charity care policy and/or financial assistance policy (for both uninsured and insured patients). If not already included in the policy, please include an explanation of how hospital personnel determine insurance status and charity care write-offs.
    2. The above policy (or separate explanation) should also include details on how uninsured patients qualify for full or partial discounts, whether the policy includes charges for non-covered services provided to Medicaid eligible and indigent care patients.
    3. The above policy (or separate explanation) should also include details on the treatment of charges for uninsured patients or patients with coverage from an entity without a hospital contractual relationship.
CMS AUDITS: S-10 (CONT’D.)

4. For insured patients, the above policy (or separate explanation) should also include deductible/coinsurance required by payer (public program/private insurance) for which the hospital has a contractual relationship.

5. For insured patients, the above policy (or separate explanation) should include the non-covered charges for days exceeding length-of-stay limits for patients covered by Medicaid or other indigent care programs.

6. For insured patients, the above policy (or separate explanation) should exclude amounts of deductible and coinsurance claimed as Medicare bad debts.
CMS AUDITS: S-10 (CONT’D.)

7. Describe the logic and process used when querying the hospital charge listings to identify the charges to report on line 20 of worksheet S-10 of the cost report (Charity care charges and uninsured discounts for the entire facility.) In other words, how do you (or would you) filter or query your records to obtain a listing of charges for S-10, with all of the necessary supporting detail. Does this query utilize any criteria from the charity care policy? Is it based solely on certain write-off codes? What date fields are you searching for (service dates, write-off dates, etc.)

8. Describe the logic and process used when querying the hospital charge listings to identify the patient payments to report on line 22 of worksheet S-10 of the cost report (Payments received from patients for amounts previously written off as charity care.) In other words, how do you (or would you) filter or query your records to obtain a listing of payments that relate to previous charity care write-offs for S-10, with all of the necessary supporting detail. Does this query utilize any criteria from the charity care policy to properly match these payments up? How do you ensure that all payments related to previous charity care write offs are included in this line?
9. Using the logic/processes described above, please submit a detailed listing of claimed charges and payments reported on worksheet S-10 line 20 and 22, columns 1 and 2. The listing should reconcile to the reported numbers, or an explanation should be provided to explain why the number initially reported was incorrect. Note that line 20 should not include “courtesy discounts” or “bad debt write-offs.” If any of these have been included in the cost report, please identify them so we can remove them through an adjustment.
9. cont. The listing should be in **Excel format** and include all of the following elements:

- Claim type (insured or uninsured),
- Primary payor plan,
- Secondary payor plan,
- Hospital’s Medicare Number,
- Patient identification number (PCN),
- Patient’s date of birth,
- Patient’s social security number,
- Patient’s gender,
- Patient name,
- Admit date,
- Discharge date,
- Service indicator (hospital inpatient or outpatient),
- Revenue code,
- Revenue code total charges for the claim,
- Date of write off to charity care,
- All patient payments received or expected to be received,
- All third-party payments received or expected to be received,
- Patient charity contractual amount by transaction/adjustment code,
- Other contractual amount by transaction/adjustment code (insurance write-off, courtesy discounts, etc.).
- Non-covered charges for days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care
CMS AUDITS: S-10 (CONT’D.)

9. cont. NOTE: For purposes of the referenced detailed patient charge/payment listing:

“Uninsured” is as follows:

- Uninsured charity care (full or partial charity write-offs);
- Non-covered services provided to Medicaid eligible and indigent care program patients written off to charity care;
- Charity care for patients with coverage from an entity without a hospital contractual relationship.

“Insured” is as follows:

- Deductibles and coinsurance under third-party coverage (public or private insurer) written off to charity care.
- Do not include deductibles and coinsurance claimed as Medicare bad debts.
- Non-covered charges for days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs if included in hospital’s charity care policy.
10. If contractual transaction/adjustment codes are used in this listing, please provide an index to these codes, with a description of what each code means.

11. If the totals from the detail patient charge listing (patient charity contractual amounts plus any patient payments/liability) do not agree to the amounts reported on Line 20 of Worksheet S-10 of the cost report, please submit an explanation and reconciliation.

12. Please ensure that the above listings only include services delivered during the current cost reporting period, and that there are no duplicates included.
13. Please ensure that any physician, professional, or other fee schedule or non-hospital services have been removed from these listings.

14. Please provide an explanation for any large variances between current and prior year (charges and payments) as reported on Worksheet S-10 Line 20 and 22.

15. Please provide a comparison of current year vs. prior year charity care charges from your audited financial statements or working trial balance. If there was a significant change between these two years, please provide an explanation for that change.
CMS AUDITS: S-10 (CONT’D.)

16. Please submit a detail listing of all bad debts (both Medicare and Non-Medicare). This listing should be in **Excel format** and include all of the following:

- Claim type (insured or uninsured),
- Primary payor plan,
- Secondary payor plan,
- Hospital’s Medicare Number,
- Patient identification number (PCN),
- Patient’s date of birth,
- Patient’s social security number,
- Patient’s gender,
- Patient name,
- Admit date,
- Discharge date,
- Service indicator (hospital inpatient or outpatient),
- Revenue code,
- Revenue code total charges for the claim,
- Date of write off to bad debt,
- All patient payments,
- All third-party payments,
- Patient charity contractual amount by transaction/adjustment code,
- Other contractual amount by transaction/adjustment code (insurance write-off, courtesy discounts, etc.),
- Patient bad debt write off.
17. A reconciliation of the bad debt write-offs from your financial accounting records to the bad debts reported on line 26 of worksheet S-10 of the cost report. Note that the bad debt write-offs in your financial accounting records are not generally the same as the bad debts expense reported in your financial statements/working trial balance. Instead, we would need to see the actual bad debt write-offs that led to a decrease in your accounts receivable and a decrease in your allowance for bad debts.

This reconciliation involves two parts:

Part 1: Reconciling your prior year ending accounts receivable from your financial statements and/or working trial balance to your current year ending accounts receivable balance (including increases from patient revenues on account, decreases from payments and decreases from write-offs)

Part 2: Reconciling the write-offs identified in Part 1 to the Medicare cost report (S-10 Line 26) bad debts by subtracting out current year recoveries, physician and other fee schedule or non-hospital bad debts, and bad debts not related to patient deductibles and coinsurance (i.e. insurance and other third-party amounts.)
18. If there are any significant variances between current year and prior year total bad debts, submit an explanation.

- And after all 18 items are provided...
  - Note that CMS will be selecting a sample of charges/payments and bad debts from your listings and will request patient documentation at that time.
CMS AUDITS – BAD DEBT / CHARITY

- Requesting all transaction activity – Tracing Total Charges to Zero (some MACs but not all)
- Reconciliation of bad debt / charity care accounts to financials
  - Actual detail – not provision for bad debt
  - Time consuming
CMS AUDITS – DATA

➢ Demographic Data Required
  • Name
  • DOB
  • Gender
  • SSN
➢ Explanation of all transactions codes and descriptions
  • Tie back to FAP
➢ Some auditors asking questions on patient detail
➢ Questioning payers, regardless of payment
➢ Total charges by revenue code that tie to total patient charges
➢ Review of anomalies (i.e. high write-off amount, large patient payments with charity)
➢ Reconciliation of year over year changes in bad debt / charity totals (i.e. >15%)
CMS AUDITS – SAMPLES

- Samples vary by MAC but generally sample 40-60 patients in 4 categories:
  - Insured
  - Uninsured
  - Inpatient
  - Outpatient

- Support Requested
  - UB
  - RA
  - Proof of income (paystub)
  - Account History

- Extrapolation Risk
  - Small sample size of 10 – 15 accounts per category (i.e. $10,000)
  - Extrapolated against entire category (i.e. $10,000,000)
PRE 10/1/2016 EXPECTED PAYMENT AUDIT ISSUE

Uninsured Discount
➢ Total charges $1,000
➢ Uninsured discount 30%
➢ Patient pays $0
➢ Remaining $700 bad debt
➢ CCR .250

S-10 Entry
➢ Line 20 = $1,000
➢ Line 21 = $250
➢ Line 22 = $700
➢ Line 23 = $-450
➢ Line 26 = $700
➢ Line 29 = $175
➢ Line 30 = $-275

You end up with a $275 “profit” on an account with $250 in cost and $0 payments
Uninsured Discount
➢ Total charges $1,000
➢ Uninsured discount 30%
➢ Patient pays $0
➢ Remaining $700 bad debt
➢ CCR .250

S-10 Entry
➢ Line 20 = $300
➢ Line 21 = $75
➢ Line 22 = $0
➢ Line 23 = $75
➢ Line 26 = $700
➢ Line 29 = $175
➢ Line 30 = $250

You end up with uncompensated cost of $250
OTHER AUDIT ISSUE

Coinsurance
and
Deductibles

vs.

Copay
AUDITS AND APPEALS

- According to Christopher Keough, Partner at Akin Gump, hospitals should assume there will be no effective mechanism to appeal adverse adjustments from audits of S-10 with respect to the impact on the UC DSH calculation.

- Final rule for FFY 2019 does not discuss any avenue or mechanism for appeal or review of an S-10 audit.

- Normal PRRB appeal process not likely helpful:
  - Normal appeals take years to get a decision from the PRRB after the issuance of an NPR.
  - By then, audited S-10 data would already be baked into the UC DSH calculation for affected FFYs.

- UC DSH statute precludes administrative or judicial review of estimates used to determine UC DSH payment (including Factor 3).
AUDITS AND APPEALS

• Takeaways:
  ➢ Should assume any audit of S-10 data is going to be the only opportunity to get the right S-10 data incorporated in the UC DSH calculation
  • Cannot assume there will be a meaningful and effective opportunity to appeal and remedy incorrect audit adjustments to S-10 data used in the UC DSH calculation (though we may try)
  ➢ Be prepared, with consulting or legal assistance as necessary, to respond to and rebut proposed adverse adjustments
  ➢ Premium on doing all you can to get it right in the original as-filed CRP
  ➢ Do not assume future opportunities to amend S-10 filings, but make good use of those opportunities if available
APPROACHES & NEXT STEPS

• FAP review
• CC write-offs
• Patient detail data
• Transaction codes review
• CRs beginning 10/1/18 and after – patient detail required at time of cost report filing
THE WRAP

• FY 2017 focus
• Very best efforts when filing CR
• Analyze UC data
• Review processes
• Review policies
CONTACT INFORMATION

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blog.southwestconsulting.net/blog
SCA EXPERIENCE

- **Southwest Consulting Associates**
  - 30 Years providing Medicare DSH assistance to hospitals in 46 states
    - As-Filed cost report
    - Retroactive Medicaid eligibility
    - Cost Report amendments
    - Reopening and appeal assistance
    - Support our work throughout the MAC audit/desk review
  - Since CMS first proposed S-10 in the FFY 2014 Rulemaking:
    - Built our S-10 practice in preparation for this change
    - 616 fiscal years contracted to prepare S-10 for filing or retroactively review for amending
    - 362 Fiscal years already completed for 129 hospitals across 21 states
    - Operations team has performed S-10 UC compliance reviews since 2014
    - Combined over 330 years of experience at SCA alone
    - Average of 14 years each