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Financial Assistance Policies: How to Position Your Organization for Success

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1

Agenda

- IRS Regulations and Requirements
- Tips for IRS Compliance
- Worksheet S-10 Overview
- S-10 Audit
- S-10 Recommendations
- Revenue Recognition
- Final Thoughts
- Questions

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2

IRS Regulations and Requirements

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3

IRS Regulations and Requirements

- Regulations under Affordable Care Act
  - 501(r)(3) – Community Health Needs Assessment
  - 501(r)(4) – Financial Assistance Policy and Emergency Medical Care Policy
  - 501(r)(5) – Limitation on Charges
  - 501(r)(6) – Billings and Collections

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4

IRS Regulations and Requirements

- Focus Today is on 501(r)(4) –
  - Policies are in place
  - Policies have required language
  - Policies are appropriately posted and translated
  - Specific language and requirements
  - Note: The CHNA has a set of requirements that are separate from the FAP; however, the other sections are addressed under FAP requirements

5

IRS Regulations and Requirements

- Policy must be in writing
- Policy must be adopted by the hospital's board or other authorized party
- Policy must cover all emergency and other medically necessary care provided by the hospital
- Policy must specify all discounts and free care available under the FAP and the eligibility criteria associated with each of these discounts and free care
- If policy expresses discounts in terms of percentages, it must specify the amounts (for example, gross charges) to which these percentages apply

6

IRS Regulations and Requirements

- FAP must contain a list of providers, other than the hospital itself, delivering emergency or other medically necessary care in the hospital and that list must specify which providers are covered by the FAP and which are not
  - **Note:** List of providers must include anyone providing emergency or medically necessary care, including non-physician providers, if applicable
- If applicable, FAP must describe any information obtained from outside sources (that is, sources other than the patient applying for assistance) that the hospital uses to determine that a patient is eligible for financial assistance (FAP-eligible)

7

IRS Regulations and Requirements

- If applicable, FAP must describe whether and under what circumstances it uses prior FAP eligibility determinations to determine that a patient is FAP-eligible
- FAP must describe how an individual may apply for financial assistance under the FAP and it (or your hospital's FAP application form) must describe all information and documentation the hospital may require an individual to provide as part of his or her FAP application

8

IRS Regulations and Requirements

- FAP or FAP application form must contain the contact information, including telephone number and physical location, of the hospital office or department that will provide information about the FAP and of either
  - The hospital office or department that can provide assistance with the FAP application process, or
  - If the hospital doesn't provide assistance with the FAP application process, at least one nonprofit organization or government agency that the hospital has identified as an available source of assistance with FAP applications

9

IRS Regulations and Requirements

- Must have a plain language summary of your hospital's FAP that contains the contact information described in previous slide, as well as the following information in language that is clear, concise and easy to understand:
  - A brief description of the eligibility requirements and assistance offered under the FAP
  - A brief summary of how to apply for assistance under the FAP
  - The direct website address (or URL) and physical locations where the individual can obtain copies of the FAP and FAP application form
  - Instructions on how the individual can obtain a free copy of the FAP and FAP application form by mail
  - A statement of the availability of translations of the FAP, the FAP application form and a plain language summary of the FAP in other languages, if applicable.
  - A statement that a FAP-eligible individual may not be charged more than AGB for emergency or other medically necessary care

10

IRS Regulations and Requirements

- Hospital must conspicuously post a complete and current copy of its FAP, FAP application form and plain language summary of the FAP on its website. It must be available on the website free of charge and without requiring the reader to create an account or provide personally identifiable information
- Hospital must make paper copies of the FAP, FAP application form and plain language summary of the FAP available upon request and without charge, both by mail and in public locations in the hospital, including, at a minimum, in the emergency room (if any) and admissions areas

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11

IRS Regulations and Requirements

- Hospital must notify and inform members of the community it serves about its FAP in a manner reasonably calculated to reach those members who are most likely to require financial assistance from the hospital
- Hospital must offer a paper copy of the plain language summary of the FAP to its patients as part of its intake or discharge process

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12

IRS Regulations and Requirements

- Hospital must include a conspicuous written notice on its billing statements that notifies and informs recipients about:
  - The availability of financial assistance under the hospital's FAP and
  - Includes the telephone number of the hospital office or department that can provide information about the FAP and FAP application process and
  - The direct website address (or URL) where copies of the FAP, FAP application form and plain language summary of the FAP may be obtained
- Hospital must set up conspicuous public displays that notify and inform patients about the FAP in public locations in the hospital, including, at a minimum, the emergency room (if applicable) and admissions areas

13

IRS Regulations and Requirements

- Hospital must translate its FAP, FAP application form and plain language summary of the FAP (and, if applicable, separate billing and collection policy and separate statement regarding AGB percentages) into the primary language(s) spoken by each language group with limited English proficiency that constitutes the lesser of 1,000 individuals or 5 percent of the community served by the hospital or of the population the hospital is likely to encounter
- Hospital must consistently carrying out the provisions provided for in its FAP

14

IRS Regulations and Requirements

- Policy must specify the method the hospital uses to determine the amounts generally billed (AGB) to individuals who have insurance covering emergency or other medically necessary care.
- If the hospital uses the "look-back" method to determine AGB, hospital's FAP must state the percentage(s) that the hospital uses to determine AGB and describe how the hospital calculated such percentage(s)?
- If not, the FAP must explain how members of the public may readily obtain such percentage(s) (and accompanying description) in writing and free of charge on the hospital's website, by mail and in public locations in the hospital, including, at a minimum, the emergency room (if any) and admissions areas.

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15

IRS Regulations and Requirements

- The amounts charged to FAP-eligible individuals for all other medical care covered under the FAP is limited to less than the gross charges for that care
- IRS recommends you select one of the following methods to determine AGB:
  - Using lowest negotiated commercial insurance rate when calculating the maximum amount that can be charged
  - Using the average of the three lowest commercially negotiated insurance rates when calculating the maximum amount that can be charged
  - Using Medicare rates when calculating the maximum amount that can be charged

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16

IRS Regulations and Requirements

- Either your hospital's FAP or a separate billing and collection policy of your hospital must describe the following:
  - Any actions that the hospital (or other authorized party) may take related to obtaining payment of a bill for medical care, including, but not limited to, any extraordinary collection actions (ECAs)
  - The process and time frames the hospital (or other authorized party) uses in taking the actions to obtain payment, including, but not limited to, the reasonable efforts it will make to determine whether an individual is FAP-eligible before engaging in any ECAs
  - The office, department, committee or other body with the final authority or responsibility for determining that the hospital has made reasonable efforts to determine whether an individual is FAP-eligible and may therefore engage in ECAs against the individual

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17

IRS Regulations and Requirements

- If your hospital has a separate billing and collection policy (as opposed to including this information in its FAP), the hospital's FAP must state that the actions the hospital may take in the event of nonpayment are described in a separate billing and collections policy and explain how members of the public may obtain this policy in writing and free of charge on the hospital's website, by mail and in public locations in the hospital, including, at a minimum, the emergency room (if any) and admissions areas

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18

IRS Regulations and Requirements

- ECAs are defined as actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that
  - Involve selling an individual's debt to another party,
  - Involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, "credit agencies"),
  - Involve deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's non-payment of one or more bills for previously provided care covered under the hospital facility's FAP, or
  - Require a legal or judicial process

19

IRS Regulations and Requirements

- Examples of actions that may require a legal or judicial process include, but are not limited to:
  - Placing a lien on an individual's property
  - Foreclosing on an individual's real property
  - Attaching or seizing an individual's bank account or any other personal property
  - Commencing a civil action against an individual
  - Causing an individual's arrest
  - Causing an individual to be subject to a writ of body attachment
  - Garnishing an individual's wages

20

IRS Regulations and Requirements

- A claim filed by a hospital facility in any bankruptcy proceeding is not an ECA
- Also, a lien placed on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries caused by a third party for which the hospital facility provided care is not an ECA

21

IRS Regulations and Requirements

- The hospital must notify the individual about the FAP before initiating any ECAs to obtain payment for the care and refrains from initiating such ECAs for at least 120 days from the date the hospital facility provides the first post-discharge billing statement for the care
- In the case of an individual who submits an incomplete FAP application during the 240 day application period, the hospital must notify the individual about how to complete the FAP application and gives the individual a reasonable opportunity to do so

22

IRS Regulations and Requirements

- In the case of an individual who submits a complete FAP application during the 240-day application period, the hospital must determine whether the individual is FAP-eligible for the care
- The application period may be longer than 240 days because the hospital must notify an individual at least 30-day before initiating one or more ECAs to obtain payment for the care
  - Note: A hospital facility may continue to accept and process FAP applications from patients at any time

23

IRS Regulations and Requirements

- Hospital must provide written notice that indicates that financial assistance is available for eligible individuals, identifies the ECAs that the hospital facility (or other authorized party) intends to initiate to obtain payment for the care, and states a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date that the written notice is provided
- Hospital facility must provide a plain language summary of the FAP with the 30-day notice
- Hospital must make a reasonable effort to provide oral notification about the FAP and how the individual may obtain assistance with the FAP application process at least 30 days before first initiating one or more ECAs to obtain payment for the care

24

IRS Regulations and Requirements

- **Emergency Medical Care Policies**
  - Hospital must have a written policy that requires it to provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are FAP-eligible (for example, requiring the hospital to comply with the Emergency Medical Treatment and Labor Act)
  - Hospital's emergency medical care policy must prohibit the hospital from engaging in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision of emergency medical care

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25

IRS Regulations and Requirements

- Hospital's emergency medical care policy must been adopted by the hospital's board, a committee of that board or a hospital official (or other party) authorized by the board
- Hospital must consistently carrying out the provisions of its emergency medical care policy

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26

Tips for IRS Compliance

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27

Tips for IRS Compliance

- Do not indicate that FAP was approved by a staff member without stating that approval authority was delegated by an “authorized body”
- Consider including a definition of medically necessary care, and if you do, need to apply this definition uniformly
- Include the language: “Discounts will be applied to gross charges”
- Include the language: “Eligible Individuals will not be charged more than amounts generally billed”

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28

Tips for IRS Compliance

- Remember – include list of those providers who are BOTH covered and NOT covered by the FAP
- If you say to see an attached list of providers, please ensure appropriate reference in policy, that this list is placed on website (and translated, if required) and update at least quarterly
- Be sure hospital only has ONE Plain Language Summary/Brochure available

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29

Tips for IRS Compliance

- Each hospital facility (in a multi-hospital organization) must have its own separate FAP and the FAP must clearly list which facilities the FAP applies to
- If using Federal Poverty Guideline metrics – be sure to update on a timely basis for changes to the FPG
- Make sure documentation requirements are stated in both the FAP and in the FAP application
- State the period of eligibility for financial assistance, once determined by FAP guidelines/application

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30

Tips for IRS Compliance

- Be sure to state how asset level/assets are considered during the eligibility determination
- Be transparent about how third party scoring is used, if applicable, during eligibility determination
- Describe how those eligible for assistance on a presumptive basis can apply for more generous assistance, if applicable

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31

Tips for IRS Compliance

- Make sure FAP clearly states how AGB discounts or amounts are calculated
- Update look back method AGB discount percentages on a timely basis (typically by 120 days after year end), if applicable
- Include the actual AGB-based discounts in the FAP
- Be sure to not require up-front payments that exceed AGB levels

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32

Tips for IRS Compliance

- Be sure to clearly state which ECAs are and are not allowed
- Be sure that FAP describes what "reasonable efforts" will be taken before any ECAs
- Be sure to state and assure that third party agencies follow the hospital policy, regarding ECAs and reasonable efforts
- Make sure emergency medical care policy prohibits requiring deposits or collection actions that interfere with the provision of emergency medical care

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33

S-10 Overview

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34

Worksheet S-10 Background

- Form in the Medicare cost report used to gather data on the cost incurred by hospitals for providing patient care services for which the hospital is not compensated – inpatient and outpatient
- Was completely revised with the changes to the Medicare cost reporting forms, 2552-10, which became effective for cost years beginning on or after May 1, 2010. All acute care hospitals, including critical access hospitals, are required to complete Worksheet S-10.
- A hospital records charges and payments, and calculates certain costs (using the cost-to-charge ratio (CCR) from Worksheet C)
- Also includes costs for non-Medicare and non-reimbursable Medicare bad debt

35

Medicare DSH

- Medicare Disproportionate Share Hospital (DSH) payment adjustment was to compensate hospitals for the high costs they incur seeing a disproportionate share of low income patients
- In order to pay for expanded coverage, the ACA mandated CMS to reduce DSH payments.
  - Starting in FY 2014,CMS adjusted Medicare DSH payments so that hospitals initially receive 25% of “empirically justified” DSH
  - Remaining 75% of DSH into a separate funding pool for DSH hospitals
    - Distributed based on proportion of uncompensated care

36

Medicare DSH

- For FFY 2020, Medicare DSH Uncompensated Care Payments are approximately $8.35 billion
  - FFY 2019 - $8.27 billion
  - FFY 2018 - $6.77 billion
  - FFY 2017 - $5.9 billion
  - FFY 2016 - $6.4 billion

37

Arkansas Providers

- DSH Supplemental Data File
  - CN FY 2020 - $52.3 million
  - CN FY 2019 - $64.3 million
  - CN FY 2018 - $56.5 million

38

S-10 Timeline

- Worksheet S-10 – first proposed to be utilized in FY 2014
- Although it was initially delayed – CMS finalized its proposal to begin incorporating UCC data in the FFY 2018 final rule
- CMS used worksheet S-10 data from FY 2014 Medicare cost reports in combination with Medicare and Medicaid low income days data from the two preceding cost reporting periods to determine distribution of UCP for FY 2018
- Then in FFY 2019, CMS used data from 2013 Medicaid days, 2016 SSI days, 2014 & 2015 UCC
- FFY 2020 final rule – CMS used data from 2013 Medicaid days, 2017 SSI days, & 2015 UCC

39

Key Definitions

- **Uncompensated care –** Consists of charity care, non-Medicare bad debt, and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances, discounts given to patients that do not meet the hospital's charity care policy, or discounts given to uninsured patients that do not meet the hospital's FAP, or bad debt reimbursed by Medicare

40

Key Definitions

- **Charity care** – Charity care and uninsured discounts result 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 FAP. Charity care and uninsured discounts can include full or partial discounts. If a patient is not eligible for discounts under the hospital's charity care policy or FAP, then any discounts or reductions given to the standard managed care rate must not be accounted for as charity care or an uninsured discount. Discounts given to patients for prompt payment must not be included as charity care. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. A hospital cannot claim as charity care amounts of unpaid deductibles and co-insurance for which it has received reimbursement from Medicare (reimbursed Medicare bad debt). (Additional guidance provided in the instruction for line 20.)

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41

Key Instructions on S-10 Line 20

For cost reporting periods <u>beginning on or after</u> October 1, 2016:

- Enter the actual charge amounts for the entire facility, except physician and other professional services that were: (1) determined in accordance with the hospital's charity care criteria/policy, and (2) were written off to charity care during this cost reporting period, regardless of when the services were provided. Do not include charges for patients given courtesy discounts or charges for uninsured patients with or without full or partial discounts who do not meet the hospital's charity care criteria. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.

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42

Key Instructions on S-10 Line 20

- Enter in column 1, the total charges, or the portion of the total charges, written off to charity care, 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. 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. The total charges or the portion of total charges is the amount the patient is not responsible for paying (e.g., 100% of charges if the patient qualified for 100% discount or 70% of charges if the patient qualified for a 70% partial discount).

43

Key Instructions on S-10 Line 20

- 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, the 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. Do not include in column 2 amounts of deductible and coinsurance claimed as Medicare bad debt.

44

S-10 Audit

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45

S-10 Audits

- First Audits of S-10 began with Federal Fiscal Year 2015
  - Audits from MACs began in Fall of 2018
  - Numerous items requested
  - Given just a two week turnaround time
  - Extensions were only granted for up to a week
- Next round of S-10 Audits looked at FFY 2017
  - Audits began in July 2019 and were completed by 12/31/19
  - Same type request as prior
  - Again given two week turnaround time, but much more lenient with extensions

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46

Audit Request Letter

- Audit Request Letter excerpt:

In the FFY 2018 Inpatient PPS Final Rule (82 FR 37990, August 14, 2017) CMS finalized their proposal to begin incorporating uncompensated/charity care data from worksheet S-10 into the calculation of Hospital Specific Factor 3 for the Disproportionate Share Hospital Uncompensated Care Payment (DSH UCP) beginning in FFY 2018. This factor determines what share of the national pool of DSH UCP funds are allocated to each provider.

Recently, CMS instructed contractors to begin audit work on the S-10 worksheet data. The above referenced cost report has been selected for an audit of the S-10 data. As a result, we are requesting the below items to complete this audit, as required by CMS. Please note that failure to submit the proper data may result in adjustments to the S-10 data, which may impact the facility's DSH UCP payment.

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47

S-10 Audit Request Items

- In order to conduct our audit, the following items are being requested:
- **Please note that the failure to submit the proper data will result in adjustments to the S-10 data, which may impact the facility's DSH UCP payment**
  1. A copy of the hospital's chrity care policy and financial assistance policy (FAP) that was in effect during the cost report period under review.
  2. A copy of the hospitals audited financial statements and/or working trial balance for the cost report period under review.
  3. A reconciliation of the bad dents claimed on Worksheet S-10, Line 26 to the audited financial statements and/o working trial balance. The reconciliation should show all of the following: Bad debts written off, Recovered included and netted, Physician and professional bad debts removed, Bad debts not related to patient liabilities (insurance and other third-party payors) and other detailed descriptions of differences.

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48

S-10 Audit Request Items

4. A detailed listing of the hospital's transaction codes and their descriptions/explanations (e.g. write-off codes, discount codes, contractual adjustment codes).
5. Detailed query logic that describes how the hospital identified patient charges included in the patient listing used to support charge on Worksheet S-10, Line 20
6. Detailed query logic that describes how the hospital identified patient payments included in the patient listing used to support payments on Worksheet S-10, Line 22
7. Detailed query logic that describes how the hospital identified bad debts included in the patient listing used to support bad dents on Worksheet s-10, Line 26
8. Detail patient listing (see attached Excel template for required detail fields) of charges claimed on Worksheet S-10, Line 20, Columns 1 and 2. see NOTE 1
9. Detail patient listing (see attached Excel template for required detail fields) of bad debts claimed on Worksheet S-10, Line 26, Columns 1 and 2. see NOTE 1

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49

S-10 Audit Request Items

- Example of Excel Template

Total Charity Care must be submitted by all hospitals. This is all payor charity care charges written off during the cost reporting period for patients who have met the hospital's charity care policy and/or financial assistance policy (FAP), regardless of patient dates of service. The amounts included here should be for those charges the patient is not responsible for paying.

TOTAL CHARITY CARE REQUIRED DATA FIELDS

a. Insurance Status When Services Were Provided (Insured or Uninsured)
b. Primary Payor Plan
c. Secondary Payor Plan
d. Payment Transaction Code
e. Patient Identification Number (PCN)
f. Patient Name
g. Patient Birth Date
h. Social Security Number
i. Patient Gender
j. Admit Date
k. Discharge Date
l. Service Indicator (Inpatient / Outpatient)
m. Revenue Code (See Note above)
n. Revenue Code Total Charges for the Claim (See Note above)
o. Date of Write Off to Charity Care
p. Total Patient Payments for Services Provided
q. Total Third Party Payments for Services Provided
r. Patient Charity Contractual Amount
p. Other Contractual Amount (insurance write-off, courtesy discount, etc.)
q. Non-Covered Charges for Days Exceeding LOS Limit for Patients Covered by Mcaid or Oth Indigent Care

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50

S-10 Audit Request Items

Total Hospital Bad Debts must be submitted by all hospitals. This is all payor bad debts for all bad debts written off during the cost reporting period.

TOTAL BAD DEBT REQUIRED DATA FIELDS

a. Insurance Status When Services Were Provided (Insured or Uninsured)
b. Primary Payor Plan
c. Secondary Payor Plan
d. Patient Identification Number (PCN)
e. Patient Name
f. Patient Birth Date
g. Social Security Number
h. Patient Gender
i. Admit Date
j. Discharge Date
k. Service Indicator (Inpatient / Outpatient)
l. Revenue Code (See Note above)
m. Revenue Code Total Charges for the Claim (See Note above)
n. Date of Write Off to Bad Debt
o. Total Patient Payments for Services Provided
p. Total Third Party Payments for Services Provided
q. Patient Charity Contractual Amount
r. Other Contractual Amount (insurance write-off, courtesy discount, etc.)
s. Patient Bad Debt Write-Off Amount

51

S-10 Audit Request Items

- Request # 3
  - A reconciliation of the bad debt write-offs from your financial accounting records to the bad debts reported on Line 26 of S-10. Note that the bad debt expense reported in your financial accounting records are not generally the same as the bad debt expense reported in your financial statements/working trial balance. Instead, we would need to see the actual bad debt write-offs that lead to a decrease in your accounts receivable and a decrease in your allowance for bad debts.

52

S-10 Audit Request Items

- Continued Request # 3
  - 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 debt 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.)

53

S-10 Audit Request - Samples

- Once all the initial requested items were received and processed by the MAC- additional sampling was requested at the patient level detail
- Two week time period given one again to pull all the requested data
  - Extensions not given for any length of time
- Criteria sampling was very different among MACs
- Some MACs only did samples on Charge/Payment listing and some did samples on both Charge/Payment listing and bad debts

54

S-10 Audit Request - Samples

- Sample Request List:

Item	Description
I.	**Charge / Payments Lisiting and Detail**
1	**Sample were selected from your charge / payments listing, please provide the following:**
a	Documentation for Charity Status Determination
a.1	Charity Care or Financial Assistance Application
a.2	Income Evaluation
a.3	Other Information used for Charity Determination such as W-2, tax returns, etc.
b	Documentation to review Charges and Payments
b.1	Patient Bill Summary (UB) to support charges
b.2	Patient Account History / Patient Billing Notes
b.3	Remittance Advice for all payers identified
b.4	Patient Payments Received
	NOTE: For Medicaid Patients who have exhausted their benefits, submit Medicaid Remittance Advice along with other items above.

55

S-10 Audit Request - Samples

- Sample Audit Findings:
  - Charity Determination Support:
    - Providers did not have all support (i.e. signed charity care application, W-2s, pay stubs, tax returns, etc.)
    - Providers did not have all support listed as a requirement in providers' policy
  - Coinsurance/Deductible/Copay from the RAs did not reconcile to the write-off amount claimed in column 2 (insured)
  - UB total charges did not match write-off amount
    - Charges were revised after filing
    - Patient with multiple accounts had combined charges into one account
  - Duplicates between charity care and bad debt listings
  - Misclassification between uninsured and insured

56

S-10 Audit Findings

- MACs initially given a deadline of September 30, 2019 to have all S-10 audit findings turned into to CMS, but it ended up being extended until 12/31/19
- The 2017 S-10 audits at least allowed more time for review of findings than the 2015 audits, but still pressed providers for time when receiving audit adjustments mid-December.
- All the MACs had different interpretations of the same instructions and we even saw different interpretations from auditors at the same MAC
  - Inconsistency on handling "errors" found during sampling (remove just errors found vs. applying error % to entire population)
  - Large extrapolations dependent on sampling interval size

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S-10 Recommendations

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58

S-10 Recommendations

- Starting with cost reporting periods on or after October 1, 2018- patient detail listings must be submitted at time of cost report filing
  - Have reports in place now to capture this data
- Providers must be ready and able to provide all documentation for each sampled patient during audit that matches the providers' policies
  - Small sample sizes and errors within those samples can lead to very large extrapolations

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59

S-10 Recommendations

- Be prepared for bad debt sampling in future S-10 audits
- There is a not a good avenue for appealing or correcting incorrect audit adjustments for S-10 data at this time
  - Providers must try to get it all correct in the original, as filed cost report
  - Not sure of future opportunities to amend S-10 filings, but if they do arise- make sure you make the best of those opportunities

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60

The Trifecta of Compliance

- IRS – Financial Assistance and Charity Care Policies
- CMS – Form S-10
- FASB – Financial Reporting for Revenue Recognition

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61

Revenue Recognition

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62

FASB Revenue Recognition

- Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts, (Topic 606)*
  - Effective dates
    - **Public Organizations** – annual reporting periods beginning after December 15, 2017, with interim application within the year;
    - **Nonpublic Organizations** – annual reporting periods beginning after December 15, 2018, with interim application following year of adoption.

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63

What is ASU 2014-09?

- The goal is to replace numerous pieces of revenue recognition guidance with a single revenue recognition standard that applies to all industries.
- 5-Step Model:
  - Identify the contract with the customer;
  - Identify the performance obligations in the contract;
  - Determine the contract price;
  - Allocate the transaction price to the performance obligation;
  - Recognize revenue when the entity satisfies a performance obligation.

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64

Application to Healthcare Industry

- Opinions have ranged from those who believe this standard does not impact their organization at all to those who believe this standard will drive fundamental changes in revenue recognition.
- We do know that a hospital's relationship with bad debt is very different from that of other industries and the new standard drastically changes the reporting model and terminology.

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65

Financial Reporting Differences

- Under the old standard, some hospitals reported bad debt as the difference between the amount they billed their patients and the amount their patients ended up paying, even in instances when the hospital never expected to receive the entire amount billed.
- Under the new standard, hospitals are permitted to report bad debt only in instances when an adverse event prevents a patient from paying what the hospital expected to receive.

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66

New Terminology Under Topic 606

- **Explicit Price Concession** – occurs when a provider accepts a discount or concession to standard pricing that is explicitly stated.
- **Implicit Price Concession** – occurs when a provider determines that it will or is likely to accept a discount to standard pricing before a credit risk assessment can be made.
- **Bad Debts** – results when patients or payors who have been determined to have the financial capacity to pay (through a formal credit assessment prior to services being rendered) are later unwilling or unable to settle the claim.

67

Financial Reporting

- The financial statement presentation under FASB Topic 606 will report patient service revenue net of implicit price concessions and explicit price concessions. [Contra Revenue Accounts]
- Additionally, bad debt expense will only be recorded if the healthcare provider accesses the patient's or payor's intent and ability to pay their responsibility based on a credit assessment prior to services being preformed and the provider is unable to collect the amount later.

68

Why is this important for today's discussion?

- On April 4, 2019, CMS issued instructions clarifying that unpaid deductible amounts claimed as bad debt must be written off to a bad debt expense account, not a contractual allowance account, to be considered for reimbursement.
- Effective with cost reporting periods beginning on or after October 1, 2019, providers must comply with these long-standing Medicare bad debt requirements.
- The April release did not reflect changes in terminology under the new accounting standard.

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69

Final Thoughts

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70

Reflections

- Medicare bad debts can be an important part of a hospital's reimbursement strategy.
- Properly capturing, reporting and classifying bad debt is critical to calculating uncompensated care, which directly impacts S-10 and DSH recoveries.
- Could this impact a NFP hospital's tax exempt status since bad debt / charity are important factors for the calculation of Community Benefits?
- Is "propensity-to-pay scoring" still a best practice?
- The April CMS release definitely caused confusion and concern.

71

Dialogue

- HFMA representatives met with CMS officials in 2019 in an attempt to educate the organization about the new terminology and the fact that operationally, the requirements for the providers to go through to claim bad debt has not changed. It's just the terminology.
- CMS has yet to clarify its position.

72

So What Can You Do?

- Does your organization currently perform any sort of reconciliation of the amount of uncompensated care costs between
  - Medicare
  - GAAP
  - IRS

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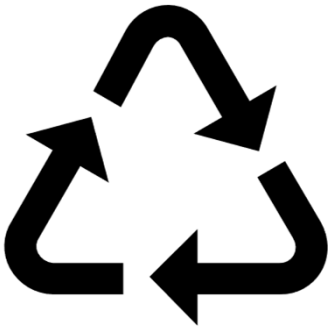
73

Coordination Is Critical: The Trifecta



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74

The Opportunity

- The implementation of Topic 606 requires obtaining an in-depth knowledge of who will pay and who likely will not.
- Use that knowledge to refine and broaden your FAP and Charity Care policies.
- Minimize IRS and CMS audit risk.
- Maximize recoveries provided under S-10 details and Uncompensated Care Pools.

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75

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Questions?

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76

THANK YOU!

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77