

How to Prepare for and Vanquish an S-10 Audit



*Smart about revenue.
Tenacious about results.*

Disclosure

Copyright 2019, BESLER. All rights reserved.

The material contained within this presentation is proprietary. Reproduction without permission is strictly prohibited.

This document may not be copied, reproduced in any manner or format or furnished to others, and derivative works that comment on or otherwise explain it or assist in its implementation may not be prepared, copied, published and distributed, in whole or in part, without written permission of BESLER.

This document may not be modified in any way, (such as, for example, removing the copyright notice or references to BESLER or other organizations).

This presentation does not represent legal advice.

The information herein is valid for the date of the presentation only.

Agenda

- Review of DSH and Uncompensated Care
- Medicare Cost Report Worksheet S-10
- Impact of Worksheet S-10
- Preparing for an Audit
- Technology Solutions
- Q&A

Disproportionate Share Hospitals (DSH)

- Additional payment for hospitals serving a significantly disproportionate number of low-income patients
- Historical (pre-ACA) formula is based on the SSI ratio and the Medicaid fraction
- Formula determines a provider's eligibility for DSH reimbursement and how much.
- Variable sized pool based on eligibility and the SSI/Medicaid factor

Uncompensated Care Costs

- UCC is an overall measure of hospital care for which no payment was received from the patient or insurer
- Sum of bad debt and financial assistance with many caveats
- Difference between bad debt and financial assistance can be considered arbitrary at best
- A hospital is responsible for defining their own policy and rules when it comes to funding their charity care pool

Medicare Cost Report Worksheet S-10

- Introduced in 2010, was intended to capture Uncompensated Care Cost (UCC) under all the hospital's Medicare provider agreements
- Until 2014, it was informational in nature with the exception of meaningful use
- Starting in 2015, the UCC was used to determine a hospital's portion of the DSH pool
- The total CMS pool for Medicare DSH Payments will be \$8.2B in 2019. 75% of the pool funding will be based on worksheet S-10

Medicare Cost Report Worksheet S-10

Uncompensated Care (see instructions for each line)					
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)				20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)				21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)				23
24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)				25
26	Total bad debt expense for the entire hospital complex (see instructions)				26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)				27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)				27.01
28	Non-Medicare bad debt expense (see instructions)				28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)				29
30	Cost of uncompensated care (line 23 column 3 plus line 29)				30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31

In Case You Missed It...

- The DSH pool is a finite number. \$8.2B in 2019
- A hospital is responsible for defining their own policy and rules when it comes to funding their charity care pool
- Charity care is defined “**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 financial assistance policy (FAP).**”
- = Finite pool of dollars distributed by arbitrary interpretation of ambiguous instructions

Impact of Worksheet S-10

- Hospitals are forced to interpret their understanding of the S-10 rules
- Because the pool is finite, one hospital's interpretation impacts every other hospital's share
- S-10 will become even more important in future years. By 2021, 100% of the DSH allocation will be based on S-10
- Higher UCC will result in better DSH reimbursement
- The interpretations must be defensible in an audit

S-10 Updates

- In Transmittal 10, CMS clarified that hospitals may include discounts given to uninsured patients who meet the hospital's charity care criteria
- 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

Preparing for an Audit

- FY2015 cost reports are being audited now
- Two weeks to respond to the MAC's initial questions and requests for data
- Challenging for hospitals to produce the documentation, data and details to support the UCC calculations
- Data on Worksheet S-10 must be defensible
- DSH payments will very likely be based on the AS-IS Cost Report

What is Being Audited


- Patient level details including logic that was applied to produce the results
- Charity care and financial assistance policies
- Any significant change/variance between reporting years
- FY 2019 will require complete detail patient listing or the form will be immediately rejected

Some Free Advice

- Develop a Cross-Departmental Workgroup
- Review and discuss the Charity Care Policies and Financial Assistance Policies
 - Specificity vs. Open
- Ensure clear definitions on Charity Care Policies
 - Define clear, non-discriminatory income levels
 - Categorize co-pays/deductibles
- Implement proper Information/Data governance
- Timelines and Deadlines

How we approach the S10 schedule

BESLER employs a hybrid approach leveraging proprietary technology to populate S-10 schedules along with expert consultants who prepare, review and submit the S-10 form.



Our services address the shortcomings that even a seasoned hospital staff may encounter to ensure a hospital receives their appropriate share of Medicare DSH funding.

BESLER and Robotic Automation

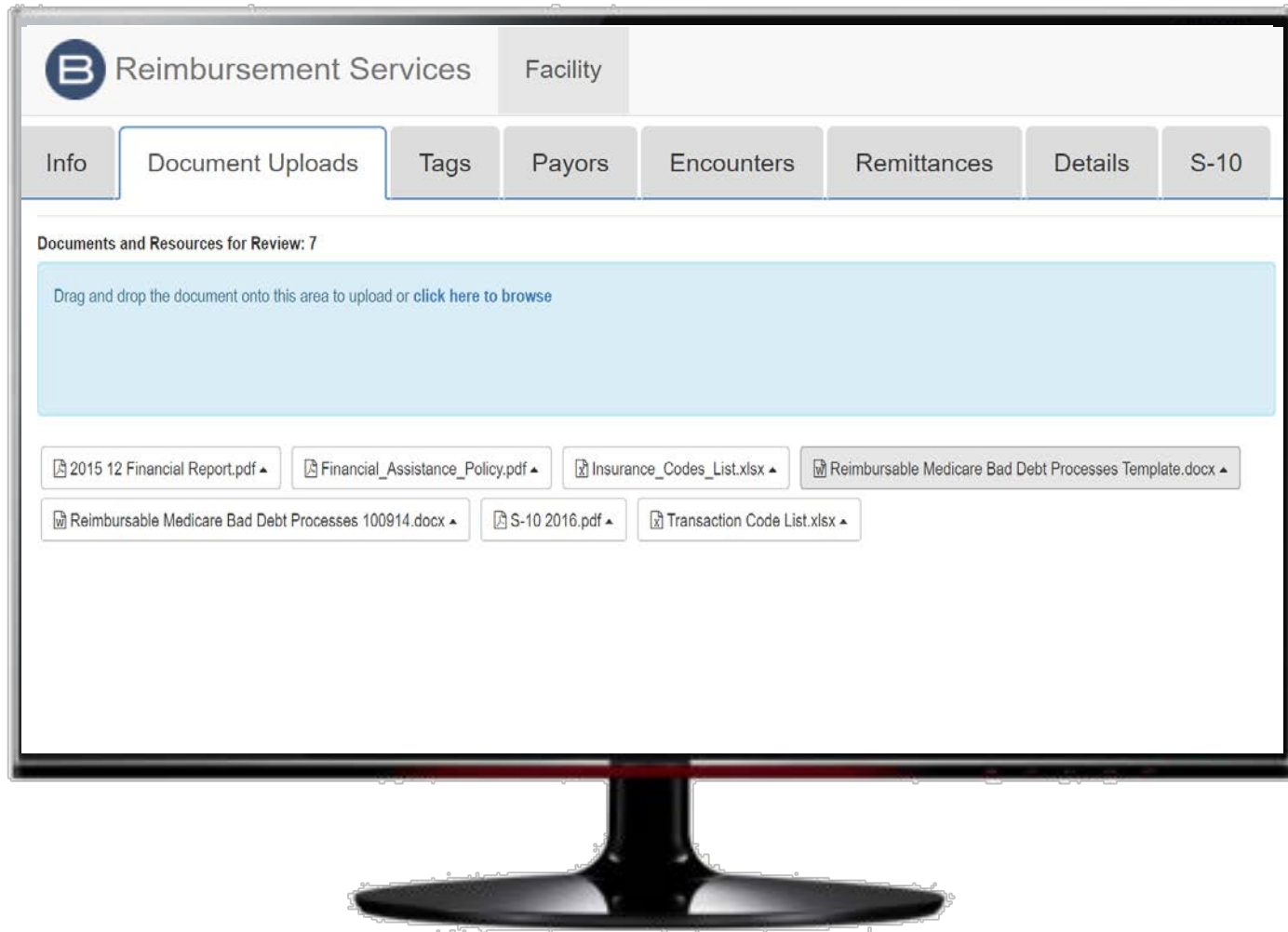
- BVerified TDRG/IME
 - Initial claim review reduced from 6 weeks to 60 minutes
 - Thorough investigation using Software Guided Workflow tools
 - Captures every claim
- Revenue Integrity Services
 - Result of focus groups
 - Audit 100% of a facilities claim
 - 1,000+ rules to identify optimization opportunities
- BRS / Worksheet S-10

How we approach the issue

- Combines proprietary technology to accurately calculate a hospital's uncompensated care cost
- Worked with CMS and MACs to discuss their proposed audit
- Provides the required backup data that will help defend against an audit
- Can adjust and re-run reports based on claim tagging
- Provides an efficient process for expertly identifying uncompensated care costs and reporting S-10 data in compliance with government regulations.

Technology Advantages

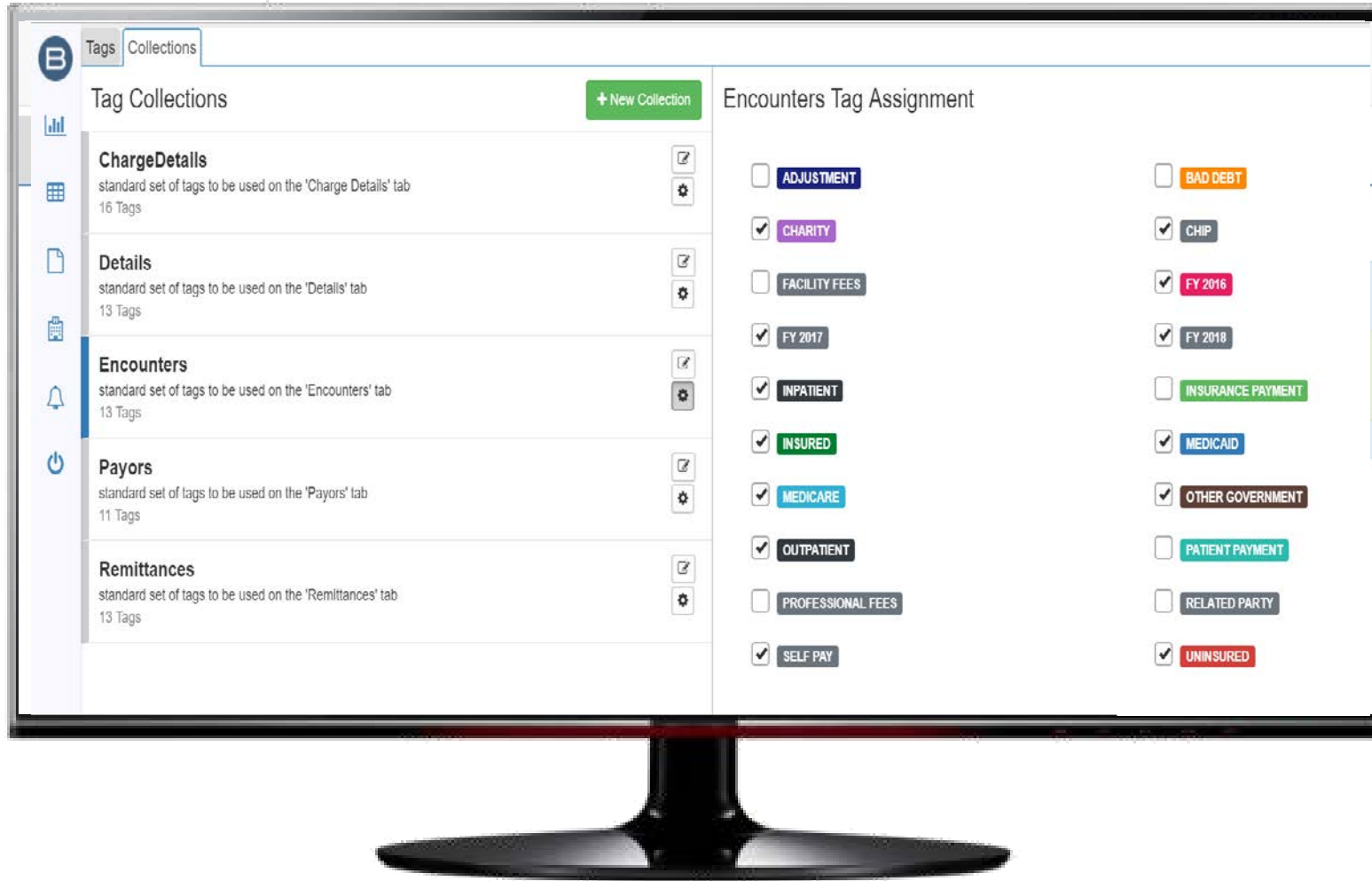
The background features a large teal triangle on the left side. On the right, there are two overlapping triangles: a dark blue one at the top and a light grey one below it. The light grey triangle contains a series of horizontal white lines, resembling a document or a list.



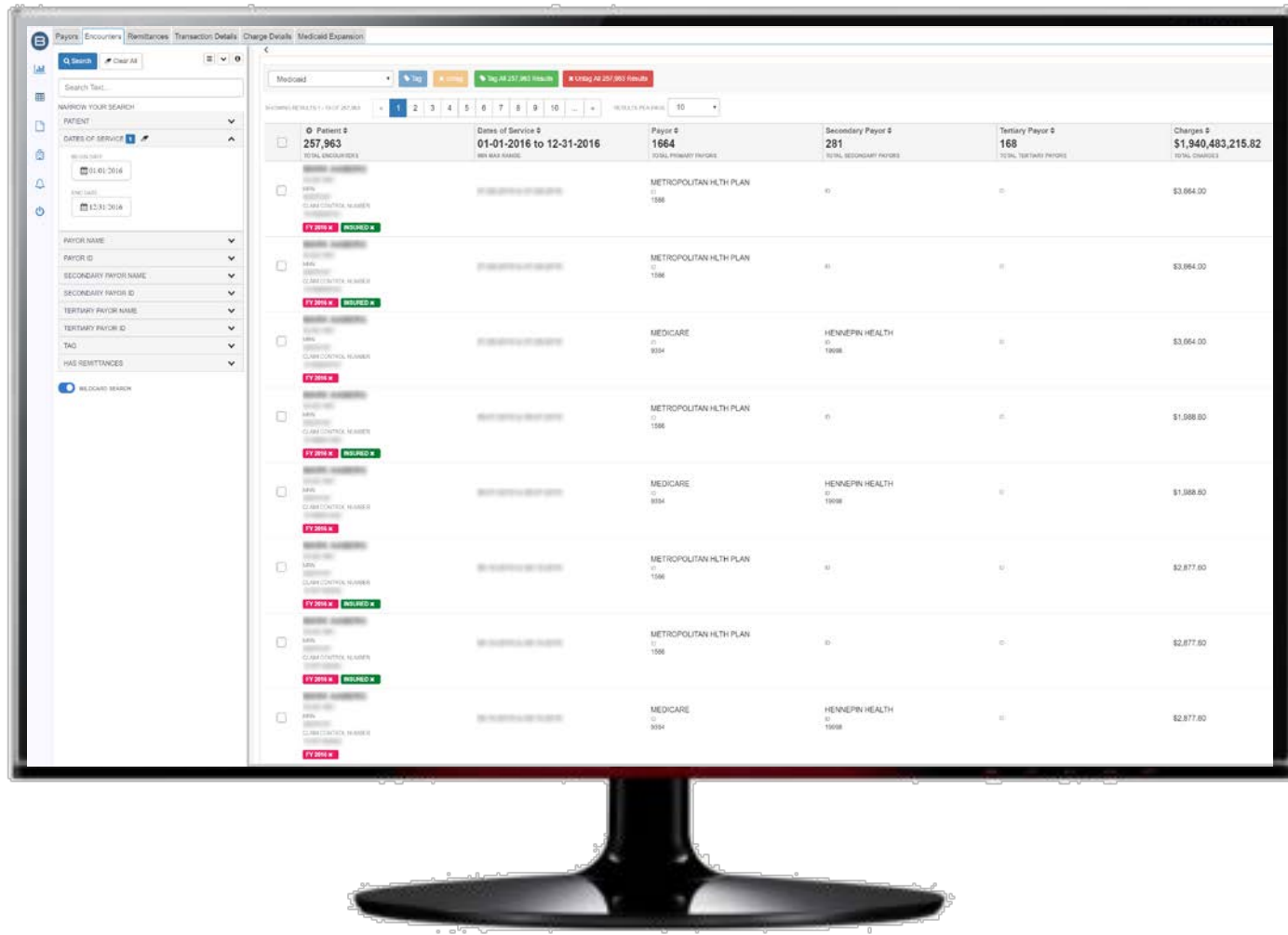
Documents can be uploaded for references.

- Bad debt Policies
- Charity Policies
- Insurance Master
- Transaction Master

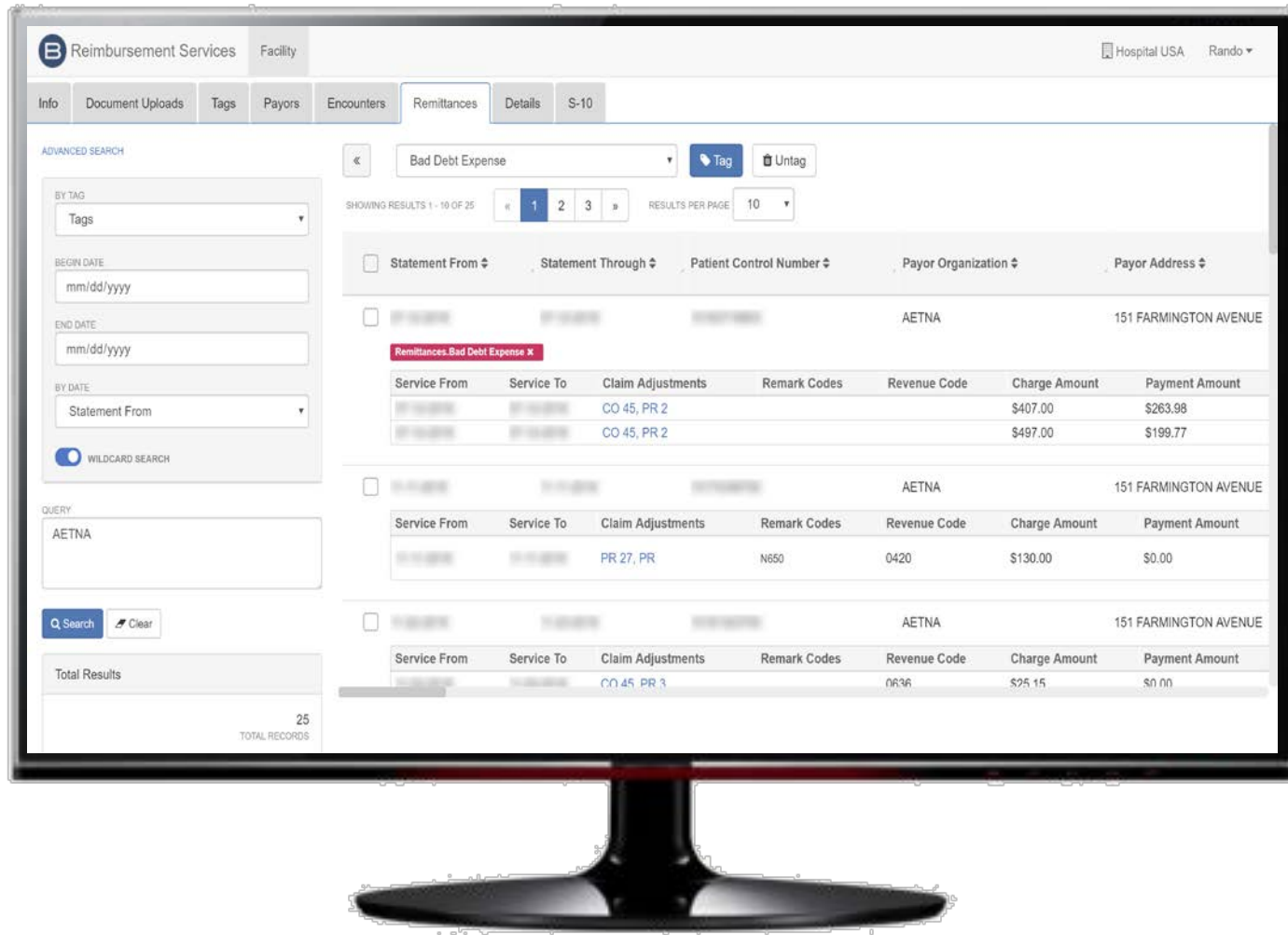
This allows providers to maintain multiple years in the same location.



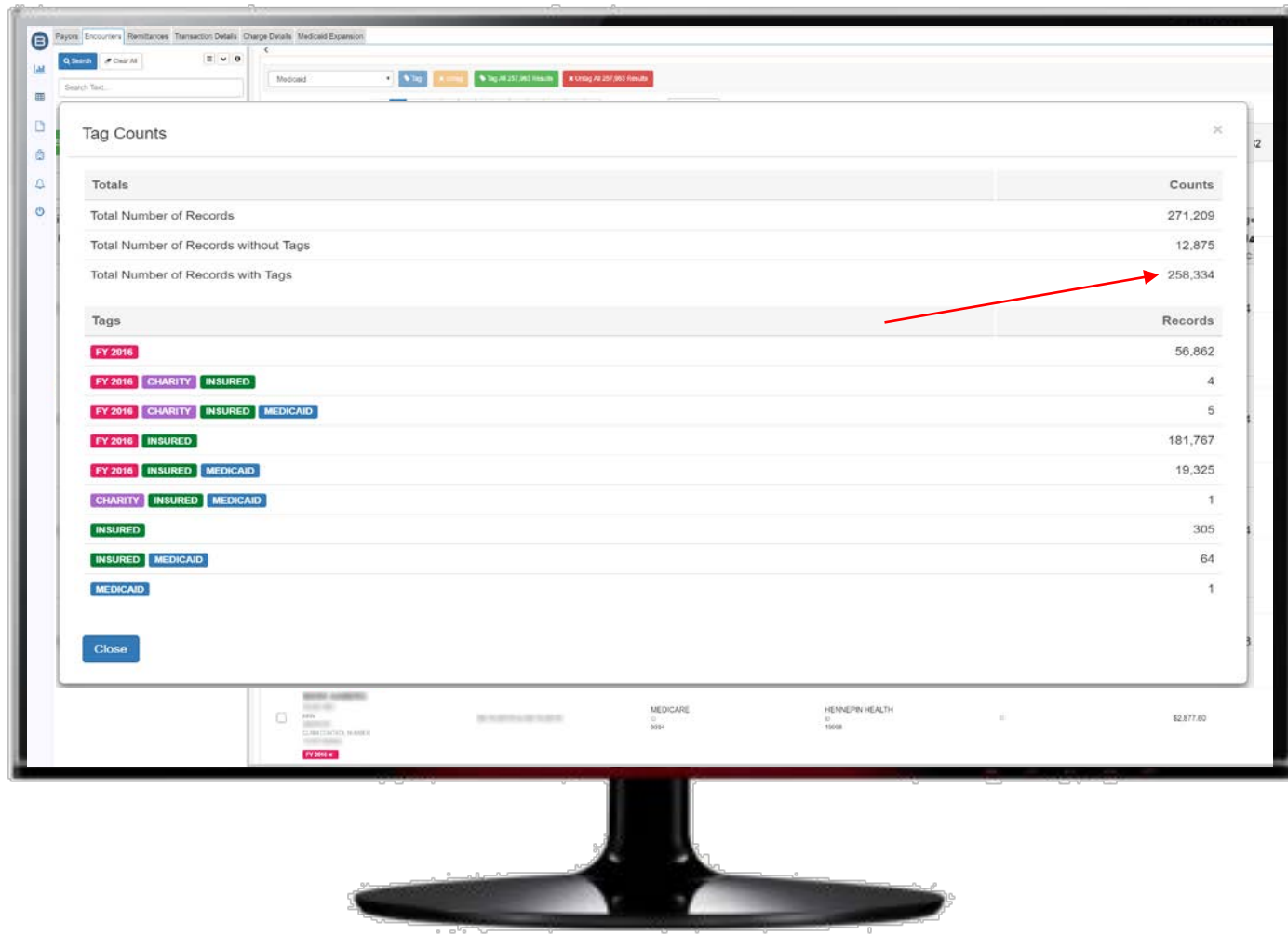
Tags are assigned to specific data files for easy identification.



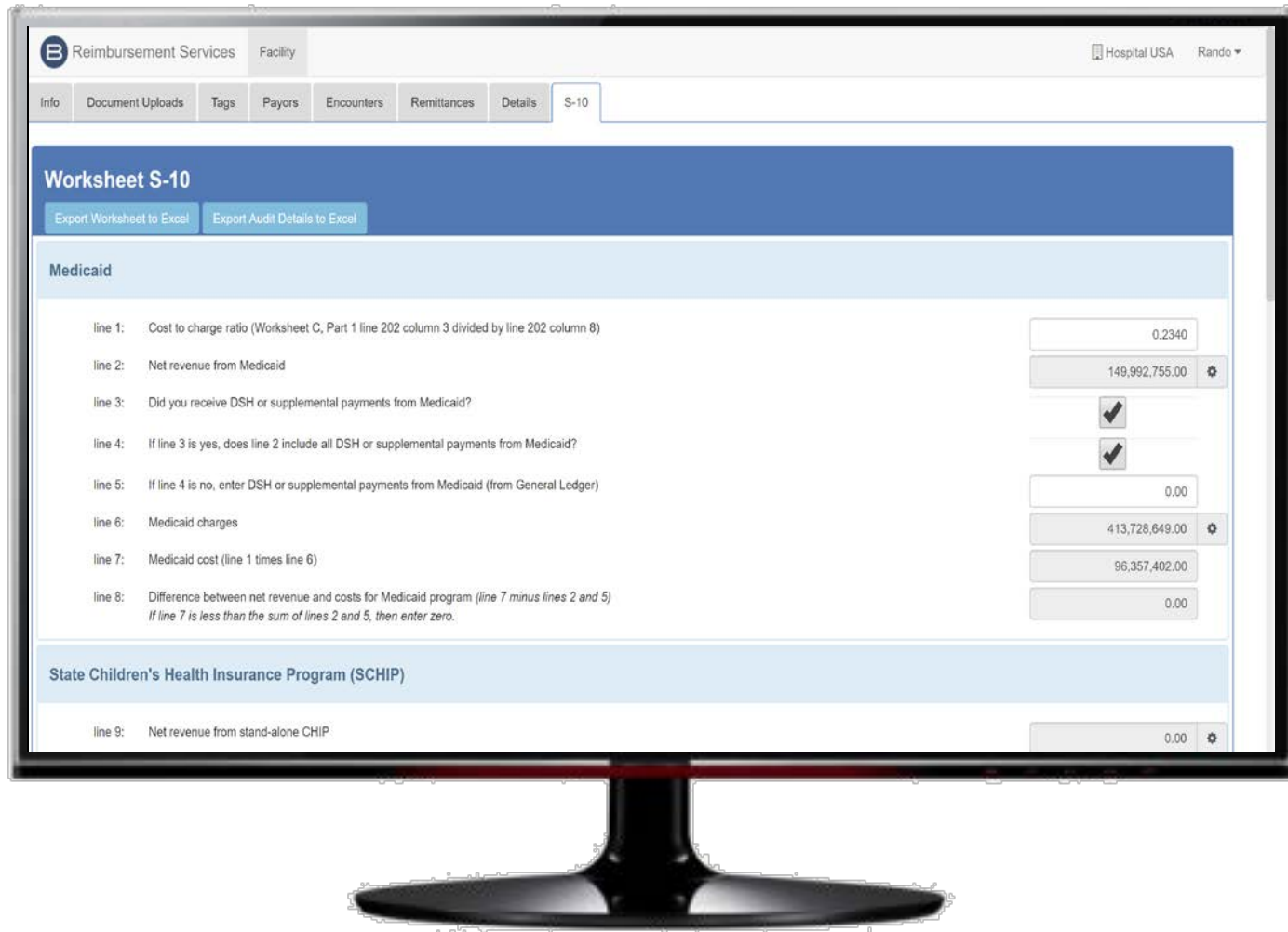
- The Patient Encounter lookup screen, built from detail data, is the starting point for the reimbursement analyst.
- It allows the reimbursement team to research specific patient encounters and review associated categories and tags.
- Similar screens for remittance and charge details



- Tool allows for tagging of payor payments, coinsurance and deductible amounts. Used for Medicare Bad debt and S-10 reporting.
- User will be able to identify secondary payor payments and move to the appropriate line on the S-10.
- Data fields are searchable



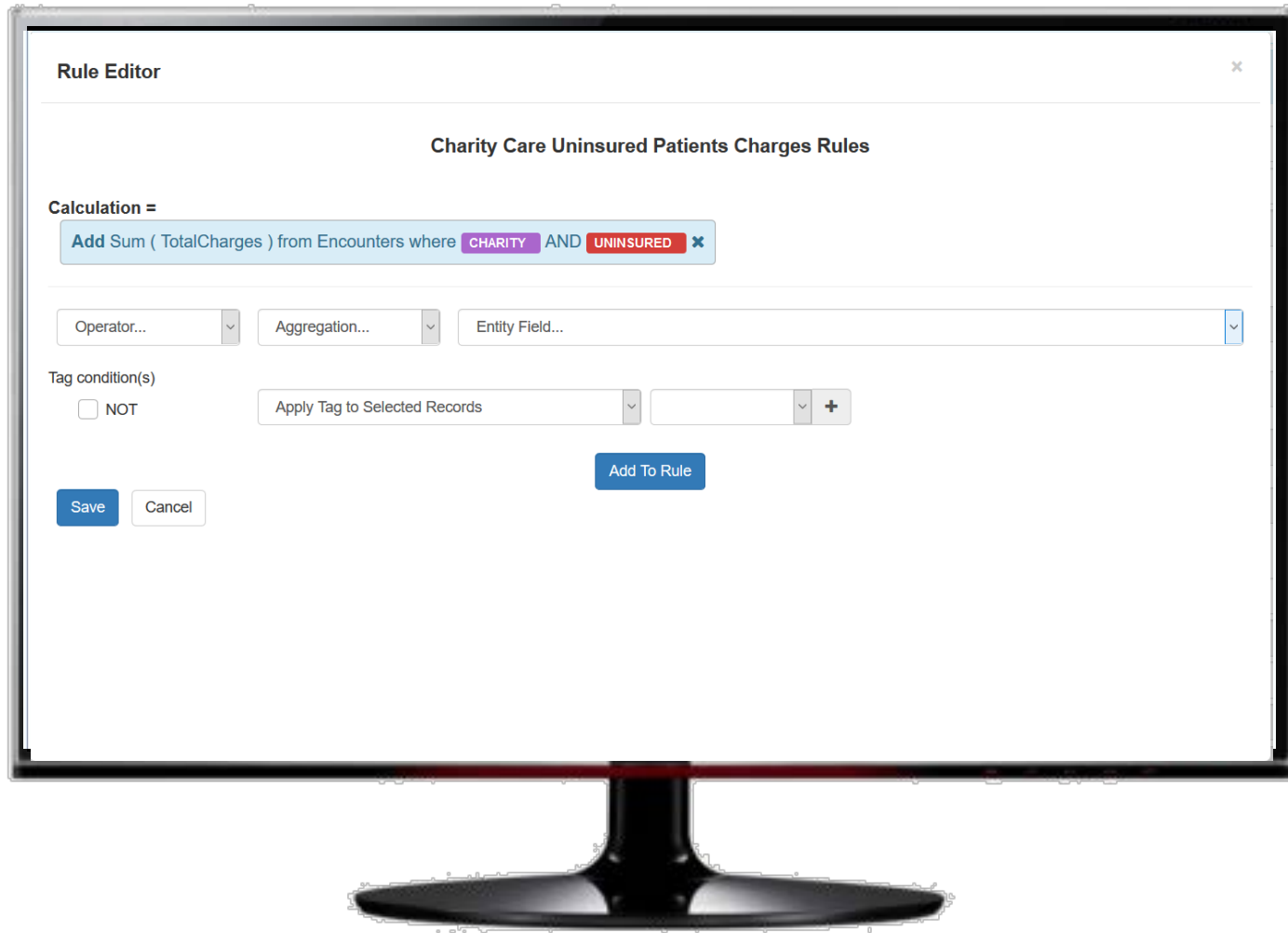
- The tag details screen, available for each of the lookup screens, allows our reimbursement analysts to identify accounts that have yet to be categorized and that have “fallen through the cracks”



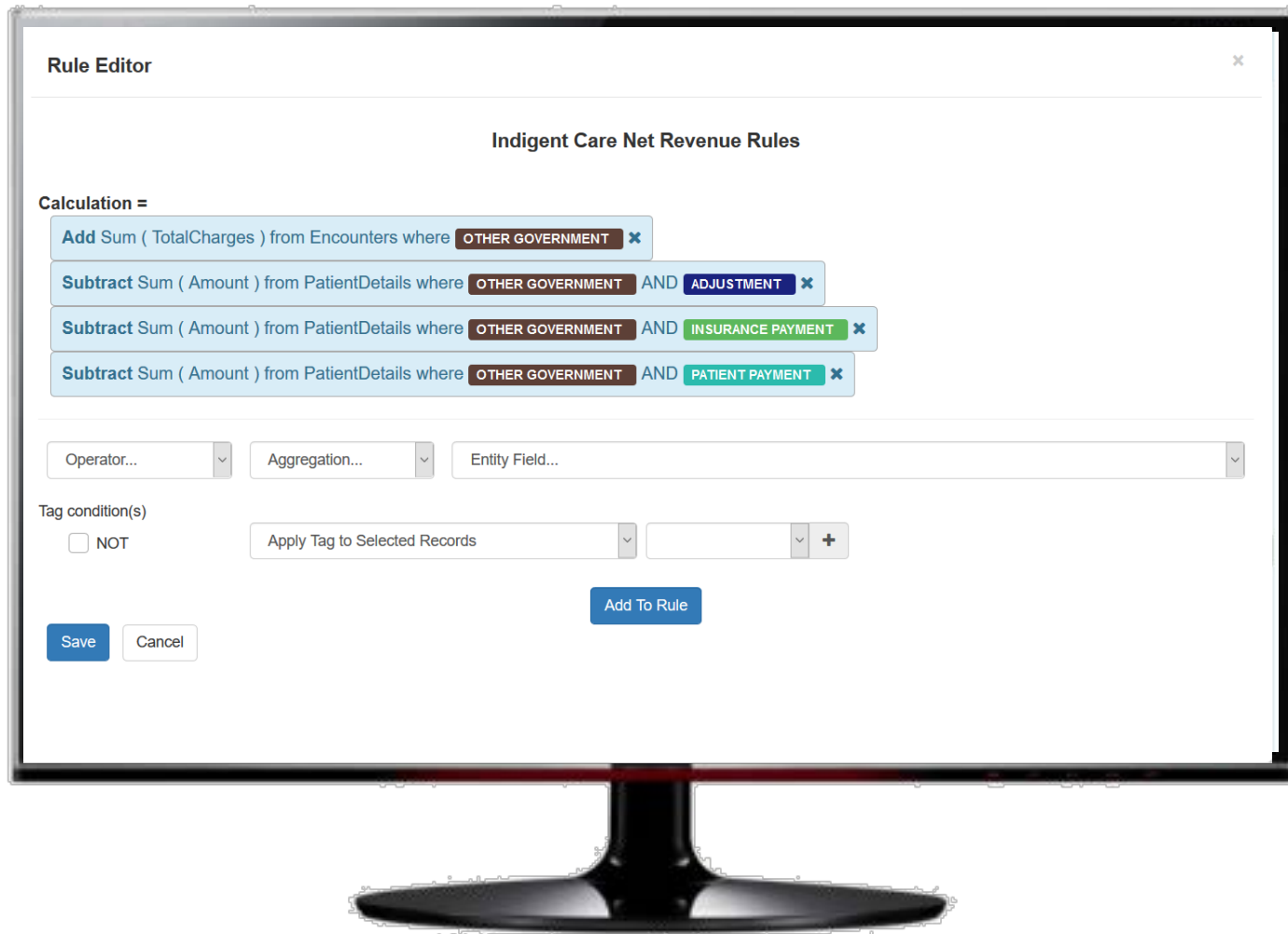
- The Cost Report Builder UI allows the Reimbursement Team User to add the S-10 worksheet data to the Cost Report.
- From this screen the user can automatically load the S-10 values derived from the customers imported data sets.

Uncompensated Care				
line 17:	Private grants, donations, or endowment income restricted to funding charity care (from General Ledger)		0.00	
line 18:	Government grants, appropriations or transfers for support of hospital operations (from General Ledger)		0.00	
line 19:	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12, and 16)		0.00	
	Uninsured Patients (col 1)	Insured Patients (col 2)	Total (col 1 + col 2)	
line 20:	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers)	16,538,337.00	8,330,430.00	24,868,767.00
line 21:	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	4,011,392.00	8,330,430.00	12,341,822.00
line 22:	Partial payment by patients approved for charity care	0.00	998,725.00	998,725.00
line 23:	Cost of charity care (line 21 minus line 22)	4,011,392.00	8,007,256.00	12,018,648.00
line 24:	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care programs?		<input type="checkbox"/>	
line 25:	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		0.00	
line 26:	Total bad debt expense for the entire hospital complex		7,970,197.00	
line 27:	Medicare bad debts for the entire hospital complex (see instructions)		648,470.00	
line 28:	Non-Medicare and non-reimbursable bad debt expense (line 26 minus line 27)		7,323,727.00	
line 29:	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,039,311.00	
line 30:	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		14,057,959.00	
line 31:	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		14,057,959.00	

- The Cost Report Builder UI allows the Reimbursement Team User to add the S-10 worksheet to the Cost Report.
- From this screen the user can automatically load the S-10 values derived from the customers imported data sets.
- Each of the values will have a way for the user to see the details behind the calculations so that they can verify which patient records were counted as bad debt, charity, etc.



- The Cost Report Builder UI allows the Reimbursement Team User to add the S-10 worksheet to the Cost Report.
- From this screen the user can automatically load the S-10 values derived from the customers imported data sets.
- Each of the values will have a way for the user to see the details behind the calculations so that they can verify which patient records were counted as bad debt, charity, etc.



- The Cost Report Builder UI allows the Reimbursement Team User to add the S-10 worksheet to the Cost Report.
- From this screen the user can automatically load the S-10 values derived from the customers imported data sets.
- Each of the values will have a way for the user to see the details behind the calculations so that they can verify which patient records were counted as bad debt, charity, etc.

Uncompensated Care				
line 17:	Private grants, donations, or endowment income restricted to funding charity care (from General Ledger)		0.00	
line 18:	Government grants, appropriations or transfers for support of hospital operations (from General Ledger)		0.00	
line 19:	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12, and 16)		0.00	
	Uninsured Patients (col 1)	Insured Patients (col 2)	Total (col 1 + col 2)	
line 20:	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers)	16,538,337.00	8,330,430.00	24,868,767.00
line 21:	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	4,011,392.00	8,330,430.00	12,341,822.00
line 22:	Partial payment by patients approved for charity care	0.00	998,725.00	998,725.00
line 23:	Cost of charity care (line 21 minus line 22)	4,011,392.00	8,007,256.00	12,018,648.00
line 24:	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care programs?			<input type="checkbox"/>
line 25:	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		0.00	
line 26:	Total bad debt expense for the entire hospital complex		7,970,197.00	
line 27:	Medicare bad debts for the entire hospital complex (see instructions)		648,470.00	
line 28:	Non-Medicare and non-reimbursable bad debt expense (line 26 minus line 27)		7,323,727.00	
line 29:	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,039,311.00	
line 30:	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		14,057,959.00	
line 31:	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		14,057,959.00	

- For every field on the S-10 there are supporting detail schedules that will be supplied for Medicare audit.
- Each of the values will have a way for the user to see the details behind the calculations so that they can verify which patient records were counted as bad debt, charity, etc. this will be used for audit and review purposes.

Be Prepared

Define CCP and FAP policies to maximize DSH

- Seek guidance when defining your policies.
- Ensure coordination between Revenue Cycle and Reimbursement departments

Complement the recovery efforts of your team

- Ensure you can identify every dollar of UCC.
- Ensure your data governance can produce evidence for UCC calculations including query methodology

Get it right the first time

- Limited time to prepare supporting documentation
- Appeal process is undefined.
- We utilize both General Ledger and claim-level approaches to validate data.

Thank you

Jonathan Besler – jbesler@BESLER.COM

Ely Labovitz - elabovitz@BESLER.COM

Learn more at www.Besler.com



*Smart about revenue.
Tenacious about results.*