

Worksheet S-10 - Hospital Uncompensated and Indigent Care Data Following  
2018 IPPS Final Rule  
Questions and Answers

Q1. Courtesy Discount Definition – Request for the Centers for Medicare and Medicaid Services (CMS) to clarify the definition of courtesy discounts as some hospitals use this term for self-pay discounts (as opposed to discounts for “friends and family”).

A1. For Medicare purposes, any discount given to a patient that is not part of the hospital’s charity care policy or that is not a discount given as part of the hospital’s written financial assistance policy (FAP) for uninsured patients, is excluded from uncompensated care. Some examples of discounts given to patients that are not part of a charity care policy or FAP include: courtesy discounts, prompt pay discounts, employee discounts, friends and family discounts, etc.

Q2. Write Off Definition – Request for CMS to clarify the definition of “written-off” as it pertains to bad debt. In many cases bad debt is “written off” a hospital’s general ledger and then sent to a collection agency for attempts to recover patient payment.

A2. Medicare recognizes Medicare bad debt when collection efforts cease and there is no reasonable expectation of recovery. 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.

Q3. Coinsurance and Deductibles as Charity Care – According to examples 1 and 2 in the MLN Matters Special Edition Article SE 17031 published on September 29, 2017 any unpaid amounts related to a coinsurance and deductible, whereby a portion of the coinsurance/deductible was written off to charity care, may be reported as charity care as opposed to bad debt. Can CMS please clarify that these unpaid patient portions can be reported on line 20, column 2 (no application of the cost-to-charge ratio (CCR))?

A3. Yes. Note that examples 1 and 2 of the MLN Matters Special Edition article SE 17031 assume the following: The hospital has a charity care policy; an insured patient has met the hospital’s charity care criteria; the health service provided was considered allowable and the cost reporting period is on or after October 1, 2016. The amounts written off to charity care for insured patients are reported on line 20, column 2 with no application of the CCR.

Q4. Coinsurance and Deductibles as Charity Care – Since instructions state to report the amount written off on line 20 column 2 (and not the patient obligation), it is unlikely that there would be any patient payments reported on line 22, column 2. Can CMS please confirm that is the expectation?

A4. For cost reporting periods beginning on or after October 1, 2016, it is unlikely that providers will report amounts on line 22, however, in the event that an amount is received, it should be reported on this line.

Q5. Insured Patient Obligation on Remaining Balance after Charity Care – What column of line 20 and what amount should be reported when an insured patient receives charity care on a remaining balance that is not the patient’s coinsurance/deductible. In this case, the insurance plan made a partial payment, and part of the remaining patient obligation was written off to charity care.

A5. The remaining balance can only represent either a deductible, co-insurance or charges for days exceeding a length-of-stay limit for patients enrolled in Medicaid or other indigent care program, and are reported on line 20, column 2. Any other amounts that may be remaining balances following the partial payment from an insurer (i.e., contractual allowances) cannot be reported on line 20, column 2.

Q6. State Laws Limiting Amounts Billed to Uninsured Patients – In some cases, hospital FAPs may not specify self-pay discounts because of a state law that requires certain discounts be automatically applied. In these cases, can the state regulation be cited as support in place of the hospital’s FAP?

A6. 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.

Q7. Medicaid Non-Covered Services and Hospital FAPs– Cost report instructions allow Medicaid non-covered charges as uncompensated care, provided these non-covered charges are specified in the hospital’s FAP. However, hospitals cannot request compensation related to non-covered services from Medicaid patients and therefore these amounts are automatically written off as charity care. Because hospitals are not pursuing collections from Medicaid patients, can CMS reconsider the requirement that non-covered Medicaid charges are specified in the hospital’s FAP as a requirement for reporting as uncompensated care?

A7. Charges for non-covered services to Medicaid patients must be specified in the hospital’s charity care policy or FAP in order to be included on line 20, column 1. The charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care programs are reported on Worksheet S-10, line 20, column 2 and also line 25 and must be specified in the hospital’s charity care policy or FAP.

Q8. Other indigent care programs – Can CMS provide a list or examples as to what programs qualify as “other indigent care programs?” Medicaid programs that are “state only” (i.e., no federal match) come to mind, however can CMS clarify if other indigent care programs are eligible?

A8. CMS does not have an exclusive list of other indigent care programs as such programs may vary by state or county.

Q9. Insurance Plans that do not have a Contractual Relationship with the Provider – Can CMS please clarify that to report uncompensated care for this group, these patients also must meet the hospital’s FAP criteria? This will help with any confusion whereby some hospitals could be reporting charges for all patients insured by a plan that does not have a contract with the hospital.

A9. Patients that have insurance plans that do not have a contractual relationship with the hospital may be deemed uninsured for the services provided. The patients must meet the hospital’s charity care policy or FAP in order for the hospital to report these uninsured charges as charity care on line 20, column 1.

Q10. Settled Cost Reports –Some cost reports from fiscal year (FY) 2014 have already been issued a Notice of Program Reimbursement (NPR). Will Medicare Administrative Contractors (MACs) still accept reopened cost reports so that Worksheet S-10 revisions can be considered? Some providers are concerned as reopened cost reports in theory must include an issue of at least \$10,000 related to the cost reporting period.

A10. The MACs must accept amended cost reports or reopening requests to amend Worksheet S-10 data.

Q11. Are all Worksheet S-10 changes to be submitted as amended cost reports?

A11. Worksheet S-10 changes must be submitted as amended cost reports if no NPR has been issued. If an NPR has been issued, a reopening request with amended Worksheet S-10 data must be submitted.

Q12. How are reports that have been settled or adjusted by the MACs for wage index adjustments to be submitted?

A12. If an NPR has been issued, a reopening request must be submitted with revised Worksheet S-10 data. If no NPR has been issued an amended cost report must be submitted and all wage index adjustments will be incorporated by the MAC.

Q13. If providers choose not to amend their FY 2014 or FY 2015 cost report, will the cost report on file with CMS be updated to reflect the revised calculation in accordance with Transmittal-11 and be reflected in Healthcare Cost Report Information System (HCRIS)?

A13. The modified calculations provided in Transmittal-11 will be applied to all FY 2014 and FY 2015 cost reports, both amended and not amended and uploaded to HCRIS; however, if the cost report fails the level 1 edits, the modifications will not be applied and the revised HCRIS files will not be generated. Providers are encouraged to review the level 1 edits and submit amended or reopening requests to clear the level 1 edits if applicable to ensure they benefit from the modified calculations.

Q14. Regarding the MLN Matters Special Edition article SE 17031 question 7 – the math does not work in the example provided. If we account for a FAP discount in the manner prescribed in question 7 then we would be upside down on a patient that paid zero. Example - \$100 charges, \$40 FAP discount, \$60 due from patient, patient pays nothing, 25% cost to charge ratio.  $\$100$  goes on charity line  $\times 25\% = \$25$  cost, less \$60 due from patient which leaves  $\$(35)$  gain. Then if the due from patient turns into bad debt in the same period that would be  $\$60 \times 25\% = 15$ .  $\$(35) + \$15$  still leave a \$20 gain for a patient that paid nothing.

A14. The instructions for line 23 specify that if line 22 is greater than line 21, enter 0. A level 1 edit has been added to ensure that if line 22 is greater than line 21 than line 23 must be zero for cost reporting periods beginning on or after October 1, 2013. In addition, if a patient liability remains uncollected and the hospital determines it to be a Medicare bad debt, it is recorded on line 27 as a hospital Medicare bad debt. The amount reported on line 27 is not multiplied by the CCR. Note that the Medicare cost report calculates a provider's cost of uncompensated care in aggregate and not at the individual patient level as reflected in the examples. Using the amounts specified in your example (which differ from the amounts specified in the MLN Matters Special Edition Article SE 17031 Example 7), the amounts reported would be follows:

For cost reporting periods beginning prior to October 1, 2016:

Line 20, column 1= $100.00$

Line 21, column 1= $25.00$

Line 22, column 1= $60.00$  (Amount expected from patient)

Line 23= $0$

Line 27= $60.00$  (The hospital has determined that the \$60.00 unpaid patient liability is a hospital Medicare bad debt. This amount is not multiplied by the CCR.)

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

Line 20, column 1= $40.00$

Line 21, column 1= $10.00$

Line 22, column 1= $0$  (There is no expectation of payment for the \$40 financial assistance.)

Line 23= $10.00$

Line 27= $60.00$  (The hospital has determined that the \$60.00 unpaid patient liability is a hospital Medicare bad debt. This amount is not multiplied by the CCR.)

Q15. Explain the difference between a FAP discount and courtesy discount.

A15. For Medicare purposes, discounts given to uninsured patients who do not meet a hospital's charity care policy, but do meet the hospital's FAP policy are included in the calculation of uncompensated care. Courtesy discounts (i.e. employee, prompt pay, clergy discounts, etc.) are not discounts granted under an FAP, but are discounts granted for some other reason. These types of discounts are not part of a charity care or FAP and will not be considered in the uncompensated care calculation.

Q16. There are numerous line items on the Worksheet S-10 that are derived from other parts of the cost report (e.g. cost-to-charge ratio, Medicare bad debts). These have material impacts on the Worksheet S-10 Line 30. When we amend the cost report on or before January 2, 2018 (which is a full re-submission of the cost report), are we permitted to adjust parts of the cost reports that flow through to S-10 (i.e. if we have supportable Medicare bad debts that weren't previously claimed for that year on Worksheet E, can we include those on Worksheet E in the submission of the amended cost report?). We understand we would have to separately discuss the Medicare bad debt reimbursement on Worksheet E, but we want to make sure those additional amounts flow through to and are included on the updated Worksheet S-10, given the spirit of the opportunity to amend the Worksheet S-10.

A16. Providers have the option to submit amended data only for Worksheet S-10, lines 20, 22, 25 and 26 for FY 2014 and FY 2015 cost reports. Additional items cannot be added to the cost report during the resubmission of Worksheet S-10 data. The purpose of affording providers the opportunity to amend FY 2014 and FY 2015 cost report Worksheet S-10 data for lines 20, 22, 25 and 26 is to allow for items pursuant to the clarifications of the uncompensated care policy, not to allow for items that were previously permissible but not claimed (i.e. supportable Medicare bad debts that weren't previously claimed for that year on Worksheet E). A provider must submit a request to their MAC to include any amended data for cost report worksheets other than Worksheet S-10 lines 20, 22, 25 and 26 and have the request reviewed by their MAC.

Q17. With Transmittal-11, issued on September 29, 2017, CMS is no longer applying the CCR to the coinsurance and deductibles on the Medicare Fee-For-Service (FFS) side. Why would CMS then apply the CCR to the coinsurance and deductibles on the Medicare Advantage side? There is a modest difference in payment rate, but generally pretty close to Medicare in terms of cost. Do you think there is a reason?

A17. For Medicare Part A and Part B, the bad debt amounts are exclusively coinsurance and deductible; therefore the CCR is not applied. The CCR is applied to all other bad debt amounts because those amounts are not limited to deductible and coinsurance.

Q18. For Medicare Advantage dual eligible (Medicare Advantage primary, Medicaid FFS secondary), after Medicare pays, a secondary bill is sent to Medicaid for reimbursement of coinsurance and deductible. Generally Medicaid does not pay anything as the amount Medicare paid is more than they would have paid in total. Are hospitals then allowed to treat that unpaid coinsurance or deductible as a bad debt? This is the approach used on the FFS side.

A18. The amounts of unpaid deductible and coinsurance may be claimed as a total facility bad debt, but cannot be claimed as a Medicare FFS bad debt.

Q19. A hospital originally filed their September 30, 2014 cost report with a CCR of 0.30000 and had \$100,000 in “Insured Charity Care Charges” reported on line 20, column 2 and \$5,000 in patient payments reported on line 22, column 2. Under the previous Worksheet S-10 methodology, the \$100,000 in charges would be multiplied by the CCR (\$30,000) and the patient payments will be subtracted from the cost amount to end up with a total Uninsured Charity Care cost of \$25,000.

Under the new Transmittal-11 methodology, all of the \$100,000 in charges would be taken as cost for line 21, minus the \$5,000 payments to result in a total cost of \$95,000. Am I correct with this assessment?

A19. Yes, the result will be \$95,000 on line 23. However, there is one other element to take into consideration here. Did the provider identify any charges on line 20, column 2, as patient days beyond the length of stay limit (reported on line 25)? If the answer to that question is no, then the assumption is that the insured charges are the patients’ deductible and coinsurance that are eligible for charity care. If there is an amount reported on line 25, that portion of the amount reported on line 20, column 2, will be subject to the CCR. The calculation will be line 20, column 2 minus line 25=A. Line 25 times the CCR=B. Line 23, column 2 will be (A+B) minus line 22.

Q20. Should or may hospitals exclude from lines 20-23 all the charges or collections on billed charges for an uninsured patient who is given a partial discount and who makes payment of an amount that is greater than the cost of the services rendered to that patient? Or, is there some other way CMS intends for hospitals to handle this situations so that a “negative” cost calculation for one uninsured patient is not ultimately offset against actual uncompensated cost of care furnished to other charity care or uninsured patients who were given a full or partial discount?

A20. As noted in Transmittal-11, for cost reporting periods beginning prior to October 1, 2016, hospitals must report the full charges of uninsured patients who are given a full or partial discount based on the hospital’s charity care or financial assistance policy on line 20, column 1. Line 22, column 1 must represent payments received and payments expected to be received from uninsured patients who have been approved for charity care or uninsured discounts for healthcare services delivered during this cost reporting period. Thus, hospitals cannot choose to exclude certain patient populations. The Medicare cost report calculates a provider’s cost of uncompensated care in aggregate. As provided for in Transmittal-11, the instructions for line 23, columns 1 and 2 specify that if the amount on line 22 is greater than line 21, enter zero. Therefore, a negative value should not be reported on line 23 or considered in the calculation of uncompensated care costs reported on line 30 and line 31. Additionally, the amounts reported on line 22 do not decrease the bad debt portion of uncompensated care; the amounts on line 22 only reduce the cost of charity care reported on line 21.