INSIGHTS FROM THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

5 STEPS FOR HOSPITALS TO MANAGE RISK AROUND FALL 2018 UNCOMPENSATED CARE CMS AUDITS

By Steven Shill and John Barry

Amid a growing uninsured population and CMS audits of uncompensated care reporting starting this fall, hospitals' lifelines will be proper patient-level documentation and clearly defined charity care policies.

DISPROPORTIONATE-SHARE HOSPITAL PAYMENT CHANGES DRIVE FALL CMS AUDITS

In 2014 under the Affordable Care Act's assumed Medicaid expansion, CMS began calculating disproportionate-share hospital (DSH) payments based on charity care and bad debt—together known as uncompensated care. DSH payments were previously calculated based on the number of Medicaid, dual-eligible and disabled patients treated. Beginning this fall, CMS will start auditing the uncompensated care data included in worksheet S-10 of a hospital's cost report. Upon audit, CMS will require hospitals to support uncompensated care amounts with patient-level data.

CMS said it would audit the top 1 percent of hospitals with a high ratio of uncompensated care to total operating costs. In its final 2019 acute-care hospital inpatient prospective payment system (IPPS) rule, which dictates the way hospitals are reimbursed based on cost reports three years in arrears, the agency then underlined that its audit protocols are confidential—underlining the importance of hospitals ensuring proper documentation in the face of little guidance.

GROWING THREATS TO THE HOSPITAL MODEL

Today's DSH calculations are based on uncompensated care data from 2015-17, largely before ACA rollbacks took shape. Once the individual mandate penalty ends next year, almost 25 percent of large businesses expect at least some of their workers and families to stop enrollment in coverage, the Kaiser Family Foundation found. As the ACA is rolled back further and the uninsured population grows, hospitals are likely to see their uncompensated

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care population grow in tandem. Since the rate at which they're reimbursed for that uncompensated care does not account for ACA changes, however, hospitals' future revenue is likely to be negatively impacted.

Additionally, the percentage of workers with a deductible increased to 85 percent this year, compared to 81 percent in 2017 and 59 percent 10 years ago, according to ***Modern Healthcare***. And the average deductible among workers who face one before their plan starts paying grew to nearly $1,600—up 4.5 percent from last year. As the number of consumers facing deductibles—and the amounts of them—grow, it will become increasingly important for hospitals to consider deductibles and co-insurance write-offs to charity in the face of uncompensated care audits.

The uncompensated care audits, and the accompanying required patient-level documentation upon audit, come at a time when hospitals already must manage heightened financial risk while maximizing quality outcomes in the process. As care traditionally provided at the hospital moves to outpatient settings and from fee-for-service to value-based reimbursement, hospitals have been forced to transform their business model to revolve around improved outcomes and consumer convenience.

At the same time, healthcare entities—hospitals included—are grappling with a new accounting standard, ASC 606, *Revenue from Contracts with Customers*. The third step of the standard—determining the transaction price—proves especially tricky for an industry transitioning to value-based reimbursement and determining the accuracy of its revenue forecasts in the process.

How Can Hospitals Manage Risk While Maximizing Quality Outcomes?

Hospitals are required to report their uncompensated care costs in a section of the Medicare cost report called the S-10 worksheet, which CMS uses to calculate DSH payments.

To successfully toe the line between allocating costs within Medicare rules to optimize reimbursement and revenue, and mitigating heightened false claims risk, healthcare organizations should keep the following five-step checklist top of mind.

STEP 1: Ensure Bright Lines on Charity Care Policies

Do you have a charity care policy with defined terms, including what is covered under the policy?

Your policy should establish clear, non-discriminatory income levels that constitute charity care, include instructions and required documentation for applying for charity care, and be available in all respective languages of your patient population.

Because an increasing number of consumers face growing deductibles, hospitals should also clearly identify and define write-offs of co-insurance within their charity care policy. As deductibles become more prevalent, hospitals could find themselves writing off co-insurance even if their patient is insured. But they can only report co-insurance amounts as part of their uncompensated care amount if patient deductibles and co-pays are included within their charity care policy.

STEP 2: Implement Proper Information Governance to Support Patient-Level Documentation

Have you implemented the policies and processes—across your entire organization—needed to ensure you're capturing and accurately recording the level of patient data required to optimize reimbursement and mitigate fraud risk?

Because patient-level data is essential to support the uncompensated care amounts in worksheet S-10 upon audit, you must ensure you have a proper information governance framework in place to do so. Hospitals are responsible for endless mounds of data and from disparate sources. The ability to accurately use and protect this data is vital to patient care and safety, as well as documentation needed for billing.

Have you then made changes to ensure patient-level documentation is happening across your organization?

This means recording the patient's information upon admittance and throughout the entire episode of care—at the front end with your billing department and at the back end with follow-up for qualifications of charity care. It's also crucial to maintain the documentation provided in each patient's record so that it's accurate and easily-accessible come an audit.

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STEP 3: Quicken Electronic Health Record (EHR) Adoption

Have you taken the steps to fully transition to EHRs, and do you have a digital transformation plan in motion?

To maintain patient documentation so that it's accurate and ready in case of an audit, EHR adoption is key. Improving your organization's documentation process involves digitally transforming the business. Part of that transformation includes making sure EHR implementation is up to speed to allow seamless and comprehensive data sharing.

How can you accelerate implementation?

To improve interoperability and patients' access to health information, CMS has streamlined EHR incentive programs—now called the Promoting Interoperability (PI) Program—to reduce the time and cost for hospitals to adopt, implement and upgrade their EHR technology. Historically, there have been challenges with EHR adoption and implementation due to lack of a streamlined standard or process for vendors, but healthcare organizations can **improve their level of standardization**, and receive payments for doing so, by following these steps:

- Adopt 2015 Edition Certified EHR Technology
- Collaborate with EHR vendors to promote uniform standards or implementation and adoption
- Participate in standards development process

Accelerating EHR implementation allows seamless and comprehensive data sharing, which in turn facilitates documentation and reduces the risk of false claims.

STEP 4: Top-Down Training & Education

Do you have the organizational infrastructure in place to lead these changes from the top down?

Changes or clarifications to charity care policies, patient-level documentation and EHR adoption begin with behavioral change from the top down. Only then will the new processes become an integrated and inherent part of the business. Employees must understand the reason for the change and what's expected of them—and to do so, they need the proper resources and training from leadership.

To give employees the **proper training**:

- Consider compensation incentives that align with goals for appropriate documentation with fewer denials
- Offer training sessions on a regular basis covering regulatory and compliance updates to remind or teach employees about documentation requirements or changes
- Conduct regular S-10 form sampling and reviews prior to audits to actively guide better documentation in the future and allow for the immediate correction of errors
- Engage an external team with expertise in documentation and reduction of false claims to ease the burden of leadership and staff
- Conduct internal annual risk assessments and chart documentation audits, with feedback sessions and actions plans to follow to correct identified deficiencies

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STEP 5: Incorporate uncompensated care changes into ASC 606 Planning

Have you incorporated uncompensated care reporting changes—and potential revenue shortfalls—into your planning for ASC 606, or *Revenue from Contracts with Customers*?

For hospitals, the third step of the standard—determining transaction price—is especially challenging. Revenues under value-based arrangements are considered a variable consideration because the reimbursements may be subject to retroactive adjustment after the fact. Under ASC 606, revenue to be recognized is limited to the amount of variable consideration where it's probable that a significant adjustment will not occur when the uncertainties are resolved. Determining the transaction price, therefore requires providers to have visibility into the costs and quality of other providers or partners within their own supply chain to make a reasonable assessment.

As hospitals are unable to predict the likelihood of a CMS audit—or the odds of CMS taking back reimbursement previously booked as revenue—they'll need to incorporate uncompensated care into their variable considerations.

Hospitals will continue to face financial and compliance challenges from all sides—especially as value-based reimbursement quickens. To manage this risk, they'll need to monitor not only their own care outcomes and financial performance, but also the performance of other hospitals and subsequently released guidance.

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