Draffin & Tucker, LLP
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Understanding the S-10 Worksheet (Part 2 of 2)

Uses of Worksheet S-10

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Additional Resource

For more information on preparing Worksheet S-10, please see the National Rural Health Resource Center's Small Rural Hospital Transition (SRHT) Project Guide "Understanding the Hospital Medicare Cost Report Uncompensated and Indigent Care Data Form (Form CMS-2552-10, Worksheet S-10)"

What is Worksheet S-10?

A 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

What costs are included?

- Medicaid
- State Children's Health Insurance Program (SCHIP)
- Other state or local government indigent care programs
- Charity care
- Bad debts

How is Worksheet S-10 being used?

- Currently used in the Medicare and Medicaid Electronic Health Record (EHR) incentive payment determination
- CMS plans on using the data to allocate Medicare DSH uncompensated care payments in the near future
- Activists have used S-10 data to lobby Congress to reconsider 340B Drug Pricing Program eligibility criteria

What are EHR incentive payments?

- Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology

- EHR incentive payments are available to CAHs through federal fiscal year (FFY) 2015 and to hospitals paid under the inpatient prospective payment system (IPPS) through FFY 2016

How is S-10 data used for EHR incentive payments?

- Charity care charges reported on S-10, Line 20, Column 3 are used to calculate Medicare and Medicaid share fractions
- Higher incentive payments are available to hospitals that provide a greater proportion of charity care
  - Increasing charity care charges on Line 20 will increase the hospital's Medicare and Medicaid share percentages, which are applied to a base amount or reasonable costs

IPPS Hospital Medicare EHR Incentive Payment Example

Component	Calculation 1	Calculation 2
Total charges	$100,000,000	$100,000,000
Less charity care charges	10,000,000	20,000,000
Equals net charges	$ 90,000,000	$ 80,000,000
% of net to total charges	90%	80%
Times total days	10,000	10,000
Equals days excl. charity	9,000	8,000
Medicare days	5,000	5,000
Medicare percentage	55.56%	62.50%
Times base payment	$2,000,000	$2,000,000
Times 1st year factor	1.00	1.00
EHR incentive payment	$1,111,111	$1,250,000
Additional payment		$138,889

Note: EHR incentive payment is prior to 2% sequestration reduction.

What are uncompensated care payments?

- FFY 2014 IPPS final rule implemented the Affordable Care Act's changes to the Medicare operating disproportionate share hospital (DSH) methodology
- The change was implemented to align DSH payments to the amount of uncompensated care hospitals provide

DSH payment method prior to October 1, 2013

- Hospitals qualified for DSH payments based on a formula that considers their
  - Medicare utilization of beneficiaries who also receive Supplemental Security Income (SSI) benefits
  - Medicaid eligible inpatient utilization

DSH payment method on or after October 1, 2013

- Two DSH payments:
  - 25% based on the old payment methodology (now called "empirically justified Medicare DSH payments") plus
  - an allocation from a new Medicare DSH uncompensated care pool

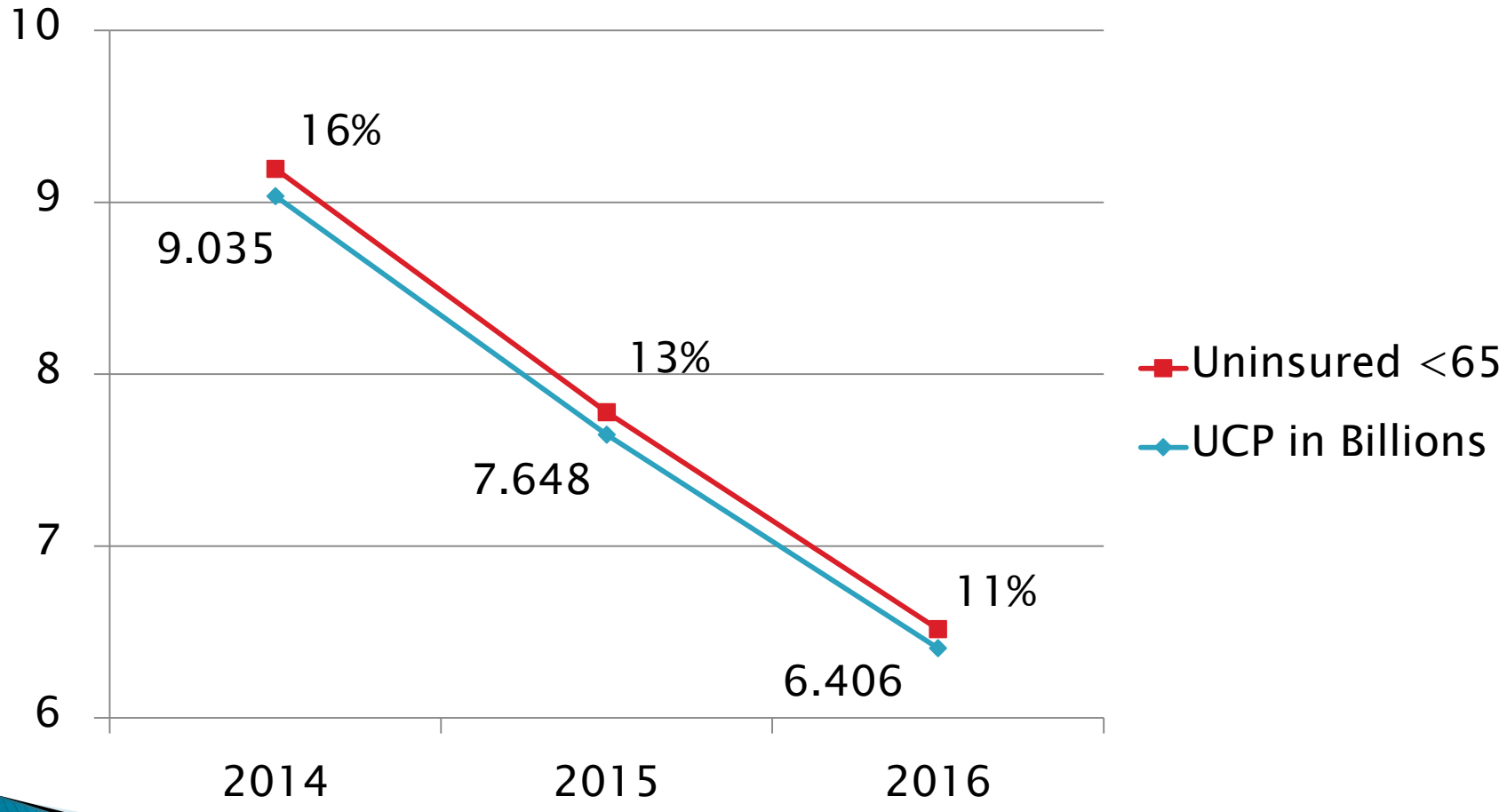
Uncompensated care pool

- Pool equals 75% of what otherwise would have been paid as Medicare DSH after a reduction for changes in the percentage of individuals under the age of 65 who are uninsured
- Each hospital qualifying for empirically justified Medicare DSH payments will receive an uncompensated care pool allocation based on its share of the total amount of uncompensated care for all Medicare DSH hospitals

Uncompensated care pool amounts

- FFY 2014 = $9.035 billion
- FFY 2015 = $7.648 billion (-15%)
- FFY 2016 = $6.406 billion (-17%)

Uncompensated care pool relation to uninsured <65



Uncompensated care pool allocation method

- CMS delayed using Worksheet S-10 data to allocate uncompensated care payments (UCP) due to concerns over inaccurate and inconsistent data
- CMS will use SSI and Medicaid days to allocate UCP until S-10 data can be relied on

Uncompensated care pool allocation using S-10 data

- CMS indicated in the FFY 2014 IPPS rule the following could be used to allocate UCP:
  - Line 23 cost of charity care plus
  - Line 29 cost of bad debt expense, net of Medicare reimbursement
    - Line 30 includes the total of Lines 23 and 29

Why isn't Medicaid uncompensated cost included?

- Medicaid shortfalls will not be considered at this time because CMS wants to avoid creating a policy that would serve as a disincentive for states wishing to expand Medicaid
- This may no longer be an issue by the time S-10 data is used to allocate UCP

How does Medicaid expansion impact the allocation of UCP?

- Medicaid days rather than charity care was used to allocate FFY 2016 UCP
- Under the current allocation methodology, states that expand their Medicaid program will receive higher UCP distributions in future periods
- Presuming no change in the current allocation methodology, as Medicaid expansion matures, the reimbursement gap will continue to grow disproportionately

How does Medicaid expansion impact the allocation of UCP? (continued)

- In theory, Medicaid expansion reduces charity care costs as more patients who were formerly uninsured are covered by Medicaid
- When CMS modifies the allocation methodology utilizing S-10 data, states that don't expand their Medicaid program will likely receive higher UCP distributions

Are we ready for CMS to use S-10 to allocate UCP?

- 2,408 hospitals are included in the FFY 2016 DSH Supplemental File
- 43 of the 2,408 hospitals reported negative uncompensated care cost on S-10 Line 30 for their cost reporting period ending in 2012
  - Negative cost was result of input errors on reports reviewed (e.g., charity care payments input on Line 22 but no charges input on Line 20; total bad debts were not input on Line 26)

Are we ready for CMS to use S-10 to allocate UCP? (continued)

- 55 of the 2,408 hospitals reported zero uncompensated care cost on S-10 Line 30 for their cost reporting periods ending in 2011 and 2012

Assumptions for 2012/2011 comparative data

- FFY 2016 UCP calculation utilized 2012 cost report data (2011 if 2012 data was not a full year or unavailable)
- For the following comparisons, 2012/2011 Worksheet S-10 Line 30 was used to calculate each hospital's percentage of uncompensated care cost to the total uncompensated care cost for all DSH hospitals
- This percentage was applied to the total UCP available to calculate individual UCPs
- The revised payment amount was compared to the FFY 2016 DSH supplemental file amount to calculate the change in payment if Worksheet S-10 was used to allocate UCP instead of SSI and Medicaid days

Findings

- Due to the variability between each hospital's change in reimbursement, the analysis lends credence to CMS's decision to not use Worksheet S-10 data at this time
- The following comparisons may not be used to predict a hospital's change in UCP due to the large fluctuations within groups

Impact on FFY 2016 UCP allocation if S-10 Line 30 was used: comparison based on bed size

Beds	Hospitals	Change in UCP
1 to 50	338	32 Million
51 to 100	378	28 Million
101 to 200	729	310 Million
201 to 300	385	(108) Million
301 to 400	236	(248) Million
401 to 500	134	142 Million
501 to 600	80	9 Million
601 to 700	54	(121) Million
701 to 800	30	88 Million
801 to 900	20	(41) Million
901 to 1,000	7	(25) Million
> 1,000	17	(66) Million

Impact on FFY 2016 UCP allocation if S-10 Line 30 was used: comparison based on census division

Division	Hospitals	Change in UCP
New England	96	(57) Million
Middle Atlantic	258	(299) Million
East North Central	373	56 Million
West North Central	141	(60) Million
South Atlantic	405	109 Million
East South Central	276	(35) Million
West South Central	378	65 Million
Mountain	137	10 Million
Pacific	305	274 Million
Puerto Rico	39	(63) Million

Assumptions for FFY 2014 comparative data

- For the following comparisons, data was obtained from cost reporting periods ending in FFY 2014
  - Worksheet S-10, Line 30, Cost of Uncompensated Care (charity care and bad debt expense) and
  - Worksheet S-10, Line 31, Total Unreimbursed and Uncompensated Care Cost (Line 30 plus unreimbursed cost of Medicaid, SCHIP, and other indigent care programs) were divided by
  - Worksheet A, Line 200, Column 7, Total Allowable Expenses to obtain an average by census division

FFY 2014 comparison based on census division: IPPS and CAHs

Division	Hospitals	Average Ln 30/WS A	Average Ln 31/WS A
New England	180	4%	7%
Middle Atlantic	397	4%	7%
East North Central	722	5%	8%
West North Central	655	4%	7%
South Atlantic	689	8%	10%
East South Central	383	6%	9%
West South Central	719	9%	11%
Mountain	375	6%	8%
Pacific	516	5%	10%

FFY 2014 comparison based on census division: IPPS hospitals only

Division	Hospitals	Average Ln 30/WS A	Average Ln 31/WS A
New England	142	3%	6%
Middle Atlantic	376	4%	7%
East North Central	514	5%	8%
West North Central	264	4%	6%
South Atlantic	592	7%	10%
East South Central	316	6%	9%
West South Central	555	9%	11%
Mountain	218	5%	8%
Pacific	402	5%	10%

Note: 73 IPPS hospitals in the database did not complete S-10.

FFY 2014 comparison based on census division: critical access hospitals only

Division	Hospitals	Average Ln 30/WS A	Average Ln 31/WS A
New England	38	6%	8%
Middle Atlantic	21	4%	9%
East North Central	208	5%	9%
West North Central	391	4%	8%
South Atlantic	97	10%	13%
East South Central	67	8%	10%
West South Central	164	11%	14%
Mountain	157	6%	9%
Pacific	114	5%	9%

Note: 15 critical access hospitals in the database did not complete S-10.

Conclusion

- Our focus of this presentation has been the impending use of the S-10 worksheet for the allocation of UCP
- However, the S-10 worksheet could be used by CMS and others for purposes outside of the UCP allocation
  - 340B qualifying criteria?
  - Tax exempt status?

Conclusion (continued)

- Hospitals should carefully review their S-10 data before filing the cost report to ensure their data is complete and accurate
- Be sure to maintain supporting documentation and comply with cost report instructions
- CMS intends on reviewing the instructions to determine if any revisions or clarifications are necessary

Questions?

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