



## Updates to Medicare's Cost Report Worksheet S-10 to Capture Uncompensated Care Data

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### PROVIDER TYPE AFFECTED

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This MLN Matters® Special Edition article is intended for all 1886(d) hospitals, including 1886(d) Puerto Rico hospitals, eligible to receive uncompensated care payments.

### WHAT YOU NEED TO KNOW

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This article is intended to provide additional guidance to 1886(d) hospitals by summarizing revisions and clarifications to the instructions for the Worksheet S-10 of the Medicare cost report. The Worksheet S-10 data is used in the computation of Factor 3 in the calculation of the uncompensated care payment for 1886(d) hospitals under the Social Security Act (SSA) eligible to receive such payments. The revisions and clarifications to the Worksheet S-10 are provided to ensure appropriate reporting of uncompensated care costs and to achieve proper Medicare reimbursement. Examples are also provided in this article as additional guidance.

The Centers for Medicare & Medicaid Services (CMS) provided an extension to allow all Inpatient Prospective Payment Systems (IPPS) hospitals to submit an amended cost report with revised Worksheet S-10 data for Fiscal Year (FY) 14 and FY 15 by October 31, 2017. The resubmission of data is not required; providers may choose to resubmit if they have additional data for lines 20, 22, 25 and 26.

### BACKGROUND

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Section 1886(r) of the Act, as added by Section 3133 of the Affordable Care Act, requires that, for FY 2014 and each subsequent fiscal year, subsection (d) hospitals that would otherwise have received a Disproportionate Share Hospital (DSH) payment made under Section 1886(d)(5)(F) of the Act will receive two separate payments, a DSH payment and a payment for the hospital's proportion of uncompensated care.

In the 2018 Medicare IPPS final rule (82 Fed. Reg. 37990, August 14, 2017), CMS indicated that it would begin to incorporate data from Worksheet S-10 in the computation of Factor 3 for the calculation of hospitals' share of uncompensated care payments for fiscal year 2018. As part

of CMS' continued desire to work with its stakeholders regarding the reporting of uncompensated care and to achieve greater clarity of the data needed to compute Factor 3, CMS has clarified the instructions and line item descriptions on the Worksheet S-10.

In Transmittal 10, CMS clarified that hospitals may include discounts given to uninsured patients who meet the hospital's charity care criteria. In Transmittal 11, CMS further clarified that full or partial discounts given to uninsured patients who meet the hospital's charity care policy or financial assistance policy/uninsured discount policy (hereinafter referred to as Financial Assistance Policy or FAP) may be included on line 20, column 1 of the Worksheet S-10. These clarifications apply to cost reporting periods beginning on or after October 1, 2013.

CMS also modified the application of the cost-to-charge-ratio (CCR). The CCR will not be applied to the deductible and coinsurance amounts for insured patients approved for charity care and non-reimbursed Medicare bad debt. The CCR will be applied to uninsured patients approved for charity care or an uninsured discount, non-Medicare bad debt, and charges for non-covered days exceeding a length of stay limit imposed on patients covered by Medicaid or other indigent care programs.

## SUMMARY OF MODIFICATIONS TO THE WORKSHEET S-10 AND EXAMPLES

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The following were implemented for Worksheet S-10: 1) a revision to the instructions for Electronic Health Records (EHR) incentive payments to apply to subsection (d) Puerto Rico hospitals for cost reporting periods beginning on or after October 1, 2016; and effective for cost reporting periods beginning on or after October 1, 2013: 2) a clarification of the definition of charity care that includes the addition of uninsured discounts reported on line 20; 3) a clarification that Medicare and non-Medicare hospital bad debt reported on line 26 must be net of recoveries; 4) the addition of line 27.01, Medicare allowable bad debts for the hospital, that will be used to compute the non-Medicare bad debt separately from the non-reimbursed Medicare bad debt; 5) modifications to the calculation of costs for both insured charity care charges not subject to the CCR, and insured non-covered days beyond a length-of-stay limit subject to the CCR; and, 6) modifications to the calculation of non-Medicare bad debt subject to the CCR and non-reimbursed Medicare bad debt (deductible and coinsurance) not subject to the CCR. The modifications to the calculations will be applied to all cost reports, however providers will not be required to amend their cost report in order to benefit from these modifications.

### ***Examples for the Worksheet S-10, Uncompensated and Indigent Care Data***

For examples 1 through 3 only, assume the following facts: A hospital has a charity care policy which determines charity care on a "sliding scale" basis and may forgive anywhere from 25% to 100% of the patient's liability. An insured patient owes the hospital \$100.00 for a deductible on an allowable hospital service. The insured patient applies for charity care and the hospital determines that he qualifies for charity care at 25%. The cost reporting period is on or after October 1, 2016.

**Example 1: Unpaid Insured Patient's Liability**

The hospital deems \$25.00 of the patient's \$100.00 liability as charity care and records this \$25.00 on line 20, column 2. The remaining \$75.00 is a patient liability. The \$75.00 remaining patient liability may subsequently be determined by the hospital to be classified as charity care or a hospital bad debt, but not both. (It is generally assumed that insured persons are not eligible for charity care, however an insured person can qualify for charity care for the portion of the charges that represents the patient liability pursuant to the hospital's charity care policy).

**Example 2: Partial Payment of Insured Patient's Liability**

The hospital deems \$25.00 of the patient's \$100.00 liability as charity care and records this \$25.00 on line 20, column 2. The patient pays \$35.00 of the \$75.00 patient liability. The hospital can determine the remaining \$40.00 patient liability to qualify as charity care or a bad debt, but not both. If the \$40.00 is determined to be charity care, it is recorded on line 20, column 2. If it is determined to be a bad debt, it is recorded on line 26 as a hospital bad debt.

**Example 3: Partial Payment of Insured Patient's Liability, a Medicare Beneficiary**

The hospital deems \$25.00 of the patient's \$100.00 liability as charity care and records this \$25.00 on line 20, column 2. The hospital makes reasonable collection efforts to collect the remaining \$75.00 patient liability. The patient pays \$35.00 of the \$75.00 patient liability. The hospital determines the unpaid \$40.00 patient liability to be a Medicare bad debt. The \$40.00 unpaid patient liability would be recorded on line 26 as a hospital bad debt and be reflected on line 27.01 as the Medicare allowable bad debt. The Medicare reimbursable bad debt, \$26.00, would be reflected on line 27 (assuming a 65% bad debt limitation pursuant to 42 CFR 413.89(h)).

**Example 4: Uninsured Patient, Sliding Scale Charity Care, Partial Payment of Patient Liability with Remaining Amount of Patient Liability Unpaid, Cost Reporting Periods Beginning on or After October 1, 2016**

A hospital has a charity care policy which determines charity care on a "sliding scale" basis and may forgive anywhere from 25% to 100% of the patient's liability. An uninsured patient owes the hospital \$1,000.00 for an allowable hospital service. The patient applies for charity care, and the hospital determines that the uninsured patient qualifies for charity care at 60%. The hospital records the \$600.00 charity care amount on line 20, column 1. The remaining \$400.00 is the patient's liability. The uninsured patient pays \$100.00 toward his liability. If the patient does not pay the remaining \$300.00 and the hospital determines the unpaid patient liability to be a bad debt, the hospital would record the \$300.00 on line 26 as a hospital bad debt. The \$100.00 payment made by the patient does not get recorded anywhere on the Worksheet S-10 because it was not a payment toward the amount deemed charity care; it was a payment toward the non-charity care patient liability.

**Example 5: Uninsured Patient, Sliding Scale Charity Care, Partial Payment of Patient Liability with Remaining Amount of Patient Liability Unpaid, Cost Reporting Periods Beginning Prior to October 1, 2016**

A hospital has a charity care policy which determines charity care on a "sliding scale" basis and may forgive anywhere from 25% to 100% of the patient's liability. An uninsured patient owes the

hospital \$1,000.00 for an allowable hospital service. The patient applies for charity care, and the hospital determines that the uninsured patient qualifies for charity care at 60%. The hospital records the entire \$1,000.00 charge as charity care on line 20, column 1. The remaining \$400.00 is the patient's liability and must be recorded on line 22 as this is a patient liability for which the hospital expects to receive payment. The uninsured patient pays \$100.00 toward his \$400.00 liability. The \$100.00 patient payment does not get recorded on Worksheet S-10 because the \$400.00 full patient liability was already recorded as an expected payment on line 22. If the \$300.00 balance remains unpaid and the hospital determines it to be a bad debt, it can be recorded as a hospital bad debt on line 26.

**Example 6: Uninsured Patient, Sliding Scale Charity Care, Partial Payment of Patient Liability with Remaining Amount of Patient Liability Unpaid, Cost Reporting Periods Beginning Prior to October 1, 2016 with Patient Liability Payment Made in a Cost Reporting Period that Began on or After October 1, 2016**

A hospital has a charity care policy which determines charity care on a "sliding scale" basis and may forgive anywhere from 25% to 100% of the patient's liability. In a cost reporting period that began prior to October 1, 2016, an uninsured patient owes the hospital \$1,000.00 for an allowable hospital service. The patient applies for charity care, and the hospital determines that the uninsured patient qualifies for charity care at 60%. The hospital records the entire \$1,000.00 charge as charity care on line 20, column 1. The remaining \$400.00 is the patient's liability, however the provider did not record the payment/expected payment on line 22 as required. Several months later, in a cost reporting period that began on or after October 1, 2016, the uninsured patient made a payment of \$100.00. This \$100.00 payment must be recorded on line 22 as a reduction of an amount previously deemed charity care.

**Example 7: Uninsured Patient Qualifies to Receive an Uninsured Patient Discount Pursuant to Hospital's FAP, Cost Reporting Periods Beginning on or After October 1, 2016**

An uninsured patient owes the hospital \$100.00 for an allowable hospital service. The uninsured patient does not qualify for charity care. The hospital has a FAP which automatically gives a 30% discount to all uninsured patients who meet the hospital's FAP. The uninsured patient meets the hospital's FAP and the hospital writes off \$30.00 as an uninsured discount on line 20, column 1. The remaining \$70.00 is a patient liability. If the \$70.00 patient liability remains uncollected and the hospital determines it to be a bad debt, it is recorded on line 26 as a hospital bad debt. (If the cost reporting period began prior to October 1, 2016 using the same scenario above, the full charges of \$100.00 would be written off on line 20, column 1. The hospital would record \$70.00 on line 22 as an expected payment. If the \$70.00 patient liability remains uncollected and the hospital determines it to be a bad debt, it is recorded on line 26 as a hospital bad debt).

**Example 8: Calculating the Cost of Insured Patients Approved for Charity Care When Line 20, Column 2 Includes Charges for Patient Days Beyond the Length-Of-Stay Limit for Medicaid or Another Indigent Care Program**

Charges for patient days beyond the length of the stay limit are recorded on line 20, column 2. At the end of the fiscal year when preparing its cost report, a hospital, whose CCR is 0.31, has accrued charges for patient days beyond the length-of-stay limit imposed on patients covered by

Medicaid in the amount of \$10,000 and is reported on line 20, column 2. The hospital also has \$550,000 in charity care charges for deductible and co-insurance amounts on line 20, column 2. The net amount reported on line 20, column 2 is \$560,000, (\$550,000 + \$10,000). The hospital answers “yes” to line 24 and reports \$10,000 on line 25. When calculating the cost of insured patients approved for charity care on line 21, column 2, the hospital must multiply line 25, \$10,000, by the CCR, 0.31 on line 1 and add it to the result of line 20, column 2, \$560,000 minus line 25, \$10,000.

$$\begin{aligned}
 &(\$560,000 - \$10,000) + (\$10,000 \times 0.31) \\
 &\quad \$550,000 + \$3,100 \\
 &= \$553,100 \text{ line 21, column 2}
 \end{aligned}$$

## ADDITIONAL INFORMATION

Additional information regarding uncompensated care and the Worksheet S-10 can be found in the 2018 IPPS Final Rule at 82 Fed. Reg. 37990 (August 14, 2017). The following resources are available to find additional information regarding instructions to the Worksheet S-10 for uncompensated care, see “Provider Reimbursement Manual” [Transmittal 11](#) containing updates to CMS Pub. 15-2, Chapter 40, Section 4012.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

## DOCUMENT HISTORY

Date of Change	Description
September 29, 2017	Initial article released.

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