REVINT SOLUTIONS INSIGHTS

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Bad Debt is Now a Key Factor in Distributing Over $8B in Medicare DSH Uncompensated Care Payments

To Our Healthcare Clients and Friends:

The Affordable Care Act (ACA) significantly changed the distribution of billions of dollars of Medicare Disproportionate Share Hospital (DSH) reimbursement by adding payment allocation based upon Uncompensated Care (UCC). Beginning in Federal Fiscal Year (FFY) 2018, bad debt became a major driver of the allocation of UCC reimbursement which is over $8.2B for this FFY alone. The onus is on hospitals to properly report bad debt on the applicable lines of the Medicare cost report (MCR) Worksheet S-10 (S-10) to obtain proper UCC reimbursement.

BACKGROUND

Under the ACA, a hospital's DSH reimbursement is composed of two parts:

- The hospital's Empirically Justified Amount (EJA) – The formula for the EJA remains the same as pre ACA, but hospitals receive only 25% of the total value of their EJA calculation.
- A prospectively determined UCC payment – The hospital's UCC payment is based upon its uncompensated care relative to the amount of uncompensated care for all DSH hospitals expressed as a percentage. UCC payment is a Zero-Sum Game!

Each year the size of the national UCC Pool changes. The UCC Pool has been as large as $9B in FFY 2014 and as small as $6B in FFY 2017. Currently it is $8.2B.

Centers for Medicare and Medicaid Services (CMS) has worked since the inception of the ACA to determine the best measure to define UCC. The UCC metric has changed each year since the ACA began. Currently the bad debt portion of Line 30 of S-10 of the MCR is a key factor.

Between FFYs 2014 and 2017, the metric CMS used to distribute the UCC Pool was the days of care provided to Low Income Insured patients (the Days Proxy). In FFY 2018, CMS began a transition from the Days Proxy to Line 30 of S-10 which is composed of the dollar amount of Charity Care and selected Medicare and Non-Medicare bad debts. For FFY 2020 and beyond, Line 30 of the S-10 is scheduled to be the sole definition and measure of UCC.

Since FFY 2018 it has been crucial for hospitals to document and report the maximum allowable amount of UCC on Line 30 of the S-10 to obtain their full, appropriate share of the UCC pool.

CMS uses Line 30 from a hospital's FFY 2014 and 2015 MCRs in the FFY 2018 and 2019 UCC calculation and is scheduled to add Line 30 from the FFY 2016 MCR in FFY 2020.

To compete wisely for its share of the UCC Pool, a hospital must clearly understand and optimize the metric CMS uses to distribute the dollars in the Pool.

CHALLENGES

Bad debt has always been a complicated issue for hospitals due to differing rules and guidelines for Medicare and Non-Medicare Bad Debt policies, procedures and reporting. In addition, the GAAP and FASB standards are not always congruent with MCR instructions which often makes reconciliation to the financial statements difficult.

There has been inconsistency throughout the country in reporting on S-10. This has kept CMS from using S-10 information prior to FFY 2018. Many hospitals and hospital associations are strongly protesting its use even now. The instructions for S-10 have been unclear and have changed often over the past years producing varying interpretations among hospitals. S-10 has never been audited for purposes of UCC reimbursement which has also contributed to disparate approaches to populating the Charity Care and Bad Debt section of the worksheet. There have been HITECH and EHR audits in the past, but none for UCC payment.

CMS stated that beginning with the FFY 2017 MCRs it would audit the S-10 for UCC. To prepare for large scale audits of the S-10, CMS instituted a sample of audits of the HFY 2015 MCR for UCC in September 2018. Each MAC selected 50 hospitals within its jurisdiction to audit. Below are the audit requirements related to Bad Debt.

The MAC requested information in two main areas. The text in italics is directly from a MAC request.

First, they asked for:

> *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).*

Second, they asked for:

> *Please submit a detailed listing of all bad debts (Medicare and non-Medicare) including all of the following detailed information.*
>
> *- 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.*
> *- **Note that we may be selecting a sample of these total bad debts from your listings and will request patient level detail at that time**.*

CHALLENGES CONT'D...

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

Source: Italicized audit request information is quoted directly from NGS Jurisdiction JK Subcontractor "S-10 Review Request Letter" sent to selected hospitals.

INSIGHTS

Beginning in 2019, a Total Bad Debt (Medicare and Non-Medicare) log along with a Charity Care patient-level log will be mandatory requirements for an acceptable as-filed MCR. The S-10 bad debt logs require several more data elements than the traditional Medicare Bad Debt log. Plus, all the information is required for Non-Medicare bad debts as well.

Medicare DSH reporting responsibility often falls in the reimbursement area. Determination of patient bad debt generally lies in the Patient Financial Services (PFS) and Revenue Cycle areas, whereas financial reporting of bad debt lies primarily in the accounting and finance area.

With the importance of UCC created by the ACA, staff from Reimbursement, PFS, Revenue Cycle, Finance and IT must prepare a coordinated plan to track, report and reconcile bad debt annually. All stakeholders should be involved in interim reporting and management of bad debt to ease the preparation of accurate bad debt logs to be submitted with the MCR. Hospitals should consider "mock audits" and should review prior years' MCR filings to uncover any areas of risk or deficiencies in meeting the CMS reporting requirements in the audit program.

SUMMARY

From billing to collection to reporting; accurately determining an institution's bad debt amount has always been complex. However, now it is even more important because of the large financial impact related to UCC payments.

Bad debt has taken on an even higher profile in a hospital's reimbursement picture. Hospitals must determine if they need to modify policies, practices and reporting to meet the new bad debt requirements.

There will be major financial impacts if a hospital does not present the optimal amount of UCC on Line 30 of S-10. Line 30 reports both Charity Care and bad debts but this article deals only with the bad debt portion of Line 30. The role of bad debt has been elevated within the institution and must be managed in a new light for a hospital to obtain its proper share of the multi-billion-dollar UCC reimbursement being distributed to hospitals.

We are pleased to have the opportunity to present this information to you. If you have any comments or questions, please contact me at (703) 581-5853.

Truly Yours,
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Larry Millner earned a Ph.D. in Health Care Administration. His career has spanned over 45 years in Health Care specializing in Health Care System Development and Health Care Reimbursement. He served as Vice President of a large not-for-profit health care system for over a dozen years, worked for and consulted with numerous federal health care programs, and served in Senior Management at leading edge Health Care information companies. He has specialized in Medicare DSH reimbursement for 25 years, most recently concentrating on the impact of the Affordable Care Act upon hospital reimbursement.

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