Worksheet S-10 Here To Stay: A First Look at MAC S-10 Audits

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Jeff Norman, Senior Client Relations Manager
Kyle Pennington, Client Relations Manager

Region 9 Webinar

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OUTLINE

- Overview of FY 2020 IPPS Proposed Rule as it pertains to Worksheet S-10
- Worksheet S-10 Data Trends
- MAC Audit Letter Review
- Summary of Audit Findings
- Audit Timeline & Potential Impact
- Best Practices & Next Steps
- Questions

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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% of 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

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UC FACTORS

- Three factors and values for FFY 2020

Factor 1	Factor 2	Factor 3
75% fixed pool of what DSH would have been as estimated by CMS for all hospitals combined under the pre-ACA formula	Reduces Factor 1 based on the change in the national uninsured rate	Provider's % of uncompensated care relative to all hospitals eligible for DSH
$12.643B	$8.488B	Hospital proxy

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UC FACTOR 3 – FFY 2020

- **FFY 2020 IPPS Proposed Rule Factor 3:**
  - CMS proposes to abandon the averaging of three cost reporting periods
  - CMS proposes to use FY 2015 S-10 data, or
  - Seeking comments on using FY 2017 data as an alternative
- 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**

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FY 2017 AUDITS COMING?

Aberrant S-10 Data – FY 2017
- CMS conducted a comparison of FY 2015 and 2017 S-10 data
- Where there was a significant positive or negative difference in percentage of total UC costs to total operating costs, hospitals must justify its reporting fluctuations (tight window).

Two Options
1. If necessary, hospital can amend its data
2. If the data remains unchanged without an acceptable response of explanation from the provider, CMS would trim the provider's data in FY 2017 using data from FY 2015 in order to determine Factor 3

Is this preparing for upcoming FY 2017 desk reviews?

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WORKSHEET S-10 ANOMALIES

- FFY 2016
  - 80 reported $0 total charity
  - 14 reported $0 uninsured charity
  - 450 reported $0 insured charity
  - 10 reported negative amounts on line 22
  - 284 reported insured charity amounts greater than uninsured charity
- FFY 2017
  - 65 reported $0 total charity
  - 7 reported $0 insured charity
  - 329 reported $0 insured charity
  - 6 reported negative amounts on line 22
  - 163 reported insured charity amounts greater than uninsured charity

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

- Began Fall 2018
- S-10 audit data request letter similar among MACs
  - 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.

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CMS AUDITS – FINANCIAL ASSISTANCE POLICY

- Do all of your policies list the effective or revision date(s)?
- Providers should have a copy of each version of the financial assistance policy readily available.
- Be aware that multiple versions of policies may be needed for one cost reporting period.
- Example: Revision in charity care policy to include third party presumptive eligibility vendor.

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

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.

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CMS AUDITS – FINANCIAL ASSISTANCE POLICY

- Line 20 Cost Report Instructions:

  …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…

- Do you have language in your policy that grants these discounts and can your hospital currently capture these non-covered Medicaid charges from other contractual adjustments?
- If your hospital is giving charity discounts for patients with a primary payer of Medicaid, MACs need to see the specific language that allows these discounts.

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

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.

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CMS AUDITS – FINANCIAL ASSISTANCE POLICY

- Line 20 Cost Report Instructions:

  "Enter in Column 1, the full charges 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."

- Several MACs requested a listing of contracted and non-contracted payers in subsequent requests after receiving initial data items.
  - Auto insurance payers a point of emphasis with MACs. Patients/Write-offs must be claimed in Line 20, Column 1.
  - Several MACs included the auto insurance payments for these patients in the uninsured Line 22 patient payment total.

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

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.

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CMS AUDITS – FINANCIAL ASSISTANCE POLICY

- Line 20 Cost Report Instructions:

  "…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, 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."
- Difference in treatment of "insured" patients between MACs
- Minimal time spent on Medicaid LOS limits
- Difference in treatment on review of duplicate check of Medicare bad debt and charity

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

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.?)

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

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?

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

9. Using the logic/processes described above, please submit a detailed listing of claimed charges and payments reported on Worksheet S-10 Lines 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.

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

9. cont'd. 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

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

9. cont'd. 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.

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CMS AUDITS – CHARITY DETAIL

- Tight timeline of 1-2 weeks to supplement what was pulled when S-10 was prepared for the filed report
- Unnecessary data elements to accurately report Worksheet S-10
  - SSN, DOB, Gender, Name, etc.
- Large data sets (millions of encounters) being re-pulled in MACs requested format
  - Limitation with Excel
  - MACs capabilities to handle these large files
  - Multiple requests from MACs after initial pull requesting data in a different format

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CMS AUDITS – CHARITY DETAIL

- Inherent issues with S-10 instructions:
  - For cost reports beginning prior to 10/1/16, charity claimed on service date
  - For cost reports beginning after 10/1/16, charity claimed on write-off date
- MACs requested all transaction activity (through current) for charity write-off accounts.
- MACs generally allowed revised listings as there was charity activity (write-offs/reversals) after time of filing that will impact this cost reporting period.

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

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.

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CMS AUDITS – TRANSACTION/ADJUSTMENT CODES

- Lack of consistency among MACs on focus of transaction/adjustment codes related to policy language
  - Some spent considerable time understanding "charity" transaction codes as well as any other transaction codes associated with charity write-off accounts.
  - Auditors asked how each transaction/adjustment code used to generate charity detail related to the financial assistance policies.
    - Easier to do this on the front-end when filing report than at audit.

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

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.

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CMS AUDITS – PROFESSIONAL FEES

- Must use charge detail to verify that professional fees are not included in Worksheet S-10
  - Examples of hospitals that previously confirmed no pro fees (separate systems) in data sets, but after receiving charge detail pro fees included in total patient charges
  - In some cases, this can be significant dollars that could be included in filed charity totals.
  - Other cases were small, but must account for it to avoid any potential adverse audit determination and potential large extrapolations due to small sample sizes

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

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

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CMS AUDITS – YEAR-OVER-YEAR COMPARISON

- Considerable time spent during audit explaining any large (>15%) variances from Lines 20 & 22, Column 1 & Column 2 from current cost report to prior year totals
  - Must be done on frontend at the time of filing
  - Extremely difficult looking back 3-4 years and determining how prior year was filed and why charity and patient payments increased/deceased significantly
- MACs not understanding the differences between financial statements and data reported on Worksheet S-10
  - In some cases, had to provide detailed reconciles between charity financial statement totals and amounts reported on Worksheet S-10

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

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.

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CMS AUDITS – BAD DEBT DETAIL

- Tight turnaround time of 1-2 weeks to supplement what was pulled when S-10 was prepared for the filed report.
- Unnecessary data elements to accurately report Worksheet S-10
  - Claim Type, SSN, DOB, Gender, Name, Admit, Discharge, Service Indicator, etc.
- Obtaining all activity for bad debt patients greater challenge than charity
  - Patients with service dates several years before time of write-off
  - Typically a system conversion at hospital somewhere between time of initial patient activity to current audit request
  - Multiple requests from MACs after initial pull requesting data in a different format

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

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.)

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CMS AUDITS – BAD DEBT DETAIL & RECONCILE

- Bad debt reconcile significant challenge for most hospitals
  - Multiple campuses and/or clinics rolled up on same cost report each with their own accounts receivable/bad debt allowance account that needed to be reconciled
- MACs had multiple reconcile templates and depending on MAC may accept either:
  - Reconciling bad debt detail with activity in bad debt allowance account from balance sheet, *or*
  - Reconciling prior year ending A/R balance with current year ending A/R that separately identifies charges, receipts, adjustments, write-offs, etc.

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CMS AUDITS – BAD DEBT DETAIL & RECONCILE

- If reconcile from the financial statements did not tie to the bad debt detail from Worksheet S-10, some MACs adjusted to the smaller financial amount at audit.
- Are you accounting for the Medicare Bad Debt Crossovers in Line 26?

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CMS AUDITS: S-10 AUDIT REQUEST LETTER

18. If there are any significant variances between current year and prior year total bad debts, submit an explanation.

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CMS AUDITS – BAD DEBT DETAIL & RECONCILE

- Year over year variances (>15%) have been relatively common in bad debt during this time frame
  - System conversions typically impacted write-offs in year of conversion.
  - Bad debt cleanups occurred that spiked bad debt from one year to next.
  - Revisions in financial assistance policies impacted bad debt write-off amounts
- Easier to document this on the front-end when filing report than at audit.

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CMS AUDITS – CHARITY SAMPLES

- Criteria for sampling varied by MAC
- Examples:
  - Uninsured & insured (inpatient & outpatient)
  - Uninsured & insured (high/low strata based on individual charity write-off amount)
  - 4 random accounts

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CMS AUDITS – CHARITY SAMPLE DOCUMENTATION

- UB – Verify total charges (less pro fees)
- FAP criteria met – underlying support for charity determination (ex. charity application, presumptive score sheet, low-income status, etc.)
- Remittance Advice/EOB – verify that charity write-off claimed in Column 2 is only patient responsibility
- Patient Account History - verify charity write-off amount

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CMS AUDITS – CHARITY SAMPLE FINDINGS

- Unable to provide support for charity determination
  - Support (W-2, pay stubs, etc.) behind the charity application approval not available.
  - If policy lists 10 items required to make charity determination, then all 10 items were required at audit.
  - Presumptive Score Sheet documentation separate from presumptive charity transaction

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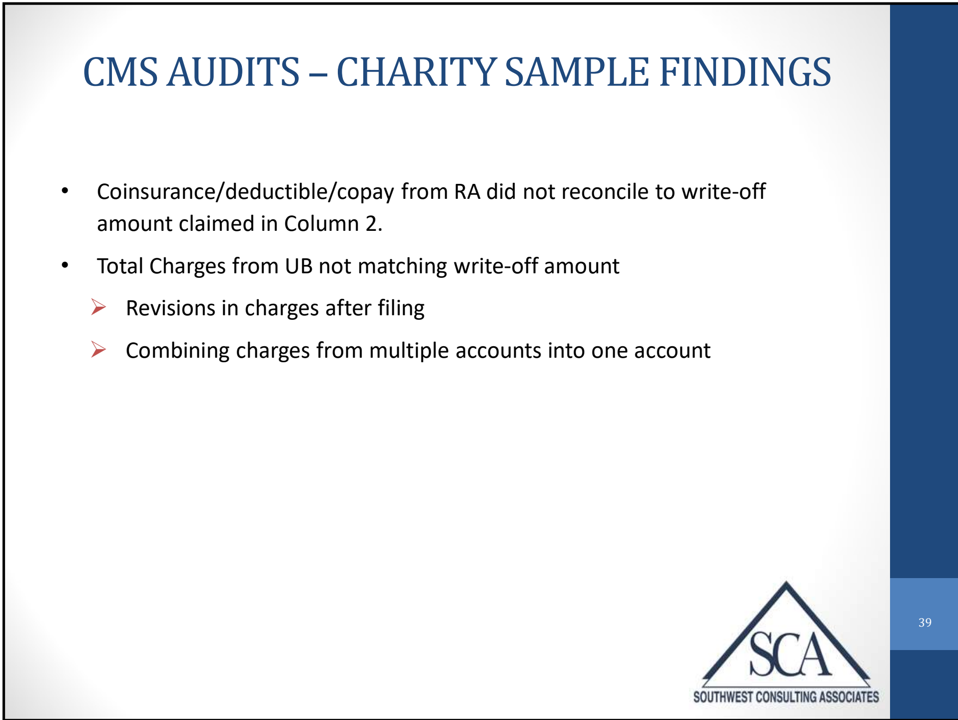

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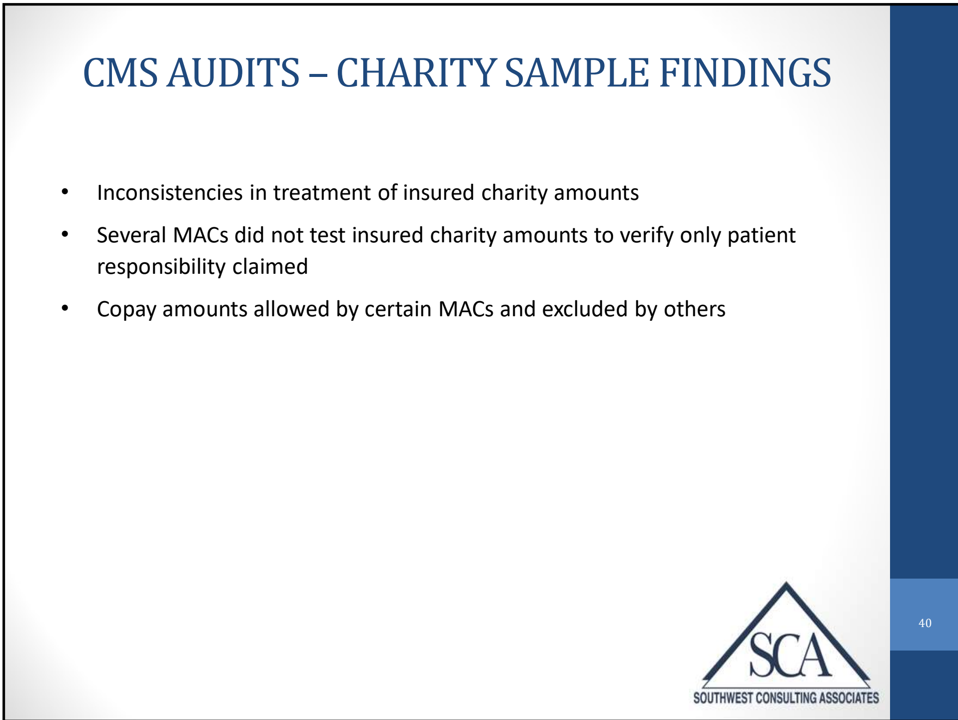

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CMS AUDITS – MAC INTERPRETATIONS

- After analyzing patient detail from original audit request, MACs had different interpretations of same instructions.
  - ➢ Even different among auditors within same MAC.
- Examples – What amount to claim for charity write-off?
  - ➢ Total charges or write-off amount for Medicaid non-covered services?
  - ➢ Medicaid payer – percentage of write-off to total charges dictated uninsured or insured column
  - ➢ Total charges or write-off amount for non-Medicaid non-covered services?

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CMS AUDITS – CHARITY & MEDICARE BAD DEBT

- Different treatment of Medicare Part A patients with charity write-offs
  - ➢ Removed all Medicare Part A accounts from uninsured and insured
  - ➢ Removed only insured charity write-off amounts with primary Medicare Part A payer
  - ➢ Removed only true duplicates between Medicare bad debt and charity totals
- S-10 instructions: "…Do not include in Column 2 amounts of deductible and coinsurance claimed as Medicare bad debt."
- Based on timing, charity write-offs may be claimed in current year and Medicare bad debt write-offs claimed in future year.

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CMS AUDITS – MAC AUDIT DETERMINATIONS

- Inconsistency on handling of ”errors” found during sampling
- If changing columns (ex. insured to uninsured):
  - Only sampled patient reclassed
  - Sample patient error extrapolated in original column but only sample patient amount reclassed to other column
  - Sample patient error extrapolated in original column and sample patient amount and extrapolated amount reclassed to other column
- Large extrapolations dependent on sampling interval size

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CMS AUDITS – BAD DEBT SAMPLING

- To our knowledge, only one MAC (CGS) sampled bad debt.
- Sampled inpatient and outpatient accounts
- Documentation Needed:
  - UB
  - Remittance Advice
  - Patient Account History with Notes
- Small sample sizes lead to potential for large extrapolation with findings

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CMS AUDITS – BAD DEBT SAMPLE FINDINGS

- Bad debt write-off more than coinsurance/deductible for insured patient
- Not applying self pay discount to portion of bad debt charges
- Unable to supply remit from system to verify patient responsibility
- Bad debt write-off amounts more than patient responsibility charges due to combined self pay balance accounts
- Reversal of bad debt write-off did not use bad debt-related transaction code overstating bad debt

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CMS AUDITS – RECAP

- Worksheet S-10 charity & bad debt must be supported by patient detail in the filed report
- Hospital must be able to provide documentation for each sampled patient during audit that verifies the patient met the criteria expressly stated in the hospital's written financial assistance policy
- Small sample sizes have potential for large extrapolations
- Must be ready for total bad debt to be sampled in future S-10 audits
- Most auditors willing to work with provider (up to a point) on revisions to S-10 during these reviews
  - ➢ Should not expect future audits to be the same

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CMS AUDITS – TIMELINE

- MACs were required to submit audit findings to CMS via HCRIS upload by January 31, 2019
  - If cost report had been previously settled, revised NPR issued with S-10 adjustments incorporated
  - If cost report not settled, no NPR issued and revised report uploaded to HCRIS
- Mid-February CMS issued TDL directing MACs to correct "expected" payment issue
- MACs had until March 15th to have these revised adjustments incorporated and loaded into HCRIS

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POTENTIAL IMPACT TO FUTURE UC REIMBURSEMENT

- These FY 2015 Worksheet S-10 audit adjustments will likely impact FFY 2020 reimbursement for those audited?
- Which data set should CMS use (FY 2015 vs. 2017)?
- What will comments be based upon?
  - Audited data vs. new instruction
  - ¾ of FY 2015 data remains unaudited (even though 50% of reimbursement has)
  - What if one year favors a hospitals reimbursement over use of another year

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POTENTIAL IMPACT TO FUTURE UC REIMBURSEMENT

- Will CMS use FY 2016 data at all?
  - If so, will audits continue similar to 2015
  - If CMS uses FY 2015 data in FFY 2020, will CMS jump to FY 2017 data in FFY 2021?
- Will CMS direct MACs to accept amended FY 2017 cost reports beyond aberrant data hospitals?
- Really in a "wait and see" situation
- Cannot assume there will be an effective opportunity to appeal and remedy incorrect audit adjustments to S-10 data used in the UC DSH calculation
  - Premium on hospitals doing all they can to get it right in the original, as-filed cost report
  - Do not assume future opportunities to amend S-10 filings, but make good use of those opportunities if available

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BEST PRACTICES & NEXT STEPS

- FAP review
  - Unique determinations per provider
  - Conform to UC program instructions
  - Conform to revised Medicare cost report S-10 instructions
- Patient detail data
  - Collecting all charge and payment data
  - Reviewing all transaction codes
  - Tracking all data
  - Providing audit support

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BEST PRACTICES & NEXT STEPS

- In focus: FFYs 2017, 2018 and after
  - Consider revising S-10 data as necessary and amend
  - CRs beginning 10/1/18 and after – patient detail required at time of cost report filing

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Questions?

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CONTACT INFORMATION

Jeff Norman, Senior Client Relations Manager
jnorman@southwestconsulting.net

Kyle Pennington, Client Relations Manager
kpennington@southwestconsulting.net

Southwest Consulting Associates
(972) 732-8100
www.southwestconsulting.net
blog.southwestconsulting.net/blog

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