

Worksheet S-10: Uncompensated Care Data

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Welcome to the provider education training for Worksheet S-10.

This training will provide a brief introduction of Worksheet S-10, Uncompensated Care Bad Debts. We will cover pertinent definitions, regulations, and the flow of the Cost Report worksheet, as well as what information is to be reported on Worksheet S-10 lines. Additionally, we will address the reporting timeliness of the Uncompensated Care Bad Debts and provide the CGS contact information for any further questions throughout the S-10 process.

Definitions

Uncompensated Care: Consists of charity care, non-Medicare bad debt, and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances, discounts given to patients that do not meet the hospital's charity care policy, or discounts given to uninsured patients that do not meet the hospital's FAP, or bad debt reimbursed by Medicare.

Charity Care and Uninsured Discounts: Charity care and uninsured discounts 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 FAP. Charity care and uninsured discounts can include full or partial discounts. If a patient is not eligible for discounts under the hospital's charity care policy or FAP, then any discounts or reductions given to the standard managed care rate must not be accounted for as charity care or an uninsured discount. Discounts given to patients for prompt payment must not be included as charity care. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. A hospital cannot claim as charity care amounts of unpaid deductibles and co-insurance for which it has received reimbursement from Medicare (reimbursed Medicare bad debt). (Additional guidance provided in the instruction for line 20.)

Non-Medicare Bad Debt: Charges for health services for which a hospital determines the non-Medicare patient has a financial responsibility to pay, but the non-Medicare patient does not pay. These amounts are subject to the cost-to-charge ratio (CCR). (Additional guidance provided in the instructions for lines 28 and 29.)

Medicare Bad Debt: When furnishing services to a Medicare beneficiary, a provider incurs costs in furnishing such covered services. A Medicare beneficiary may be responsible for paying a share of those costs as part of their applicable deductible and/or coinsurance amounts. When a Medicare beneficiary, or other responsible party, fails to pay the deductible and/or coinsurance amounts, the provider has incurred costs of furnishing services that are unrecovered. If the unpaid deductible and coinsurance amounts meet the criteria of 42 CFR 413.89, then these amounts may be allowable as Medicare bad debt (see CMS Pub. 15-1, chapter 3). Amounts reimbursed as a Medicare bad debt cannot be claimed as charity care. **Non-Reimbursable Medicare Bad Debt:** The amount of allowable Medicare coinsurance and deductibles



considered to be uncollectible but are not reimbursed by Medicare under the requirements of 42 CFR 413.89(h) and CMS Pub. 15-1, chapter 3. (Additional guidance provided in the instructions for lines 27 and 27.01.)

Net Revenue: Actual payments received or expected to be received from a payer (including co-insurance payments from the patient) for services delivered during this cost reporting period. Net revenue will typically be charges (gross revenue) less contractual allowance. (Applies to lines 2, 9, and 13.)

Public Programs: Federal, State, and/or local government programs paying, in full or in part, for health care (e.g., Medicare, Medicaid, CHIP and/or other Federal, State, or locally operated programs).

Regulations

Section 112(b) of the Balanced Budget Refinement Act (BBRA) requires that short-term acute care hospitals (§1886(d) of the Act) submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated. Charity care charge data, as referenced in section 4102 of American Recovery and Reinvestment Act of 2009, may be used to calculate the EHR technology incentive payments made to §1886(d) hospitals and CAHs. Section 1886(n)(6)(B) of the Act, as added by section 602 of Consolidated Appropriations Act, 2016 adds subsection (d) Puerto Rico hospitals as eligible hospitals under the EHR incentive program. In addition, section 1886(r)(2) of the Act, as added by section 3133 of the ACA, requires an additional payment for uncompensated care for 1886(d) DSH eligible hospitals. Charity care charge data, discounts given to uninsured patients that meet the hospital's financial assistance policy/uninsured discount policy (hereinafter referred to as "financial assistance policy" or FAP), non-Medicare bad debt, and non-reimbursed Medicare bad debt may be used in the calculation of the uncompensated care payment. Section 1886(d) hospitals and CAHs are required to complete this worksheet.

Factor 3

What Cost Report Elements Does DSH UCP Factor 3 Use?

CMS has stated in various Federal Registers that they will be using Worksheet S-10 Line 30 in calculating the DSH UCP Factor 3. This line 30 is the sum of two separate elements:

Line 23: Cost of Charity Care

Plus

Line 29: Cost of Non-Medicare and Non-Reimbursable Medicare Bad Debt Expense

Combined, these two elements make up an Uncompensated Care amount.

Line 23 (Cost of Charity Care) is impacted by three separate inputs on Worksheet S-10:

Line 20: Charity Care Charges and Uninsured Discounts for the Entire Facility (Columns 1 & 2)

Line 22: Payments Received from Patients for Amounts Previously Written Off as Charity Care

Line 21: Maybe be reduced by line 25 Charges for Patient Days Beyond the Indigent Care Program's Length of Stay Limit if the provider includes "Y" on line 24.

Line 29 (Cost of Non-Medicare and Non-Reimbursable Medicare Bad Debt Expense) is impacted by one input on Worksheet S-10, in addition to all of the Medicare bad debt amounts reported on each settlement worksheet.

Line 26: Total Bad Debt Expense for the Entire Hospital Complex

When Will the S-10 Data Be Used for the DSH UCP Factor 3?

The FFY 2018 DSH UCP Factor 3 will be the first to incorporate S-10 data. It will incorporate an average of three elements. The 2014 S-10 data, and alternative data from the 2012 and 2013

cost reports.

The FFY 2019 DSH UCP Factor 3 will use an average of 2014 and 2015 S-10 data, along with alternative data from the 2013 cost report.

The FFY 2020 DSH UCP Factor 3 will use S-10 data from the 2015 cost report (i.e. cost reporting periods beginning between 10/01/14 - 09/30/15).

The FFY 2021 DSH UCP Factor 3 will use S-10 data from the 2017 cost report (i.e. cost reporting periods beginning between 10/01/16 - 09/30/17).

The use of further DSH UCP Factors will be dependent on CMS' issuance of the proposed and final IPPS Rules.

Line 1

Cost to Charge Ratio

Enter the CCR resulting from Worksheet C, Part I, line 202, column 3, divided by Worksheet C, Part I, line 202, column 8.

For all inclusive rate no-charge-structure providers, enter your ratio as calculated in accordance with CMS Pub. 15-1, chapter 22, §2208.

Line 20

Charity Care Charges and Uninsured Discounts for the Entire Facility

For cost reporting periods beginning on or after October 1, 2016:

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. Do not include charges for patients given courtesy discounts or charges for uninsured patients with or without full or partial discounts who do not meet the hospital's charity care criteria or FAP. 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.

Enter in column 1, the total charges, or the portion of the total charges, written off to charity care, for uninsured patients, and patients with coverage from an entity that does not have a contractual relationship with the provider who meet the hospital's charity care policy or FAP. In addition, enter in column 1, charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs, if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria. The total charges or the portion of total charges is the amount the patient is not responsible for paying (e.g., 100% of charges if the patient qualified for 100% discount or 70% of charges if the patient qualified for a 70% partial discount).

Enter in column 2, the deductible and coinsurance payments required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship that were written off to charity care. In addition, enter in column 2, the non-covered charges for days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria. Do not include in column 2 amounts of deductible and coinsurance claimed as Medicare bad debt.

Note: When reporting charity care or uninsured discounts for cost reporting periods beginning on or after October 1, 2016, amounts a hospital received for charity care charges reported on line 20 of a prior cost reporting period and not reported on line 22 of a prior cost reporting period, must be offset on line 22 of the current cost report. Lines 20 and 22 must be completed independently. Do not record on line 20 net charity care charges; line 20 must include all charges and line 22 must include all receipts.

Column 3 calculates the sum of Columns 1 & 2.

Line 20 - Further Clarification

Providers should be splitting claims for patients with covered and non-covered charges noted on their remits.

The determination of being insured is not based on the patient but the charges instead.

Note: For an insured patient (including a Medicare beneficiary) that has exhausted their benefits or otherwise has a non-covered portion of the claim, any charges that were approved for charity care related to the non-covered service must be reported in line 20 column 1 (subject to the CCR). Any charity care approved deductibles and coinsurance related to the covered portion of the claim will be reported on line 20 column 2 (not subject to the CCR).

Cost reporting instructions state: Enter in column 1, the total charges, or the portion of total charges, written off to charity care, for uninsured patients, and patients with coverage from an entity that does not have a contractual relationship with the provider who meet the hospital's charity care policy or FAP.

All implications in the language point to the fact that full charges are not to be reported for charity for uncompensated care. Insured charges are reduced by the contractual allowances by the insurance plans and uninsured by the cost to charge ratio. If full charges for non-covered charges for insured patients are reported in column 2 of line 20, they are not netted by contractual adjustments or the CCR, resulting in full charges being reported for uncompensated care (this would overstate the amounts to be reported).

Line 21

Cost of patients approved for charity care and uninsured discounts.

Providers should be splitting claims for patients with covered and non-covered charges noted on their remits.

Column 1: Enter in column 1, the cost of uninsured patients approved for charity care and uninsured discounts by multiplying line 20, column 1, times the CCR on line 1.

Column 2: Enter in column 2, the deductibles and coinsurance not subject to the CCR on line 1 for insured patients approved for charity care (line 20, column 2, minus line 25), plus the non-covered charges for insured patients for days exceeding a length-of-stay limit that are subject to the CCR on line 1 (line 25 multiplied by line 1).

Column 2, if the provider indicates "Y" to line 24 that any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported on line 20, column 2, HFS will reduce the amount that flows to line 21 column 2 from line 20 by the amount reported on line 25 column 1 times the CCR on line 1 which in turn reduces line 23.

Line 22

Payments Received from Patients for Amounts Previously Written Off as Charity Care

For cost reporting periods beginning on or after October 1, 2016, charity care charges or uninsured discounts reported on line 20 include amounts written off with no expectation of payment. Enter all payments received during this cost reporting period, regardless of when the services were provided, from patients for amounts previously written off on line 20 as charity care or uninsured discounts. Enter such payments for the entire facility, except physician or other professional services. Use column 1 for payments received from uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider and, use column 2 for payments received from patients covered by a public program or a private insurer with which the provider has a contractual relationship. Do not include grants or other mechanisms of funding for charity care on line 22. Payments entered on this line must not exceed charity care or uninsured discount amounts written off in the cost reporting period. Do not include payments received that represent a patient's liability or, amounts that were not previously written off on line 20 as charity care or uninsured discounts.

Line 25

Charges for Patient Days Beyond Indigent Care Program's Length of Stay Limit

If you answered yes to question 24, enter charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program for services delivered during this cost reporting period. The amount must match the amount of such charges included in line 20, column 2.

Line 26

Total Bad Debt Expense for the Entire Hospital Complex

Reporting Timeliness for Uncompensated Care Bad Debts

Not subject to PRM Chapter 3 (reportable at the end of the collection cycle).

To be claimed when first determined a Bad Debt (the beginning of the collection cycle):

First goes out to Collection; or

First hits a Bad Debt status, whichever method is used in the provider system.

Enter the total facility (entire hospital complex) amount of bad debts (Medicare bad debts and non-Medicare bad debts), net of recoveries, written off during this cost reporting period on balances owed by patients regardless of the date of service. Include such bad debts for all services except physician and other professional services. Amounts from line 20 above must not be included here. The amount reported must also include the amounts reported on Worksheets: E, Part A, line 64; E, Part B, line 34; E-2, line 17, columns 1 and 2; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; E-3, Part VII, line 34; I-5, line 5 (line 5.05, column 2 for cost reporting periods that overlap or begin on or after January 1, 2011); J-3, line 21; M-3, line 23; and N-4, line 9. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.

Lines 27 & 27.01

Medicare Reimbursable and Allowable Bad Debts for the Entire Hospital Complex

Line 27: Enter the total facility (entire hospital complex, including PARHM demonstration) Medicare reimbursable (also referred to as adjusted) bad debts, pursuant to 42 CFR 413.89(h), as the sum of Worksheets: E, Part A, line 65; E, Part B, line 35; E-2, line 17, columns 1 and 2 (line 17.01, columns 1 and 2 for cost reporting periods that begin on or after October 1, 2012); E-3, Part I, line 12; E-3, Part II, line 24; E-3, Part III, line 25; E-3, Part IV, line 15; E-3, Part V, line 26; E-3, Part VI, line 10; I-5, line 11; J-3, line 21 (line 22 for cost reporting periods that begin on or after October 1, 2012); M-3, line 23 (line 23.01 for cost reporting periods that begin on or after October 1, 2012); and N-4, line 10.

Line 27.01: Enter the total facility (entire hospital complex, including PARHM demonstration) Medicare allowable bad debts as the sum of Worksheets: E, Part A, line 64; E, Part B, line 34; E-2, line 17, columns 1 and 2; E-3, Part I, line 11; E-3, Part II, lines 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; I-5, line 5.05, column 2; J-3, line 21; M-3, line 23; and N-4, line 9. The amount entered on this line must also be included in the amount on line 26.

Lines 28-31

Line 28: Effective for cost reporting periods beginning before October 1, 2013, calculate the non-Medicare bad debt expense by subtracting line 27 from line 26. Effective for cost reporting periods beginning on or after October 1, 2013, calculate the non-Medicare bad debt expense by subtracting line 27.01 from line 26.

Line 29: Calculate the cost of non-Medicare and non-reimbursable Medicare bad debt expense. For cost reporting periods beginning on or after October 1, 2013, the cost of non-Medicare bad debt expense is calculated by multiplying line 28 by the CCR on line 1. The cost of non-reimbursable Medicare bad debt expense is calculated by subtracting line 27 from line 27.01 (this amount is not multiplied by the CCR on line 1). Enter the sum of the non-Medicare bad debt expense and the non-reimbursable Medicare bad debt expense.

Line 30: Calculate the cost of uncompensated care by entering the sum of lines 23, column 3, and line 29.

Line 31: Calculate the cost of unreimbursed and uncompensated care and by entering the sum of lines 19 and 30.

S-10 Questions

Contact CGS Administrators at S10UNITS@cgsadmin.com.