Michael Passanante:  I’m Mike Passanante, your host for the Hospital Finance Podcast. Today, I’ll be joined by Scott Besler who is a Senior Manager in our Reimbursement Team here at BESLER Consulting. Scott’s going to walk us through future uses of the S-10 worksheet. Welcome Scott.

Scott Besler: Hi Michael. Thank you very much.

Michael: Excellent! We’re so happy to have you here. First off, just to set things up, can you give us a quick overview of what the S-10 is?

Scott: Sure! Worksheet S-10 is a worksheet from the Medicare Cost Report. Ever since the 2552-10, the S-10 has had 31 lines of data and most recently is used for the EHR or HIT payment for hospitals. They’re hoping to use it for future DSH allocations.

Michael: Why is the data and the information reported on worksheet S-10 so important?

Scott: CMS and its most recent proposed and Final Rule of 2016 had indicated that it wanted to utilize the charity care and bad debt data from the S-10 that’s reported on the S-10 as part of their new Medicare DSH Uncompensated Care portion, specifically pointing to lines 23 (which is the cost of charity care) and line 29 (which is non-Medicare bad debt cost).

Again, some members of congress have long wanted to compare a hospital’s not-for-profits status to the provision of charity care. This would create a ratio of charity care to net patient service revenue.

And of course, the increase scrutiny of hospital charges by the public highlights the amount of uncompensated care provided by hospitals. Keep in mind that Medicare Cost Report data is publicly available. So it’s a resource for not only members of congress but for the entire hospital community.
Michael: So what other sources document a hospital’s uncompensated care?

Scott: Well, there’s a Form 990 Schedule H which is an IRS requirement for tax-exempt hospitals. There’s also the audited financial statements specifically in the footnotes of those financial statements. There’s Community Benefit Reporting, Community Health Needs Assessments. And then, there are other state and local reports. There’s also the Medicaid DSH Service that each state must provide (and these reports must be provided annually). And then there’s the Worksheet S-10 from the Medicare Cost Report.

Michael: Okay. So, let’s dig into some of the potential issues concerning the use of the S-10. Can you tell us what those are?

Scott: Okay, right off the bat, the cost-to-charge ratio that they use, it’s not by department. It’s one all-encompassing cost-to-charge ratio. So on the cost report, there are multiple departments and there are cost-to-charge ratios for each of them. The S-10 utilizes one cost-to-charge ratio.

This cost-to-charge ratio that’s used excludes interns and residents costs. There’s no physician cost in this. It also includes, as I’ve said, all the departments, but also hospital, sub-provider and SNF. And why that’s important is all of these have different reimbursement mechanisms, so you’re putting all of them together to create one cost-to-charge ratio and it’s a one-size-fits-all.

There’s also the charity care initial obligation. It’s for services in the cost reporting period. However, that may not be ample time for hospitals to go back and make sure that certain patients are eligible for charity care.

And then there are issues with bad debt expense. Again, same timing as the charity care issue. And then, the bad debt cost. The cost-to-charge ratio is applied to this amount and Medicare bad debt is not at charges, at least for some hospitals.
Charity care criteria also can vary significantly by provider and of course by state. Some states have, I guess, liberal interpretation of what would qualify for charity care versus a more strict policy as to what patients qualify for charity care. So you’re not comparing apples to apples.

**Michael:** So we talked about the S-10. We’ve heard the terms ‘uncompensated care’ and Factor 3 mentioned and talked about that. Can you unpack that for us a little bit and tell us what they’re all about.

**Scott:** Sure the Affordable Care Act split the DSH calculation to two components, empirically justified DSH and uncompensated care.

The empirically justified DSH is the traditional DSH calculation, Medicaid days and SSI percentage. The DSH uncompensated care pool is a pool that’s allocated among DSH hospitals, all DSH hospitals based upon their uncompensated care percentage to the total. The Secretary is responsible for developing this application and this allocation methodology which is in turn Factor 3 and currently the calculation uses Medicare days and SSI.

So even though it’s split into two components, both components currently being used are essentially the same. So you’re really not going to have that many winners and losers that fall in and out because of the way the methodology is.

Traditionally, what was supposed to happen when they made this switch was you were supposed to find more hospitals receiving uncompensated care dollars from this DSH pool. That just hasn’t happen with the current methodology because they’re still using Medicare days and the SSI percentages.

**Michael:** So Scott, why wasn’t the S-10 used for the calculation of Factor 3?

**Scott:** Well, hospitals did express their concerns to CMS on a provider call back in January of 2013 which is just over three years ago. CMS claimed on the call that the S-10 was still a new data source and it was used specifically for the EHR and...
HIT payment. Specifically, the total obligation of charity care patients which is line 20 on column 3 of the S-10.

Also, that the S-10 at that time had not been subject to an audit other than that for EHR. CMS also believed that once it could be audited like it does with wage index that it would help to drive payment and it would help to also make a more accurate and complete submission of this worksheet.

Hospitals did say that they also did not have adequate and accurate time to review the data. The S-10 instructions potentially require more clarity if they’re going to be used for uncompensated care mainly centering around bad debt, charity care, and as I’ve mentioned earlier, the cost-to-charge ratios.

Recently, in the proposed and final IPPS 2016 rules, CMS stated that they still intend to propose through future rule-making the use of the Worksheet S-10 data for purposes of determining Factor 3.

Commenters ran the gamut of how they responded. They want changes to the form – basically, should charity care charges be for in-patient, out-patient or both. Also, should charity care charges be separate with a separate cost-to-charge ratio for each? Should they include physician cost? Should they include medical education? Charity care charges should be reported on write-off date, not the service date?

And then, presumptive eligibility came into the mix because they believe that should be used to identify charity care accounts.

They also wanted to implement an audit process similar to that of wage index. There’s a 4-year lag between the time hospitals submit their cost report and that data is used to drive payment. Hospitals wanted a similar time lag so that they could review and possibly appeal any S-10 adjustments. Similar to that of wage
index, there is a mechanism for hospitals to do that and they wanted to go along those lines.

One of the issues with this, I believe, is the S-10 may work for what they currently use it for which is the EHR and HIT payment. I don’t know if CMS can make it a one-size-fits-all and have this worksheet solve two issues. It can’t solve the EHR issue and it may not be able to solve the uncompensated care issue. They may have to come up with a different worksheet. I don’t know if that’s going to happen. But from what it appears, they want many different tweaks made to this S-10. So the S-10 as we know now may be under a major overhaul when it comes to fruition.

Michael: So when should someone be using the S-10?

Scott: Well, CMS is undecided. However, CMS has committed that they will make revisions to the instructions. And it has to come from CMS. CMS has to work with the MACs and the MACs will work with the hospitals.

Too often, you’ll see MACs have different interpretations of CMS’ rule-making. What I think can definitely help the provider community and the MACs is if CMS has strict instructions as to what’s included and what’s not included. Bad debt is a prime example. Bad debt provision is not at charges. Yet, we do know hospitals do put that charge amount there. It’s not strict in the instructions. It hasn’t been completely audited for that. We’ve seen it successfully audited both ways. Hospitals have charges in there, hospitals have it at cost.

In order to make an apples to apples comparison, it has to be one or the other. The timeline that they say they will address that in the proposed 2017 Final Rule, look for it April or May this year.

And like I said, CMS plans to revise the instructions. So I think they’re going to add more clarity because I do think that there’s a gray area that can lead to more
issues going forward. And the more issues will just prolong the window as to when this is actually going to see the light of day.

**Michael:** Yeah, so there are some changes coming.

**Scott:** Yes.

**Michael:** So let’s take this in a slightly different direction or expand on that a little bit. Has there been any modeling on the S-10 and its potential impact on DSH hospitals?

**Scott:** Yes. I mean, this is an issue that hospitals have been aware of for the past three or four years. Hospitals have been looking at their S-10. At first glance, we’ve seen over 120 DSH hospitals did not even complete Worksheet S-10. So if this is a worksheet that’s going to be used for future allocation of DSH funds, I suggest that those 120+ hospitals, go back, resubmit their cost report, look at their S-10 and complete it as accurately as possible through their interpretation.

One thing we’ve noticed is that the top three of the losers were all New York hospitals that received major dollars in DSH funding. One of these hospitals had a loss in excess of $50+ million. The winners had low Medicaid days and high uncompensated care cost. Subsequently, the losers had high Medicaid days and low uncompensated care cost.

And again, one thing to note (and this can’t be discounted) is that some of the biggest losers were from some states that had the most political clout and muscle. So anything you saw on this modeling probably can drastically change once CMS clarifies the instructions. We’ve seen it work in the past where the political clout will drive the numbers and then the calculation.

**Michael:** So before, you mentioned some changes that you thought might happen in the 2017 IPPS rule. Looking into your crystal ball, what do you think are the likelihood that some change are coming?
Scott: Well, I think CMS had said that they’d like to soon develop new instructions or clarify the instructions. I think we would have to ask CMS how they define soon. However, this is also an election year. So this is a type of heavy lift. I don’t know if anything’s going to be forthcoming for federal fiscal year 2017.

It will be most likely in the proposed rule as CMS had indicated. And CMS has always kept their word. However, you’re looking for an implementation, I think 2017 may be too close, but 2018 is not that far away.

So it is something hospitals should be looking at. I suggest pay attention to that proposal when it comes out.

Michael: Obviously, hospitals should be looking at this. What should they be doing now between this point and the time when any changes might actually come into place?

Scott: Well, the first thing I would do is I would review and evaluate all my Worksheet S-10’s. I would go back for the past three years. You don’t know if CMS is going to use one year in particular or a rolling average of three years. CMS has been pretty tight-lipped on how they intend to use the S-10. I would prepare the S-10 as if CMS was going to use it tomorrow. So look for how they would calculate the uncompensated care allocation as a basis for Factor 3.

And again, continuous scrutiny review of the reporting of the Medicaid days on a hospital’s S2 and S3. Make sure when you review your cost report, they are items that you’re definitely taking a notice to. Especially if you’re a DSH hospital, you’re already looking at this data. It takes a little more time just to look at it again.

And again, await the proposed rule. It’s almost like you’re going to be waiting for Christmas that you’re going to be excited for.

Michael: Scott, great information. I really appreciate you taking the time with us today on the program.
Scott: Thank you Michael.