

Connecting the Dots on Uncompensated Care Reporting

Healthcare Summit 2018:
Simplifying Healthcare

September 18, 2018

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- History of DSH and Recent Changes
- Medicare Bad Debt Overview
- Worksheet S-10
- EHR Audit Experience – Impact on DSH?
- Section 501 (r)
- Revenue Recognition Developments

Agenda

After This Session, You'll Be Able To:

- Explain the regulatory/policy history and evolving legal framework surrounding Uncompensated Care reporting
- Examine high-impact reimbursement areas of Uncompensated Care Cost reimbursement in the cost report
- Explore the key drivers of Medicare reimbursement for Uncompensated Care
- Consider the implications of requirements for 501r, Schedule H reporting and the new revenue recognition standard



History of DSH and Recent Changes

History of DSH and Recent Changes



DSH Facts:



DSH payments began

- Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)-Study TEFRA rate adjustments for low income patients
- Deficit Reduction Act of 1984 (DRA) – Identify and define DSH Hospitals
- Consolidated Omnibus Reconciliation Act of 1985 (COBRA) – Congress mandated DSH adjustments
- DSH Payments started in 1986



Provided payments to hospitals that serve the most vulnerable population

- Medicaid beneficiaries
- Low income Medicare beneficiaries
- Uninsured and underinsured



Additional payments to address financial burden for hospitals that serve a disproportionately high percentage of low income and uninsured patients

History of DSH and Recent Changes



DSH Facts Cont'd::

- Patient Protection & Affordable Care Act (“ACA”) – March 2010
 - Significant Changes to Medicare DSH Adjustment
 - New Formula for Calculating DSH Beginning FY 2014
 - Medicare DSH hospitals receive 25% of DSH reimbursement based on the traditional DSH formula.
 - Remaining 75% of the amount that would have been received as Medicare DSH would be redistributed to DSH hospitals based on S-10 uncompensated care and additional factors
 - For 2014, 2015, 2016, and 2017 CMS Used low-income insured days from filed cost reports
- ACA is estimated to expand coverage to 32 million Americans by 2019
- Medicare DSH payments cut by \$22 billion from FY 2014-2019 due to hospitals caring for fewer uninsured patients
- Uncompensated Care Portion – Significant Reimbursement \$\$ (See Chart on Slide 11)

History of DSH and Recent Changes



DSH Adjustment (Empirically Justified):

DSH adjustment based on two fractions: Medicare fraction (SSI percentage) and Medicaid fraction

- Medicare fraction – Days of patients entitled to both Medicare Part A and SSI/total days of patients entitled to Medicare Part A; obtained from CMS
- Medicaid percentage – Days of patients eligible for Title XIX Medicaid, but not entitled to Medicare Part A/total patient days
- Sum $\geq 15\%$ to qualify ($>20.2\%$ higher adjustment factors)

Similar calculation for rehab units – Level Income Payment (LIP)

340B payments are tied to the DSH Allowable Percentage-See next Slide

PSYCH PPS hospitals not eligible for DSH payments

History of DSH and Recent Changes

Hospital	Contract Requirement	DSH %	GPO Prohibition	Orphan Drug Exclusion
DSH Hospital	Yes	>11.75%	Yes	No
Children's Hospital	Yes	>11.75%	Yes	No
Free-Standing Cancer Hospital	Yes	>11.75%	Yes	Yes
Critical Access Hospital	Yes	N/A	No	Yes
Rural Referral Center	Yes	≥ 8%	No	Yes
Sole Community Hospital	Yes	≤ 8%	No	Yes

History of DSH and Recent Changes



DSH Adjustment (Uncompensated Care):

Factor 1

- Represents CMS' estimate of 75% (100% minus 25%) of its estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year

Factor 2

- Section 1886(r)(2)(B) of the Act establishes Factor 2 in the calculation of the uncompensated care payment; specifically, section 1886(r)(2)(B)(i) of the Act provides that for each of FYs 2014, 2015, 2016 and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals who are uninsured in 2013, the last year before coverage expansion under the Affordable Care Act
- Percent of individuals without insurance for 2013 (March 2013 CBO estimate): 18%
- $1 - ((0.0948 - 0.14) / 0.14) = 1 - .3229 = 0.6771 - .002 = 0.6751$ - Applicable factor (.1% for 2014, .2% for FY 2015 – FY 2019)

History of DSH and Recent Changes



DSH Adjustment (Uncompensated Care) Cont'd

Factor 3

- Factor 3 distribution to each DSH Hospital (Hospital that qualifies for traditional DSH reimbursement) is based on the following: “For FY 2019, a hospital's Factor 3 is the average of three individual Factor 3s calculated based on cost reporting periods beginning in FY 2013, and FY 2014 and FY 2015. The individual Factor 3 for FY 2013 is based on Medicaid days and Medicare SSI days, while the Factor 3 for FY 2014 and 2015 is based on hospital uncompensated care costs.” (FY 2019 DSH Supplemental File, tab 1). For cost reports beginning in FY 2013, the CMS Factor 3 table is taking Medicaid days for FY 2013 and SSI days in FFY 2016 to be used in the overall average for each Hospital. For cost reports beginning in FY 2014 and 2015, CMS is taking Line 30 on W/S S-10. This is the cost of uncompensated care (cost of charity care on line 23 + cost of non-Medicare and non-reimbursable Medicare bad debt expense-Ln 29). This is compared to total uncompensated care for all DSH Hospitals to determine the portion related to a given DSH Hospital (FY 2012 and FY 2013 Medicaid/SSI days are also compared to the total for each of the respective years).

History of DSH and Recent Changes

FYE	DSH Estimate	Factor 1 (75% of total DSH)	Percentage of Uninsured	Factor 2 Percentage	Factor 2 Dollar Amount
2014	12,772,000,000	9,579,000,000	17.00%	94.30%	9,032,997,000
2015	13,383,462,196	10,037,596,647	13.75%	76.19%	7,647,644,885
2016	13,411,096,528	10,058,322,396	11.50%	63.69%	6,406,145,534
2017	14,396,635,710	10,797,476,782	10.00%	55.36%	5,977,483,146
2018	15,552,939,524	11,664,704,643	8.15%	58.01%	6,766,695,164
2019	16,294,703,939	12,221,027,954	9.48%	67.51%	8,250,415,972

Medicare Bad Debts Overview

Medicare Bad Debts Overview



Allowable Medicare Bad Debts:

- Medicare beneficiary's unpaid deductible and coinsurance amounts related to covered services
- Medicaid HMO unpaid deductible and coinsurance amounts
- Regulations for allowable criteria at 42 CFR 413.89
 - Amounts must be related to covered services
 - Reasonable collection efforts were made
 - Debt is uncollectible when claimed as worthless
 - Business judgement must have established that recovery of the debt in the future is not likely
- Reimbursed at 65% of actual Medicare bad debts
- Sufficient documentation must be maintained

Medicare Bad Debts Overview

Excluded Coinsurance and Deductible Amounts:

- Amounts related to fee reimbursed services
- Amounts related to professional services
- Amount still at collection agencies
- Accounts that payments have been made on starting the 120 days over
- Medicare HMO bad debts

Medicare Bad Debts Overview

Traditional Category:

- Medicare beneficiary not eligible for Medicaid
- Medicare beneficiary does not meet charity care policy
- Returned from collection agency
- Written off 120 days from the first bill
- Reasonable collection efforts documented in patient records-PRM 15-1, chapter 310
 - Collection efforts must be similar to effort made for non-Medicare patients
 - Bill issued in a timely fashion shortly after discharge
 - Subsequent billings including collection letters or phone calls
 - Collection effort may include aggressive language such as indicating court action to obtain payment
 - Use of a collection agency

Medicare Bad Debts Overview

Medicare/Medicaid Dual-Eligible Category (Crossovers):

- Medicare beneficiary-Primary and Medicaid secondary
- Must bill Medicaid and retain RA (Charges should be same as those billed Medicare)
- Include out of state Medicaid patients
- Claim Medicaid Managed Care amounts
- Include out of state Medicaid patients
- Prove that no other insurance exists
- No additional collection efforts

Medicare Bad Debts Overview

Medicare - Indigent/Charity Category:

- Traditional Medicare beneficiary deemed indigent and meets the charity policy guidelines
- Beneficiary not eligible for Medicaid
- No collection efforts necessary
- Indigence must be determined by the hospital, not the patient
 - Must take into account a patient's total resources
 - No other source would be legally responsible
 - Indigence determination must be documented in patient's file

Medicare Bad Debts Overview

Recoveries:

- Must be netted against bad debt expense claimed even if from a prior year
- Restarts the 120 day period even if amount is immaterial
- Amount must be prorated for covered and uncovered services

Worksheet S-10

Worksheet S-10



Medicare Uncompensated Care DSH Payments

- Traditionally, the formula for determining disproportionate share hospital (DSH) payments centered on Medicare Supplemental Security Income (SSI) and Medicaid Title 19 patient days.
- Under the ACA, 75% of the formula is driven by uncompensated care. The uncompensated care formula is based on a hospital's share of uncompensated care compared to all hospitals nationally.
- The prospectively determined annual amount is equal to an estimate of 75% of what otherwise would have been paid as Medicare DSH payments, adjusted for decreases in the rate of uninsured individuals and other factors.
- For FY 2014, 2015, 2016, and 2017 CMS has continued to use inpatient Medicaid days and Medicare SSI days ("low-income insured days") from filed Medicare cost reports to determine Factor 3 of the uncompensated care DSH component of the new formula.

Worksheet S-10



Medicare Definitions – Uncompensated Care



Uncompensated care – Charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt; uncompensated care does not include courtesy allowances or 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.



Charity care and Uninsured Discounts – Health services for which a hospital demonstrates that the patient is unable to pay; charity care and uninsured discounts results 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 patients is not eligible for discounts under the hospital's FAP, then any discounts or reductions must not be accounted for as charity care or an uninsured discount. Discounts given to patients for prompt payment is not included as charity care. For Medicare purposes, charity care is not reimbursable and unpaid amounts are not considered an allowable bad debt. A hospital cannot claim as charity care amounts of unpaid deductibles and coinsurance for which it has received reimbursement from Medicare as A Medicare bad debt.

Worksheet S-10



Medicare Definitions – Bad Debts

- **Non-Medicare bad debt** – Charges for Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the ***non-Medicare patient is unwilling to settle the claims. These amounts are subject to the cost to charge ratio (CCR).***
- **Medicare bad debt** – When furnishing services to a Medicare patient, a provider incurs costs in furnishing such covered services. A Medicare beneficiary may be responsible for paying a share of those costs as their applicable deductible and coinsurance amounts. When a Medicare beneficiary fails to pay their share, the provider has incurred costs of furnishing services that are unrecovered. If the unpaid amounts meet the criteria for allowable Medicare bad debts then these amounts are reimbursed as Medicare bad debts and cannot be claimed as charity care.
- **Non-reimbursable Medicare bad debt** – The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are not reimbursed by Medicare under the requirements of §413.89 of the regulations and of Chapter 3 of the Provider Reimbursement Manual Part 1.

Worksheet S-10



During the FY 2017 rulemaking process, CMS indicated:

- Worksheet S-10 will be used for calculating Factor 3 of the revised DSH calculation no later than FY 2021.
- For FY 2017, Medicaid days and SSI days (share of low-income insured days) will continue to be the proxy for Factor 3, but data will come from three cost-reporting years (FYs 2011, 2012, and 2013).
- CMS will issue rulemaking for a temporary solution for Factor 3 of the new DSH for FFYs 2018-2020/1. Will use three cost-reporting years for data in FFY 2018 and subsequent years.
- The definition of Uncompensated Care for FY 2018 and subsequent fiscal years will be the cost of charity care plus the cost of non-Medicare bad debt expense (excluding Medicaid shortfalls).
- Worksheet S-10, Line 26 (bad debt) is to be reported based on write-off dates during the cost reporting period, regardless of the date of service.
- Effective for cost reporting periods beginning on or after October 1, 2016, Worksheet S-10, Line 20 (charity care) will be revised to align more closely with Line 26, to instruct hospitals to report charity care written off during the cost reporting period, not based on the date of service.
- CMS will change the Medicare cost report instructions accordingly.

Worksheet S-10



In the 2018 IPPS Proposed Rule:

Proposed Time Period for Calculating Factor 3 (Incorporating S-10 data)

- FY 2018 (FY 2012 & 2013 Low-income insured days; FY 2014 S-10)
- FY 2019 (FY 2013 Low-income insured days; FY 2014 & 2015 S-10)
- FY 2020 (FY 2014, 2015, and 2016 S-10)

Definition of Uncompensated Care

- Cost of Charity Care (Line 23) plus Cost of non-Medicare bad debt expense (Line 29)

Worksheet S-10 Audits

- Instructions to MACs still under development
 - Expect cost reports beginning in FY 2017 will be first with S-10 subject to desk review
 - Cost reports beginning in FY 2014, FY 2015, and FY 2016 to be subject to further scrutiny after submission
 - “Predictability is an important part of the process for reporting data on S-10”

Worksheet S-10



In the 2018 IPPS Final Rule:

With respect to the audit process, in the FY 2017 IPPS final rule, CMS stated that they intended to provide standardized instruction to the MACs to guide them in determining when and how often a hospital's Worksheet S-10 should be reviewed. As of the FY 2018 IPPS final rule, **the instructions for the MACs are still under development and will be provided to the MACs as soon as possible and in advance of any audit.** In the FY 2018 IPPS proposed rule, CMS stated their belief **that cost reports beginning in FY 2017 (on or after October 1, 2016) will be the first cost reports for which the Worksheet S-10 data will be subject to a desk review.** As of the FY 2018 IPPS final rule, CMS stated that in addition to the aforementioned, they expect **cost reports beginning in FY 2014, FY 2015, and FY 2016 to be subject to further scrutiny after submission.**

Worksheet S-10



In the 2018 IPPS Final Rule Cont'd:

Relative to FY 2018 Factor 3 determinations, CMS is adopting MedPACs suggestion that FY 2014 reported uncompensated care costs in excess of 50% of a hospital's FY 2014 total operating expenses (as reported on Worksheet G, Part 3, Line 4) maybe potentially aberrant. Therefore, it is appropriate to utilize 2015 data in such instances. Accordingly, CMS will determine the ratio of FY 2015 uncompensated care costs to FY 2015 total operating expenses from the hospital's FY 2015 cost report and apply that ratio to the FY 2014 total operating expenses from the hospital's FY 2014 cost report to determine an adjusted amount of uncompensated care costs for FY 2014.

Worksheet S-10



Other CMS Communications:

Cost Report Revisions and Deadline Changes

- Transmittal 10 updated cost report instructions (November 18, 2016)
- Transmittal 11 issued revised cost report instruction (September 29, 2017)
- CMS released article in its September 29, 2017 MLN Matters referencing revisions/clarifications to instructions for S-10
- July 13, 2017 CMS announces through mlInconnects the opportunity to resubmit data for FY 2014 Worksheet S-10 by September 30, 2017. Please note that these revised data will not be used to calculate Factor 3 for FY 2018, but will be available for use in future years
- Through Change Request 10026, Transmittal 1863, issued June 30, 2017, CMS instructs MACs to accept amended Worksheets S-10 of **FY 2015** cost reports submitted by hospitals by September 30, 2017
- September 25, 2017 CMS announced extension to submit an amended cost report with revised Worksheet S-10 data for FY 2014 and FY 2015 by October 31, 2017
- October 20, 2017 CMS announced another extension to submit an amended cost report with revised Worksheet S-10 data for FY 2014 and FY 2015 by January 2, 2018

Worksheet S-10



In the 2019 IPPS Proposed Rule:

We have instructed the MACs to review situations where a hospital has an extremely high ratio of uncompensated care costs to total operating costs with the hospital. We do not intend to make the MACs' review protocols public. As stated in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56964), for program integrity reasons, CMS desk review and audit protocols are confidential and are for CMS and MAC use only. **If the hospital cannot justify its reported uncompensated care amount, we believe it would be appropriate to utilize data from another fiscal year to address the potentially aberrant Worksheet S-10 data for FY 2014 or FY 2015.**

Similar in concept to the approach we used in FY 2018, in cases where a hospital's uncompensated care costs for FY 2014 are an extremely high ratio of its total operating costs and the hospital cannot justify the amount it reported, we are proposing to determine the ratio of FY 2015 uncompensated care costs to FY 2015 total operating expenses from the hospital's FY 2015 cost report and apply that ratio to the FY 2014 total operating expenses from the hospital's FY 2014 cost report to determine an adjusted amount of uncompensated care costs for FY 2014. We would then use this adjusted amount to determine Factor 3 for FY 2019. The same approach would be used for FY 2015 data by looking at FY 2016 and adjusting accordingly.

Worksheet S-10



In the 2019 IPPS Proposed Rule Cont'd:

For FY 2019, we also believe that **situations where there were extremely large dollar increases or decreases in a hospital's uncompensated care costs when it resubmitted its FY 2014 Worksheet S-10 or FY 2015 Worksheet S-10 data, or when the data it had previously submitted were reprocessed by the MAC, may reflect potentially aberrant data and warrant further review. For example, although we do not make our actual review protocols public, we might conclude that it would be appropriate to review hospitals with increases or decreases in uncompensated care costs in the top 1 percent of such changes.**

We have instructed our MACs to review these situations with each hospital. If it is determined after this review that an increase or decrease in uncompensated care costs cannot be justified by the hospital, we are proposing to follow the same approach that we are proposing to use to address situations when a hospital's ratio of its uncompensated care costs to its operating expenses is extremely high and the hospital cannot justify its reported amount.

Worksheet S-10



In the 2019 IPPS Proposed Rule Cont'd:

Specifically, if after review, the increase or decrease in uncompensated care costs for FY 2014 or FY 2015 cannot be justified by the hospital, we would determine the ratio of the uncompensated care costs to total operating expenses from the hospital's cost report for the subsequent fiscal year and apply that ratio to the total operating expenses from the hospital's resubmitted cost report with the large increase or decrease in ***uncompensated care payments*** to determine an adjusted amount of uncompensated care costs for the applicable fiscal year.

We have tentatively included the data for hospitals where there was an extremely large increase or decrease in ***uncompensated care payments*** when calculating Factor 3 for this proposed rule. However, **we note that our calculation of Factor 3 for the final rule will be contingent on the results of the ongoing MAC reviews of these hospitals. In the event those reviews necessitate supplemental data edits, we would incorporate such edits in the final rule for the purpose of correcting aberrant data.**

Worksheet S-10



In the 2019 IPPS Proposed Rule Cont'd:

It is also possible that when we examine the FY 2016 Worksheet S-10 data, we may determine that the use of multiple years of Worksheet S-10 data is no longer necessary in calculating Factor 3 for FY 2020.

In this proposed rule, we are proposing that, effective for cost reporting periods beginning on or after October 1, 2018, in order for hospitals reporting charity care and/or uninsured discounts to have an acceptable cost report submission under § 413.24(f)(5), **the provider must submit a detailed listing of charity care and/or uninsured discounts that contains information such as the patient name, dates of service, insurer (if applicable), and the amount of charity care and/or uninsured discount given that corresponds to the amount claimed in the hospital's cost report as a supporting document** with the hospital's cost report.

EHR Audit Experience - Impact on DSH?

EHR Audits and Impact on DSH

- Medicare incentive payments were authorized over 5-year period for providers who adopted EHR technology and attested to its meaningful use (January 1, 2011 to December 31, 2016). CMS payments to hospitals total \$14.6B.
- Once a hospital successfully attested to its meaningful use, it was eligible for Medicare EHR incentive payments.
- The Medicare Share calculated as:
$$\frac{\text{Inpatient Medicare Part A Days} + \text{Inpatient Medicare Part C Days}}{\text{Total Inpatient Days} \times [(\text{Total Charges} - \text{Charity Care Charges}) / \text{Total Charges}]}$$

Note: CMS will use total charges from Worksheet C and charity care charges from Worksheet S-10.
- Several factors influence Medicare EHR incentive payments, including **Charity Care Charges** reported on Worksheet S-10, Line 20 of the cost report. An increase in this factor increases Medicare Share, resulting in higher incentive payment.

EHR Audits and Impact on DSH

- To receive the incentive payments to which a hospital is entitled, Worksheet S-10 Charity Care Charges should be:
 - Reported accurately
 - Reflect the charity care policy
 - Refreshed before final settlement of cost report
 - Reconciled to other reports that also reflect charity care (IRS Form 990, Schedule H, and footnotes to Audited Financial Statements)

Note: CMS will use total charges from Worksheet C and charity care charges from Worksheet S-10.

- Charity Care Charges reported on Worksheet S-10 are for claims with dates of service during the cost report fiscal year end that have been written-off by the time the cost report is filed
- For many hospitals Charity Care Charges may be understated on initial submission of the cost report

EHR Audits and Impact on DSH

HITECH Auditing Standards:



Health Information Technology for Economic and Clinical Health (HITECH) Act, Enacted as Part of American Recovery and Reinvestment Act of 2009

- CMS directed MACs to audit the data elements used to calculate Medicare EHR incentive payments
- Audits are designed to validate:
 - Total Discharges
 - Number of Part A and Part C inpatient bed days
 - Total Charges
 - **Total Charges Attributed to Charity Care**
- These are separate from meaningful use attestation audits performed by Figliozi & Company.
- Be prepared to share details to support charity care amounts reported on cost report and to reconcile with amounts reported on IRS Form 990, Schedule H, and Audited Financial Statements


EHR Audits and Impact on DSH

HITECH Auditing Standards Cont'd:

- MACs have accepted listing of refreshed charity care charge data submitted at time of audit
- MACs have employed the use of statistical sampling methodologies
- Requests for supporting documentation for sampled accounts include:
 - Uniform bill detailing gross charges for services provided and documentation of deductible and coinsurance amounts, such as reported on explanation of benefits or remittance advices
 - Charity care applications and supporting documentation, such as pay stubs, other evidence of income, bank statements, and financial portfolios
- Error rates are then established based on acceptance of the supporting documentation by auditor, which can result in significant disallowances
- HITECH adjustments are incorporated with any other desk review adjustments before settlement issued
- Any additional supporting documentation not furnished at time of audit will require reopening request

EHR Audits and Impact on DSH

Reasonable Collection Effort (CMS Pub. 15-1, §310) :

 It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also Includes other actions such as:

- Subsequent billings
- Collection letters
- Telephone calls or personal contacts

 Documentation required

- The provider's collection effort should be documented in the patient's file by:
 - Copies of the bill(s)
 - Follow-up letters
 - Reports of telephone and personal contact, etc.

EHR Audits and Impact on DSH

Indigent or Medically Indigent Patients (CMS Pub. 15-1, §312) :

- Sometimes provider establishes before discharge or within a reasonable time before the current admission that the patient is indigent or medically indigent
- Providers can deem Medicare beneficiaries indigent or medically indigent when they have also been determined eligible for Medicaid as either categorically needy or medically needy
- Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of a Medicare beneficiary under the following guidelines:
 - The patient's indigence must be determined by the provider, not by the patient (i.e. a patient's signed declaration of inability to pay medical bills cannot be considered proof)
 - The provider should take into account a patient's total resources, which includes, but not limited to, an analyses of assets (only those convertible to cash and unnecessary for daily living), liabilities, and income and expenses
 - The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill (e.g. Title XIX, local welfare agency, and guardian)
 - **The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination**

Financial Assistance and Section 501(r)

Financial Assistance and Section 501(r)



Evolution of 501(r) – Internal Revenue Code:

○ The Patient Protection and Affordable Care Act (March 23, 2010) added 501(r) to the Internal Revenue Code:

1. Conduct a Community Health Needs Assessment (CHNA) every 3 years
2. Establish financial assistance and emergency medical care policies
3. Limitations on charges for emergency or other medically necessary care to FAP-eligible individuals
4. No Extraordinary Collection Actions (ECAs) before making reasonable efforts to determine whether an individual is FAP-eligible

○ Final Regulations were issued December 29, 2014

○ Effective for tax years beginning after December 29, 2015

○ Before the final regulations became effective, organizations could rely on a reasonable, good faith interpretation of 501(r)

Financial Assistance and Section 501(r)



Conducting a Community Health Needs Assessment (CHNA):

- Conduct CHNA once every 3 years
- Define the community served
- Assess the health needs of the community
- Take into account input received from persons who represent the broad interests of the community
- Document the CHNA in a written report that is adopted by the board
- Make the CHNA report widely available



Financial Assistance and Section 501(r)



Conducting a Community Health Needs Assessment (CHNA):



An implementation strategy must:

- Describe the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions,
- Identify the resources the hospital facility plans to commit to address the health need,
- Describe any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need, and
- Describe any significant health need that is not being addressed

Financial Assistance and Section 501(r)



Establishing 501(r)-Compliant Policies - Financial Assistance:



A Financial Assistance Policy (FAP) must include:

- Eligibility criteria for financial assistance
- Basis for calculating amounts charged to patients
- Method for applying for financial assistance
- Actions the hospital may take in the event of nonpayment
- Presumptive eligibility criteria and information sources used
- List of any providers delivering emergency or other medically necessary care in the hospital (specifying which providers are covered by the FAP and which are not)



Hospitals must make FAP, FAP application form, and plain language summary of FAP “widely available”

Financial Assistance and Section 501(r)



Limitation on Charges – Amounts Generally Billed (AGB):

- Hospitals must limit the amount charged to FAP-eligible individuals, in the case of emergency or other medically necessary care, to not more than amounts generally billed to individuals who have insurance covering such care (AGB)
- Look-Back Method
 - Hospital must calculate AGB % at least annually by dividing the sum of the amounts of all its claims for emergency and other medically necessary care that have been allowed by health insurers during a prior 12-month period by the sum of the associated gross charges for those claims
- Prospective Medicare or Medicaid Method
 - Determine AGB by using the billing and coding process the hospital would use if the FAP-eligible individual were a Medicare fee-for-service or Medicaid beneficiary
 - AGB is amount Medicare or Medicaid would allow (including both the amount reimbursed and the amount beneficiary would be personally responsible for)

Financial Assistance and Section 501(r)



Collection Actions:

- Hospitals may not engage in Extraordinary Collection Actions (ECAs) against an individual before making reasonable efforts to determine whether the individual is eligible for assistance under its FAP
- ECAs include reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus
- ECAs include deferring or denying, or requiring a payment before providing, medically necessary care
- ECAs include placing a lien on an individual's property, commencing a civil action against an individual, garnishing an individual's wages, etc.

Financial Assistance and Section 501(r)



Collection Actions – Billing and Collection Policy:

Reasonable efforts to determine whether an individual is FAP-eligible include:

- Notifying the individual about the FAP and refraining from initiating any ECAs for at least 120 days from first post-discharge billing statement
- Following specified procedures for individuals who submit a **complete** FAP application during application period (240 days)
- Following specified procedures for individuals who submit an **incomplete** FAP application during application period (240 days)
- If hospital sells or refers debt to another party, entering into a legally binding written agreement to ensure that no ECAs are taken until reasonable efforts have been made to determine FAP-eligibility

Financial Assistance and Section 501(r)



Operational Compliance – Why so Important?

- Avoidance of penalties (including loss of exemption)
- Form 990, Schedule H reporting
- Potential impact on property and sales tax exemption
- Attorney General scrutiny
- Media scrutiny
- Public perception
- Potential impact on tax-exempt bond financing

Financial Assistance and Section 501(r)



The number of Tax Exempt and Governmental Entities audits appears to be up, especially with respect to hospitals and 501r audits.

Approaches IRS is using to select charitable hospitals for review:

- Reviewing hospital websites
- Data-driven approach –questions on Form 990 / Schedule H can target noncompliance with Section 501(r)
- Information Document Requests
- Financial assistance policies, copies of application forms and instructions, plain-language summaries, translated FAP documents
- Hospitals are asked how they notify and inform patients of financial assistance
- What actions have hospitals taken with regard to widely publicizing the availability of financial assistance

Audits and compliance checks of 2016 tax year are more detailed than those of 2015 tax year.

Refer to IRS “Issue Snapshot” (dated 4/3/2018)

<https://www.irs.gov/charities-non-profits/financial-assistance-policies-faps>

Financial Assistance and Section 501(r)



Loss of Section 501(c)(3) Status for Section 501(r) Noncompliance:

- August 4, 2017: The IRS issued a 501(c)(3) revocation for a hospital due to its failure to comply with 501(r).
- The IRS stated the hospital failed to make its Community Health Needs Assessment available and it did not complete and adopt an implementation strategy for the CHNA.
- Indication of a pattern? Maybe not. The IRS noted this hospital's refused to comply because it was a government owned hospital.
- However, the IRS did state the lack of the CHNA and implementation strategy was "egregious."

Financial Assistance and Section 501(r)



Correction and Disclosure of Section 501(r) Omissions or Errors:

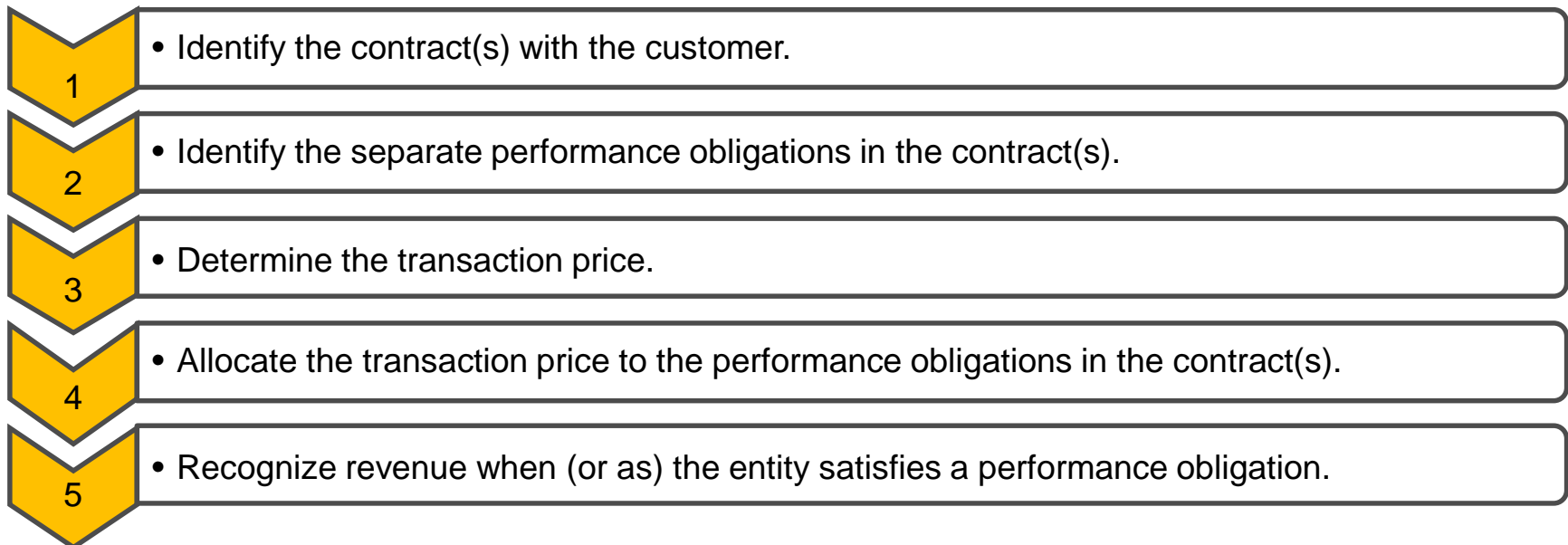
- Rev. Proc. 2015-21 provides guidance regarding correction and disclosure procedures for hospitals with regarding to section 501(r) omissions or errors
- Three “types” of omissions or errors:
 - Omissions or errors that are minor and either inadvertent or due to reasonable cause, which the hospital corrects
 - Willful or egregious failures
 - Failures that are excused if corrected and disclosed in accordance with the Revenue Procedure

Revenue Recognition Developments

Revenue Recognition Developments

New Five-Step Model to Recognize Revenue :

Core Principle: Recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.



Revenue Recognition Developments



Impairment Loss / Bad Debt Expense



Current Guidance (605): the collectability assessment does not affect revenue recognition; it only affects the presentation of bad debt expense on the income statement.

- For entities that pre-qualify patients for services: an uncollectible amount would likely be recognized as bad debt expense; classified in operating expense.
- For entities that do not pre-qualify patients for services: an uncollectible amount would likely be recognized as a reduction in net revenue.



New Standard (606): Impairment loss (bad debt) will be classified as an operating expense for all entities.

- Recognize when a patient-specific event becomes known to the entity that suggest a patient no longer has the intent and ability to pay
- It is anticipated that the amount of impairment loss (bad debt expense) will decrease under the new standard
- Entities that experience frequent subsequent cumulative adjustments should re-assess whether its estimation process is appropriate
- Charity care is not impacted by this new standard (does not qualify for recognition as revenue)

Revenue Recognition Developments



Impairment Loss / Bad Debt Expense Cont'd:



What Constitutes an Impairment Loss under 606?

Variable Consideration Factors (Reduce the Transaction Price) - Recognize to Net Revenue -

- Variable consideration can result from discounts, price concessions (implicit or explicit), etc.
- Business practice of not performing a credit assessment prior to providing services (for example if services are required by law)
- Having a mission to provide services without consideration of a patient's ability or intent to pay
- A history or policy of providing financial or hardship discounts
- A history or policy of accepting less than the price stated in the contract

Impairment Loss Factors (Record a Loss) Recognize to Operating Expense-

- Requires judgement to differentiate between a price concession and impairment loss
- Business practice performing credit assessments prior to providing services (for example elective surgeries) and full payment is expected
- A patient-specific event becomes known to the entity that suggests the patient no longer has the ability and intent to pay the amount due
- A bankrupt insurer or payor

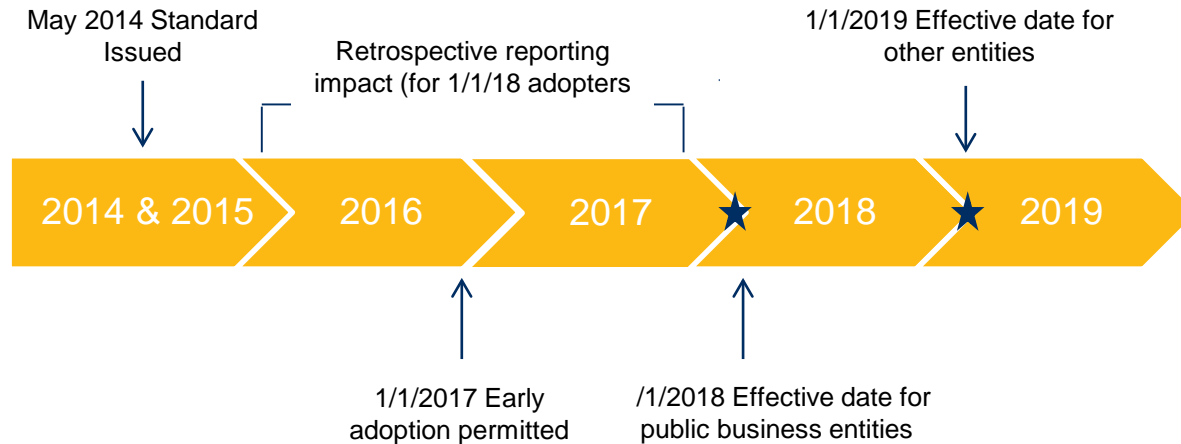
Revenue Recognition Developments



Implementation & Transition – Effective Dates:

Organizations with conduit debt meet the definition of a “Public Business Entity”

A public business entity, a NFP that has issued, or is a conduit bond obligator for, securities that are traded, listed, or quoted on an exchange or an over-the-counter market.



Revenue Recognition Developments



Implementation & Transition – Two Approaches:

Full Retrospective

- Apply Topic 606 to all prior periods presented
- Certain practical expedients are allowed:
- For completed contracts, do not have to restate if they begin and end in same year
 - For completed contracts having variable consideration, may use the transaction price at the date the contract was completed (rather than estimating variable consideration)
 - For all reporting periods presented before the date of initial application, do not have to disclose the amount of the transaction price allocated to remaining performance obligations and the explanation of when the entity expects to recognize that amount in revenue

Modified Retrospective

- No restatement of prior periods; recognize a cumulative effect adjustment to equity or net assets at beginning of period
- An entity can choose to apply to only contracts that are not completed contracts at date of initial application or all contracts at date of initial application
- Disclose in the year of adoption the effect on current year, by line item, along with an explanation of the reasons for changes.

ASC606-10-65, *Transition and Open Effective Date Information*

Revenue Recognition Developments



Implementation Recommendations:

The new principles based standard requires significant assessments and judgements. Organizations will need to develop and maintain documentation supporting their contracts (and revenue streams) along with proving out the accuracy of portfolio estimates as part of a successful transition.

Keys to Success

1. Re-assessment of revenue recognition accounting policies and procedures
2. Greater analysis and documentation of the types of contracts and types of patients (customers)
3. Consideration of variable constraints estimates, including identifying and quantifying self-pay (ie. uninsured or underinsured) patients' intent and ability: deductibles, co-pays, co-insurance, qualifying patients for program assistance (including Federal and State programs), price concessions and discounts offered, etc.
4. Portfolio assessments (and modeling) for identifying and validating size and composition; it is anticipated most organizations will need to disaggregate their current levels and / or classes.

Revenue Recognition Developments



Implementation Recommendations Cont'd:



Keys to Success Cont'd

5. Monitoring the ongoing accuracy of portfolio estimates
6. Evaluate future disclosure requirements
7. Determining the best transition method
8. Consider tax implications of changes
 - For-profit: Impact on current and deferred taxes; net income
 - Not-for-profit: Form 990 reporting; revenue in excess of expenses
9. Assess the impact on financial and business practices
 - Discussions needed with creditors and other financial statement users
 - Impact on agreements tied to revenue (for example, incentive compensation agreements)
 - Determine approach of collaborative business partners
10. Consult with your accounting firm on adopting best practices

Revenue Recognition Developments



Topic 606 Takeaways

- Amount of uncompensated care provided by hospitals will not change but how they report it for financial statement purposes will change.
- Medicare and Tax reporting rules have not changed with respect to revenue recognition, so this will require dual/parallel reporting methodologies
- Health Systems need to justify their tax exempt status and the bad debt calculation is a big part of that number.
- The term bad debts will become implicit price concessions.
- Not-for-profit health systems will want to disclose the implicit price concession in their footnote of financial statements.
- Health systems do not anticipate a material impact on finances. There will be shifts between bad debts and other categories of uncompensated care such as charity care and uninsured discounts.



Revenue Recognition Developments

Resources:

➤ Crowe Revenue Recognition Resource Center – publications and videos:
www.crowe.com/revenue-recognition

➤ Crowe Healthcare Revenue Cycle - publications and videos:
www.crowe.com/industries/healthcare

➤ FASB and AICPA –
publications and
webinars

 <p>ARTICLE</p>	 <p>WEBINAR</p>
<p>Self-Pay Becomes Ground Zero for Hospital Margins (Benchmarking Report)</p>	<p>On-Demand Healthcare Webinars</p>



September 2017

Revenue From Contracts With Customers
Understanding and Implementing the New Rules

An article by Scott Johnson, CPA, and Mark J. Winkler, CPA

DOWNLOAD

➤ Healthcare industry associations

Summary

- ▶ Traditional DSH has been reduced to 25% of DSH payment and Uncompensated Care payment makes up 75%
- ▶ New S-10 methodology is in three year phase-in period for calculation of factor three
- ▶ Audits\Desk reviews of Uncompensated Care Costs (UCC) reported on S-10 will begin with 2017 reported data (cost reports beginning after 10/01/16). Cost reports beginning prior to this time frame will be subject to further scrutiny after submission
- ▶ Understanding the importance of collaboration between Revenue Cycle, Regulatory Reimbursement, Patient Financial Services, Finance and Tax in accurate reporting of uncompensated care elements is vital for reimbursement
- ▶ New Revenue Recognition standards will cause additional record keeping for reporting of Community Benefits for hospitals and to properly report Medicare Uncompensated Care DSH and Medicare bad debts



Thank you

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