A Holistic Approach to Uncompensated Care

From Crowe LLP

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Your presenters

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Agenda

- Worksheet S-10
- Disproportionate Share Hospital (DSH)
- Medicare Bad Debt (MDB)
- Key Data Elements
- Integrated / Holistic Approach
- Questions

Learning Objectives

- Understand general concepts related to Worksheet S-10, Disproportionate Share Hospitals (DSH) and Medicare bad debt reporting (including recent developments)
- Describe how healthcare teams can use integrated data and the Crowe RCA system to produce more timely and accurate uncompensated care reporting
- Outline how protected health information (PHI) risk can be reduced through the use of a “single source of truth”
- Assess current processes and next steps for streamlining and increasing the effectiveness of uncompensated care efforts

Uncompensated Care

The American Hospital Association has reported that hospitals provided more than $660 billion in uncompensated care to their patients since 2000. Some of this care may be reimbursable through uncompensated care pool and reimbursable bad debts. Our presentation will focus on these sources of available funding to reimburse hospitals for uncompensated care.

- Uncompensated care pool – $8.29 billion for federal fiscal year 2021
- Reimbursable bad debts – 65% of unpaid Medicare deductibles and coinsurance

Worksheet S-10

Worksheet S-10 General Concepts

What is Worksheet S-10?

- Used to calculate hospital's uncompensated care cost (Factor 3) and utilized for hospital's share of uncompensated care pool of funds
- FFY 2020 IPPS Final Rule finalized single year of S-10 data for Factor 3 calculation rather than three year cost report averaging
- Components of Worksheet S-10:
  - Cost-to-Charge Ratio (CCR)
  - Unreimbursed Cost
    - Medicaid, CHIP, Indigent Care Programs
  - Uncompensated Care
    - Charity Care
    - Bad Debts

Worksheet S-10 General Concepts

Amounts Reported on Line 20 Column 1

- Uninsured Charity written off during the cost reporting period
- Uninsured patients and insured patients covered by non-contracted (inferred) payer with the hospital
- Non-covered services from Medicaid or other indigent care programs stated in provider's Financial Assistance Policy (FAP)
- No physician or professional service fees
- No courtesy discounts or prompt pay discounts

Line 20 Column 2

- Insured Charity written off during the cost reporting period
- Coinsurance, co-pay and deductible amounts for insured patients written off during fiscal year.
- Non-covered charges for days exceeding length-of-stay limits for patients covered by Medicaid or other indigent care programs stated in provider's FAP **(Reduced by CCR)**
- No physician or professional service fees

Worksheet S-10 General Concepts

Line 22 Column 1 and Column 2

- Enter all payments received from the patient during the cost reporting period, regardless of when the services were provided, from patients for amounts previously written off on Line 20
- Payments recorded on Line 22 must not exceed charity care or uninsured discount amounts written off
  - Example:
    - *Uninsured patient with $100 write off for a provider with CCR of .2000 would be represented as $20. Any payment recorded on Line 22 for this patient could not exceed $20*
- **Do not include payments received that represent the patient's liability amount**
  - Timely credit balance adjudication will impact this
  - What is your hospital's process for attempting to collect after charity determination has been made?
- Do not record payments made for physician or other professional services
- Do not include grants or other mechanisms of funding for charity care

Worksheet S-10 General Concepts

Line 26

- Total facility bad debts including Medicare and non-Medicare bad debt
  - Medicare Allowable amounts are backed out on Line 27.01
- Any recovery or reactivation transactions that would ultimately reduce bad debt
- Regardless of service date, amounts written off during the cost reporting period
- Do not include the following amounts:
  - Amounts related to physician or other professional services
  - Bad debt amounts that were the obligation a private insurance rather than the patient's
  - Any amounts that may have been written off to charity on Line 20

Worksheet S-10 General Concepts

Why is Worksheet S-10 Important?

- Quantifies Uncompensated Care Cost (Charity and Bad Debt) amounts written off by the hospital during the cost reporting period
- Assists in quantifying government/public program shortfalls with respect to Non-Covered services and Length of Stay Limitations
- Uncompensated Care Cost (Line 30) used to determine Factor 3
  - Factor 3 ultimately applied against uncompensated care pool of funds to determine hospital's share of uncompensated care reimbursement

Additional items of Importance:

- Some states are using S-10 data to determine additional uncompensated care funding (Ex. Waiver 1115 program in Texas)
- Provides operations feedback into the financial assistance protocols followed by the hospital
- Improves business office practices going forward to minimize uncompensated care costs and create mechanisms to accurately quantify, report and support uncompensated care costs.

Financial Assistance Policy

Policy Review

- Account for all transaction codes associated with uncompensated care mapped in RCA
- Directly trace all transactions included on Worksheet S-10 to the hospital's Financial Assistance Policy
  - Potential to include amounts as uncompensated care cost that had not been included originally
  - Identify risk items **before** audit to avoid egregious error extrapolations
  - Provide feedback to leadership for future Financial Assistance Policies to resolve future reporting risk

- Transactions usually not mapped as charity care within RCA
  - Self-pay or uninsured discounts
  - Medicaid Non-covered charges / Length of Stay Limitations
  - State specific indigent programs

FFY 2018 Audit Requests and Experiences

FFY 2018 Worksheet S-10 Audit

- Detailed query logic on how Line 20 charity and Line 26 bad debt are identified and reported on Worksheet S-10
- Transaction level support for all amounts reported on Lines 20 and 26 of Worksheet S-10
- Copy of FAP, financial statements, working trial balance
- Reconciliations of both charity and bad debt to general ledger
- Reconciling posted transactions to charges for every account reported
  - Total Charges – payments – contractual adjustments – admin adjustments – denials – bad debt and/or charity write offs
- Explanations of year over year changes between reported charity and bad debt
- Many auditors are still very new to Worksheet S-10 and prone to making inaccurate proposed adjustments
  - Example: Lack understanding of general hospital finance and ultimately how an account adjudicates

DSH

Medicare Disproportionate Share Hospital (DSH)

What is DSH?

- DSH payments began in 1986
- Provided payments to hospitals that serve the most vulnerable population
  - Medicaid beneficiaries
  - Low-income Medicare beneficiaries
  - Uninsured and underinsured
- DSH Adjustment (Empirically Justified) based on two fractions: Medicare fraction (SSI percentage) and Medicaid fraction
- Medicare Fraction – Days of patients entitled to both Medicare Part A and SSI/Total Patient Days Entitled to Medicare Part A; obtained from CMS
- Medicaid Percentage – Days of patients eligible for Title XIX Medicaid, but not entitled to Medicare Part A/Total Patient Days
- Sum ≥15% to qualify (>20.2% higher adjustment factors)

Medicare Disproportionate Share Hospital (DSH) continued

Why DSH is still very important

- New Formula for Calculating DSH Beginning FY 2014
  - Medicare DSH hospitals receive 25% of DSH reimbursement based on the traditional DSH formula
  - Remaining 75% of the amount that would have been received as Medicare DSH would be redistributed to DSH hospitals based on S-10 uncompensated care and additional factors
- Factor 1:
  - Represents CMS' estimate of 75% (100% minus 25%) of its estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year
- DSH supporting detail must be submitted at time of cost report submission in order to be accepted
  - Timely filings for retroactive Medicaid Days
- Used for 340(b) eligibility
  - >11.75% for DSH, Children's, Free-Standing Cancer Hospital
  - >=8% for Rural Referral and Sole Community Hospital
- Similar calculation utilized for rehab units (LIP)

Medicare Bad Debt

Medicare Bad Debt

What is Medicare Bad Debt

- Qualifying unpaid Medicare patient deductible and coinsurance (D&C) amounts from Part A & B
- Gross and net amounts are reported on the annual Medicare Cost Report
- Detailed Exhibit 2 listings submitted with Medicare Cost Report (soon to be revised to Exhibit 2a)

What it is not

- Unpaid D&C which does not follow hospital written policies
- Unpaid Medicare HMO (Part C) D&C amounts *(may be reimbursable via individual plan)*
- Eligible on unpaid fee-based coinsurance
- Eligible on non-covered/denied charges *(with no D&C assigned)*
- ***NEW*** D&C written down to non-bad debt expense mapped GL transaction code

Medicare Bad Debt

Categories

- Dual Eligible / Crossover: Medicare with Medicaid (or Medicaid HMO) secondary
- Self Pay: Unpaid D&C sent and returned from final collection agency
- Charity: Financial assistance qualified
- Deceased: Passed away (in-house or during billing cycle)
- Bankrupt: Discharge or reorg of debts

Crossovers

- Must have fully-adjudicated Medicaid or Medicaid HMO remittance (claim status 2 with CO45 or CO23) prior to written off
- A zero payment on a denied remittance is not the same as a zero payment on a paid remittance
- Must be written down to GL-mapped Bad Debt Expense (not Medicaid Contractual) transaction code for cost reports beginning 10/1/2019
- Retain remittance advice for MAC audit

Medicare Bad Debt

Self Pay

- Must be returned from final agency prior to claiming
- First patient statement sent within 120 days of Medicare payment or last commercial remittance, whichever is later
- No payment in the last 120 days of collection (if so, restart collection clock)
- Similar collection effort, regardless of payer. Non-Medicare accounts often selected for audit review
- Collection policies must be documented, retained and match the actual process
- Agencies must retain activity for future audit support
- Return transaction in PAS to zero out the bad debt receivable (claim on this transaction date) must be shortly after final agency close

Financial Assistance

- Charity qualification prior to write-off
- Policy must contain income and asset test and require supporting documentation. Retain policy and all documentation gathered for audit
- Presumptive eligibility (predictive scoring, etc.) not allowable MBD
- Charity calculation checklist strongly encouraged
- Must be written down to GL-mapped Bad Debt Expense (not Charity) transaction code for cost reports beginning 10/1/2019

Medicare Bad Debt

Deceased

- Probate checked for an estate prior to write off (and documented in account notes)
- Written policy helps determine threshold to search probate and file claim
- Most collection agencies do not search probate
- Must be written down to GL-mapped Bad Debt Expense (not Charity) transaction code for cost reports beginning 10/1/2019

Bankrupt

- Write off on initial court notice typical, as long as balance moved to self pay if Discharge of Debts not received
- PACER.gov recommended for updates on cases
- Must be written down to GL-mapped Bad Debt Expense (not Charity) transaction code for cost reports beginning 10/1/2019

Medicare Bad Debt

Regulatory Update and Audit Experience

- The majority of MBD updates (120 day rule, similar collection effort, asset/income test, elimination of expense/liability test) were expected as they have been long-time audit checks by every MAC
- Confirming similar collection effort between Medicare and non-Medicare accounts was not in the final regs but is widely reviewed by auditors and should be part of the pre-submission process
- Columns on Medicare Bad Debt listing recently revised in new Exhibit 2a (effective 10/1/2020) to enable a “more auditable” deliverable (goal to reduce documentation requirements at audit)

Key Data Elements

Key Data Elements

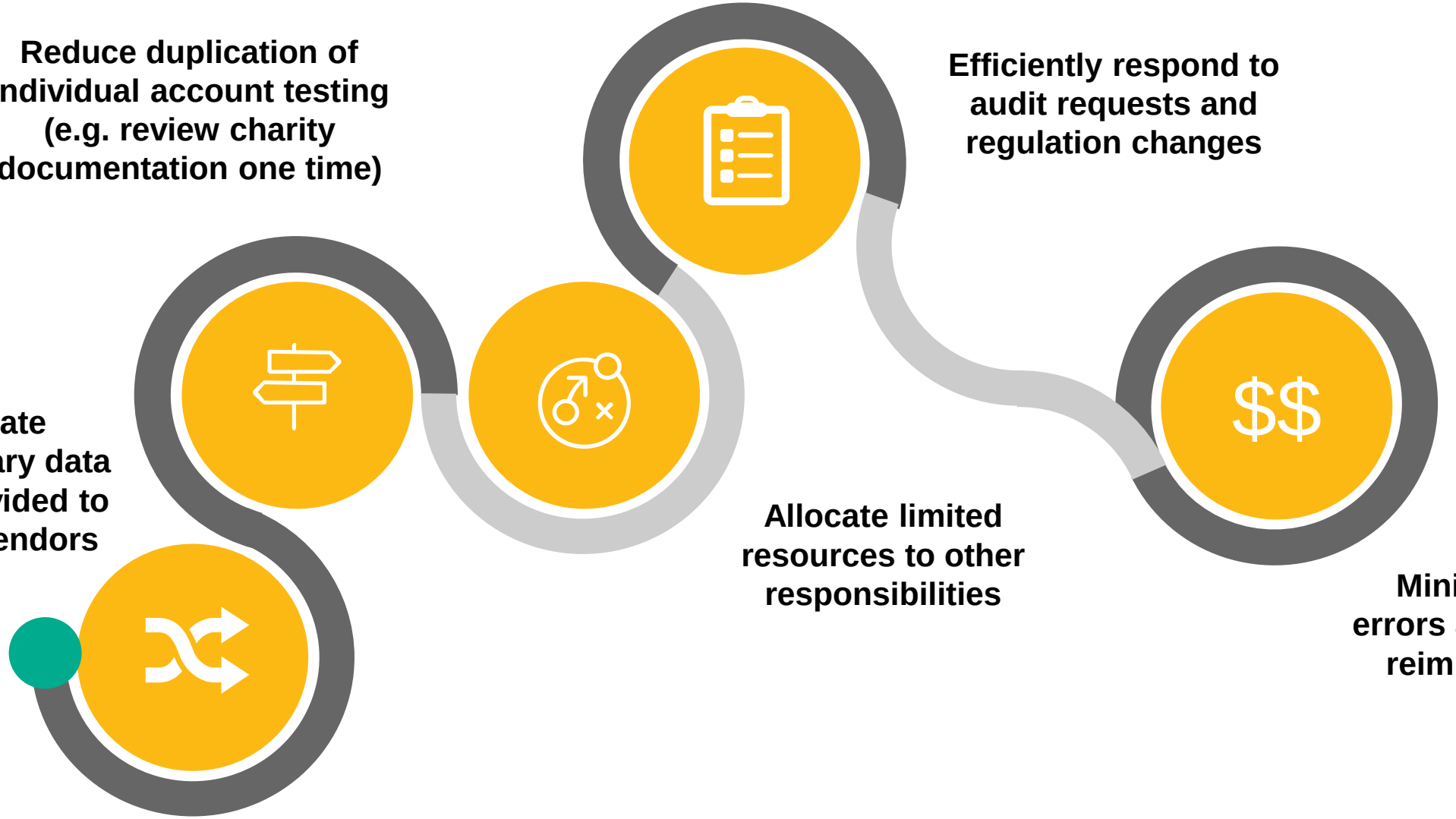
Key Data Element	S-10	DSH	MBD	Comments
Demographic information	✓	✓	✓	Available via Crowe CFS / RCA
Transaction activity	✓	✓	✓	Available via Crowe CFS / RCA
Transaction code descriptions	✓	✓	✓	Available via Crowe CFS / RCA
Payer information	✓	✓	✓	Available via Crowe CFS / RCA
Financial assistance policy	✓	✓	✓	
Medicaid and Medicaid HMO 835's		✓	✓	Available via Crowe CFS / PA
Medicare and Medicaid eligibility		✓		
Patient statements			✓	
Medicare detailed PS&R			✓	
Prior MBD listing			✓	
Collection agency inventories			✓	

Integrated / Holistic Approach

Benefits of an Integrated / Holistic Approach

Reduce duplication of individual account testing (e.g. review charity documentation one time)

Efficiently respond to audit requests and regulation changes



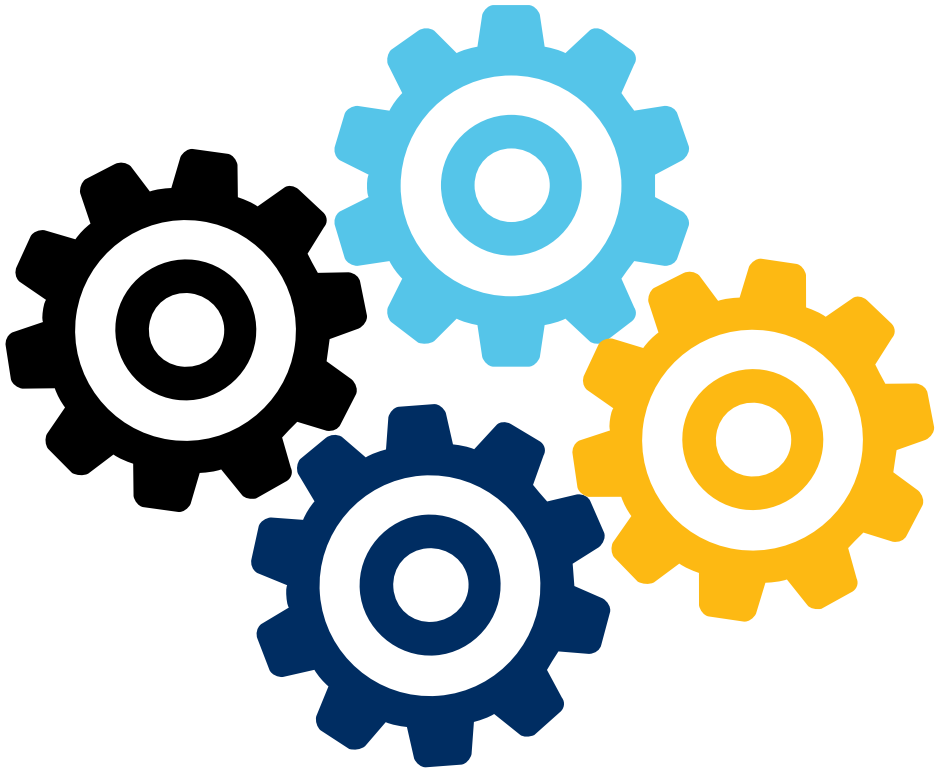
Eliminate unnecessary data feeds provided to outside vendors

Allocate limited resources to other responsibilities

Minimize risk, errors and optimize reimbursement

Best Practice Recommendations

- Use consistent data sets that tie to the general ledger
- Crosswalk FAP from business office to posted transaction activity and regulatory guidance
- Confirm general ledger mapping to bad debt expense for all Medicare bad debt accounts
- Cross-train team to understand uncompensated care landscape
- Single point of contact leveraging consistent data sets for audit requests
- Coordinated approach to review appropriateness of uncompensated care accounts
- Perform calculations/reasonableness checks on S-10, DSH and MBD listings prior to submission



Thank You

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