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Capturing Charity and Uncompensated Care Today and Looking Ahead

HFMA Western Region Symposium
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Primary Focus of this Presentation

- To identify why a multi-disciplined approach is imperative when reporting the cost of uncompensated care to governmental agencies and hospital stakeholders.
- To assist hospitals in the consideration of updates to financial assistance policies (FAP) and changes to the reporting of patient transaction detail.
- To encourage hospitals to review and potentially change the handling of individual Remittance Advice CARC/RARC remarks codes.

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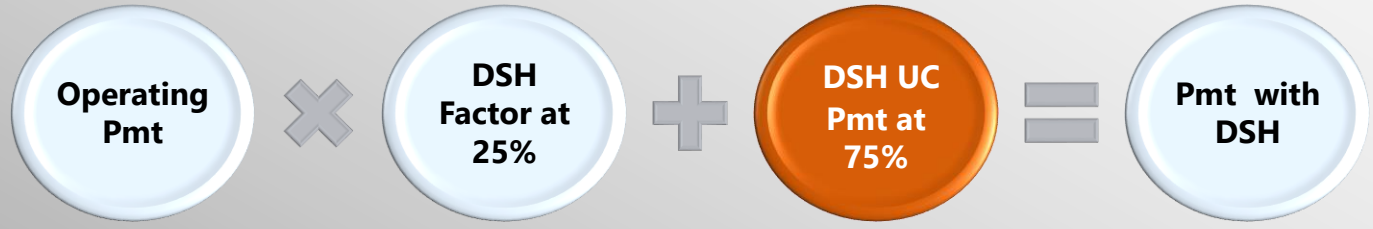
Section 1: Background

The Significance of Uncompensated Care Reporting

Section 1: Background

Pre ACA (simplified hospital payment)

Post ACA (simplified hospital payment)



Medicare DSH UC Payments for FFY 2019

- $8.3B of national UC payments for Federal Fiscal Year (FFY) 2019.
- FFY 2019 will be the second year worksheet S-10 is used to determine hospital UC payments.

Section 1: Background

CMS Transmittal 11 – Uncompensated Care

Includes:

- Charity care, uninsured discounts and non-covered Medicaid.
- Non-Medicare bad debt.
- Non-reimbursable Medicare bad debt.

Excludes:

- Discounts given to patients that do not meet the hospital's FAP.
- Courtesy allowances (including prompt pay discounts).*
- Bad debt reimbursed by Medicare.
- Flat fee and package rates?

*CMS characterizes "courtesy" as discounts for prompt pay, friends and family, etc. Policies using the term "courtesy" should evaluate either changing the terminology or defining the terminology in the policy as charity care.

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Section 1: Background

CRs Beginning Before 10/1/16

- Charity based on full hospital charges and date of service.
- Bad Debt based on write-off amount and write-off date.

CRs Beginning On/After 10/1/16

- Charity based on hospital charges written-off and write-off date.
- Bad Debt based on write-off date.

New reporting requirement for Cost Reports (CR) beginning on or after 10/1/18:

- Hospitals must include a detailed listing of charity care and/or uninsured discounts reconciling to the amount claimed in the hospital's cost report (WS S-10).
- CMS cites including information such as patient name, dates of service, insurer (if applicable), and the amount of charity care and/or uninsured discount.

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Section 2: Financial Assistance Policies

Policy Language Determines Uncompensated Care Reporting

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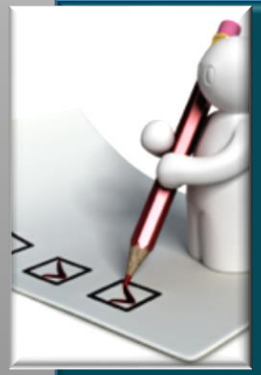
Section 2: Financial Assistance Policies



IRS Section 501(r)

- UC amounts depend on financial assistance policy.
- Reported as "Financial Assistance" on Schedule H of Form 990.

Medicare Cost Report

- UC amounts depend on financial assistance policy.
- Reported on worksheet S-10 of the Medicare Cost Report.

Uncompensated care is also recorded on financial statements, community benefit reports, state government reports and Medicaid DSH Surveys.

Section 2: Financial Assistance Policies
Community Benefit Cost Reporting

- IRS 990 Schedule H
  - Community Health Needs Assessments
- WS S-10 Uncompensated Care
- Other Governmental Programs for Care to Indigent Populations

- Tax Exempt Status
- Uncompensated Care Payments
- Benchmarking and Targeting of Governmental Resources
- Funding from State 1115 Waiver Programs

- Tip: Meet with a multi-disciplined staff to discuss what is truly uncompensated care. If certain amounts are not allowable for reporting, quantify and maintain these costs to tell the "whole story" when needed.
- Tip: Establish a standardized approach to capturing all uncompensated care, with the ability to tailor reports based on varying and evolving program instructions.

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Section 2: Financial Assistance Policies

Presumptive Eligibility

- There is no CMS requirement regarding a hospital's presumptive eligibility process / standards.
- Tip: In the FAP, include language of the hospital's presumptive eligibility process and/or tools (i.e., PARO).
- Tip: Maintain log of each account granted charity care under presumptive eligibility.
- Tip: Determine if transaction/alias codes are unique for each type of charity care adjustment, including physician fees or other excluded services.

Existing Laws

- CMS FAQs - "The state regulation may be cited, however, the hospital's written charity care policy or FAP must also include its state law requirement regarding discounts that are automatically applied."

*Determine if the FAP covers hospital services vs. non-allowable professional services (physicians). For UC Reporting, only hospital amounts (not professional amounts) may be reported.

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Section 2: Financial Assistance Policies

Insured Patients

- Ensure FAPs clearly state how discounts are applied to uninsured patients and insured patients. **This is significant as coinsurance and deductibles are not reduced by the CCR.**
- **Tip**: Consider reviewing charity coinsurance and deductible (C+D) amounts ending up as bad debt (reduced by CCR) in relation to the hospital's policy. Uncollectable C+D recognized as charity is not reduced by the CCR.

Insured Patients Not Under Contract with the Hospital

- CMS may allow the difference between charges and payment as uncompensated care, provided this is in a hospital FAP.
- **Tip:** Include if and how financial assistance is available for insured patients and is determined as "charity", when an insurance carrier is not under contract with the hospital or when a commercial carrier denies a claim.

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Section 2: Financial Assistance Policies

Non-Covered Medicaid

What are non-covered services?

The term "non-covered" has different meanings across the healthcare industry.

What guidance is provided on non-covered services?

CMS has not defined "non-covered" for purposes of uncompensated care reporting.

Non-Covered Per Contract vs. Non-Billable / Denials

- Non-covered example: lab-work for inpatient stay.
- Non-Billable / Denials examples: TAR, Medical Necessity, Billing (Untimely filing), etc.

Data Sources

- Patient transaction detail.
- Medicaid 835 Remittance Advice.
- Revenue Codes, Claim Adjustment Reasoning Codes (CARC) and Remittance Advise Remark Codes (RARC).

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Section 2: Financial Assistance Policies
Non-Covered Medicaid

Tip: Define what is included as a "non-covered" service for Medicaid eligible patients in the FAP. Also, specify if and how non-covered services are determined as charity for Medicaid eligible patients (or other indigent care program).

Tip: When reporting non-covered Medicaid services, ensure amount reported as charity care reflects the non-covered charges (as opposed to the amount not reimbursed by Medicaid).

Tip: Non-covered Medicaid can be identified by reviewing transaction detail and by reviewing zero balance accounts with no insurance payment.

Tip: Review and apply specific write off rules for CARC/RARC codes determined to be included in non-covered policy definition.

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Section 2: Financial Assistance Policies

Recapping Clarification Needed from CMS Regarding FAPs and UC Reporting

Presumptive Eligibility

- Is there ideal presumptive eligibility language that hospitals should include their FAPs?
- What support will CMS find sufficient for claims approved for charity care under presumptive eligibility?

Definition of Non-Covered

- What is the definition of "specified" regarding non-covered Medicaid services in a hospital's FAP?
- CMS does not define "non-covered" services in S-10 instructions. No current S-10 distinction between non-covered and non-billable (denials).

Non-Contractual Relationship

- Why is this UC category separate from any other charity care qualification?
- Can hospitals report charges related to non-covered services provided to commercially insured patients? What is the difference between these non-covered services and "out of network" patients when determining uncompensated care?

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Section 3: Bad Debt

Keys to Reporting Net Cost

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Section 3: Bad Debt

Includes: Medicare bad debts and non-Medicare bad debts - net of recoveries.
Excludes: Amounts related to professional services (physicians) and any amounts already reported (as charity care) on WS S-10 line 20.

Tip: Medicare FFS allowable bad debts must be included in the total, as these amounts are automatically deducted from the total and treated separately in the calculation of UC cost.

Tip: In the S-10 FAQ, regarding the definition of "write-off", CMS refers to Medicare rules stating, "If a hospital writes off bad debt in a general ledger and continues collection, Medicare would not recognize this as a Medicare bad debt. The amount reported for all other non-Medicare bad debts must be net of recovery."

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Section 3: Bad Debt

Not All Bad Debts are Treated Equal

Co-ins and Deductibles from Insured Patients Determined as Charity Care	Co-ins and Deductibles from Non-reimbursed Portion of Medicare Bad Debts	Co-ins and Deductibles from Insured Patients Not Eligible for Charity Care
Line 20 Col 2	Line 29	Line 26
No CCR Reduction	No CCR Reduction	**CCR Reduction**

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Section 3: Bad Debt

FASB Accounting Standards Codification Topic 606 - Revenue Recognition

Intent

Consistency in reporting revenue across industries

Effective Date

Fiscal Periods Beginning After 12/15/17

Est. Impact to Financial Reports

Hospital reporting of bad debt will decrease

Impact on WS S-10

CMS clarification may be needed for reporting consistency

- Focus is on implied performance obligations.
- *"A performance obligation can be explicit in a contract or it can be **implied**."*
- Amounts not historically collected are considered an implicit promise of service (implicit price concession).*

- Hospitals may reclassify amounts previously written off as bad debt to charity.
- This may involve determining the likelihood of collecting on accounts.
- Amounts historically not collected would then be deemed charity for UC reporting.

*FASB Topic 606 at https://asc.fasb.org/imageRoot/32/79982032.pdf. Refer to example 12, Case B "Implicit Promise of Service" on implicit price concessions.

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Section 4: Working with UC Data

S-10 Reporting and Preparing for Audit

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Section 4: Working with UC Data

Data Source	Purpose
Transaction Code Report - Charity Care, Uninsured Discounts and Bad Debt	To determine the transaction codes and appropriate amounts to report as uncompensated care considering the value that each transaction represents (charge vs. expected payment) and account reversals.
Hospital Policies: Financial Assistance, Charity Care and Bad Debt	To identify allowable uncompensated care amounts and determine which transaction codes (above) match each FAP category.
Patient Transaction and Remittance Detail	To report charges and payments associated with transaction and revenue codes allowable for UC cost reporting.
Listing of Non-Contracted Insurance Plans	To determine potential claims eligible as uncompensated care whereby the entity does not have a contractual relationship with the provider.

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Section 4: Working with UC Data

Data Source	Purpose
Bad Debt Accounting Process	To understand the accounting of hospital bad debts, specifically when/how accounts are written off as bad debt including how reversals and recoveries are recognized.
Detailed listing of Medicare Bad Debt log for the respective cost reporting years	To ensure the Medicare bad debts reported on the cost report are included in the amount of total reported bad debt (Line 26).
Sample of Accounts Reported on WS S-10 Tip: Sample accounts with large amount, transactions spanning multiple fiscal years, as well as other random accounts.	To sample and test accounts for audit support. Account support may include, but is not limited to: ○ All Patient Transaction Detail ○ All Revenue Codes and Associated Revenue Code Charges ○ Completed patient eligibility forms for FAP/charity care ○ Remittance Advice and Patient Notes/Screen Shots

Section 4: Working with UC Data

Identify Account Types

Summarize Data

Support Determined UC Amounts

Identify Hospital Policy Definitions

Sample Claims for Appropriateness of Reporting

Going forward, reporting in future years...

Collaborate and discuss what processes can be improved to better capture UC data.

Changes to FAP language and new transaction codes may assist with capturing all UC costs.

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Section 4: Working with UC Data

Key Takeaways

Working with **IT** on A/R queries will help reduce time. The data is LARGE.

Collaborating on the policy language with **PFS and FAP experts** is an integral part of understanding data for S-10 reporting.

Using **transaction codes and R/A detail** that corresponds with the hospital's FAP provides comprehensive support.

Sampling Claims

For every claim there is a different story.
Be prepared to understand different encounter types and transactions.
Ensure the hospital is following its policy with procedure.
Employ routine control measures on policy and claim processing.
Include large dollar amounts in the sample.

Section 4: Working with UC Data

Notable MAC S-10 "Review" Requests (Sept. 2018)

- "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."
- "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."
  - Hospitals are also being asked to provide all transaction codes used to adjudicate each uncompensated care claim.
- "A reconciliation of the bad debt write-offs from your financial accounting records to bad debts reported on line 26 of worksheet S-10 of the cost report."

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Section 4: Working with UC Data

Notable MAC S-10 Audit Requests (Sept. 2018)

Requested Data Fields to Support Uncompensated Care Data

- 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 (N/A for much of California)*
- Revenue code total charges for the claim *(N/A for much of CA)*
- 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 S-10 Resources

Source	Link
FFY 2018 IPPS Final Rule Summary	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page.html
FFY 2019 IPPS Final Rule and Correction Notice	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page.html
CMS Cost Report Instructions in Transmittal 11	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R11p240.pdf
MLN Matters Update (SE17031)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html
CMS Worksheet S-10 FAQs	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Worksheet-S-10-UCC-QandAs.pdf

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Thank You

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