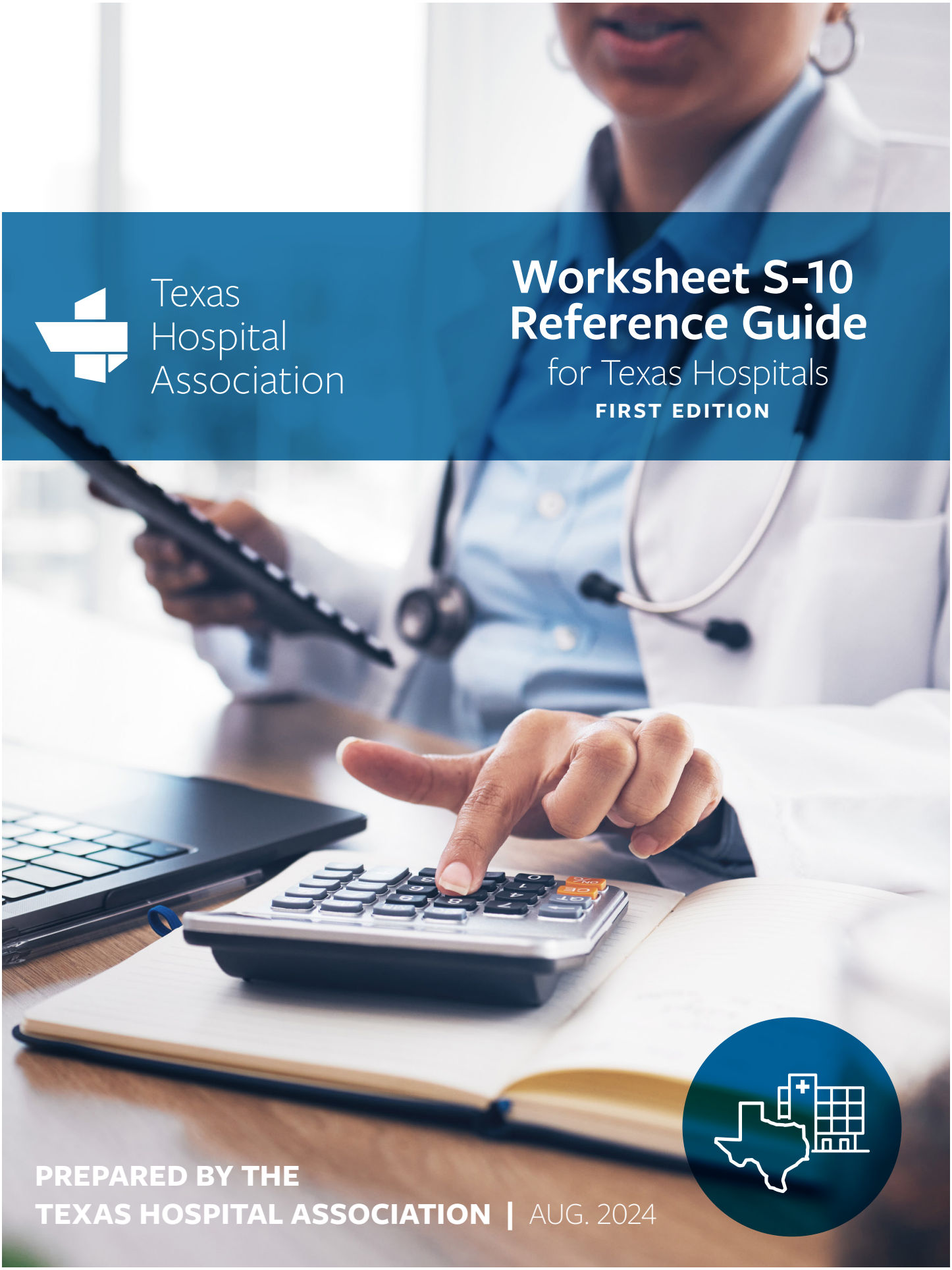

Texas Hospital Association

Worksheet S-10 Reference Guide

for Texas Hospitals

FIRST EDITION

PREPARED BY THE TEXAS HOSPITAL ASSOCIATION | AUG. 2024

ABOUT THIS GUIDE

Worksheet S-10 Reference Guide for Texas Hospitals was prepared with contributions from members of the Texas Hospital Association (THA) Policy Committee on Hospital Reimbursement and external firms with expertise in Medicare cost report preparation. THA offers this guide as a resource to Texas hospitals and hospital systems who report uncompensated and indigent care amounts to the Centers for Medicare & Medicaid Services (CMS) on Worksheet S-10, and for users of such data. The guide addresses items in Worksheet S-10 with significance to the hospital industry. This reference document is intended to align with regulatory guidance and generally accepted accounting principles at the time of publication and may be updated as circumstances evolve. Consultation with certified public accountants, independent auditors and reimbursement consultants in preparation of Worksheet S-10 is highly recommended.

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Texas hospitals deliver a significant amount of care to low-income Medicaid beneficiaries, indigent patients and the uninsured. Federal law requires that short-term acute care hospitals and critical access hospitals submit cost reports to the Centers for Medicare & Medicaid Services (CMS) containing data on costs incurred and payments received on such care. Medicare Cost Report Worksheet S-10 provides for the collection of uncompensated and indigent care data.

Worksheet S-10 is a data collection tool with situational utility for assessing the financial experience of hospitals and systems delivering care to low-income patients. Worksheet S-10 data for all inpatient prospective payment system hospitals that receive Medicare uncompensated care payments is subject to audit by the Medicare Administrative Contractors. Critical access hospitals and children's hospitals are not required to complete Worksheet S-10 for Medicare cost report purposes, but generally complete an equivalent of Worksheet S-10 due to the reliance the Texas Health and Human Services Commission (HHSC) places on Worksheet S-10 data for purposes of calculating certain Medicaid supplemental payments.

Worksheet S-10 is a cost ***estimator*** and differs from a true accounting instrument. Each Worksheet S-10 derives from nonstandardized inputs such as the hospital's individual charity care policy. CMS furnishes general instructions on the completion of Worksheet S-10 that allow hospitals some discretion in classifying uninsured and indigent care costs and payments. This creates some variation of acceptable practices in reporting such amounts.

This guide focuses on S-10 fields that may support activities of regulatory significance, including but not limited to:

- Gathering evidence of an organization's fulfillment of charitable mission;
- Calculating supplemental reimbursement; and
- Policymaking or legislation.

This guide was compiled by a workgroup of hospital financial management experts. All are experienced in hospital financial practices and Medicare cost report Worksheet S-10 preparation.

HOW TO USE THIS GUIDE

Information in this guide is provided for two primary audiences: (1) Worksheet S-10 preparers, and (2) users of Worksheet S-10 data.

- **Section 1 provides background information** on hospital charity care policies and the cost-to-charge ratio from which Worksheet S-10 derives valuations of uncompensated care, Medicaid and indigent care costs.
- **Section 2 is for preparers.** Information in this section is intended to promote greater consistency in financial reporting practices on Worksheet S-10 with the ultimate goal of providing the best information possible to policymakers and other users of S-10 data. This section offers suggestions for industry conventions and options for Worksheet S-10 preparation.
- **Section 3 is for data users.** Information in this section is intended to describe Worksheet S-10's usefulness and limitations to ensure S-10 data are viewed and interpreted with appropriate context. Data users are encouraged to review sections 1 and 2, as the discussion in section 3 is supported by evidence presented in prior sections.

[1] TX Health & Safety Code, Sec. 331.004(b)(2)(A)(B)

SECTION 1:
S-10 INPUTS AND SOURCES OF VARIATION

SECTION 1: S-10 INPUTS AND SOURCES OF VARIATION

Worksheet S-10 data derives valuations of Medicaid, indigent care and uninsured charity care costs using nonstandard inputs with variability across the hospital industry. In this section, we describe these sources of variation and discuss their implications for regulatory uses of S-10 data.

HOSPITAL CHARITY CARE AND FINANCIAL ASSISTANCE POLICIES

Texas hospitals adopt charity care policies to ensure that patients' financial circumstances do not prevent them from seeking or receiving necessary health care. Charity care policies describe when and how hospitals will provide free or discounted care without expectation of reimbursement to individuals who are uninsured, underinsured, ineligible for government programs or otherwise unable to pay.

Most Texas hospitals maintain a charity care policy regardless of ownership type (public or private), taxable status or charitable mission. Nonprofit hospitals with a charitable mission are required to maintain a charity care policy as a condition of tax exemption. The charity care duties of Texas nonprofit hospitals with tax-exempt status are set forth by Section 501(r)(4) of the federal Internal Revenue Code and Chapter 311 of the Texas Health and Safety Code.

In Texas, any hospital receiving supplemental reimbursement from the Medicaid 1115 waiver uncompensated care (UC) pool must maintain a financial assistance policy adhering to the charity care principles of the Healthcare Financial Management Association (HFMA).[1] This includes investor-owned hospitals not required by law to maintain a charity care policy. Texas hospitals must be able to identify charity-eligible patient accounts for the purposes of UC payment.

Hospitals have different approaches to recognizing charity care. Within acceptable industry principles and practices, each hospital may establish its own charity care and financial assistance policy according to its mission, financial condition and duties under law. Charity care policies are often influenced by:

- Whether a hospital's mission is explicitly charitable;
- Whether a hospital can access tax revenues for the provision of charity care;
- The social and economic profile of the community served by the hospital;
- The array of specialized services provided by the hospital; and
- The sophistication of administrative tasks the hospital can support related to gathering and verifying evidence of patient charity care eligibility.

[1] **See HFMA Principles & Practices Board Statement 15.**

The HFMA Principles & Practices Board clearly states: "No single set of criteria for charity care policies is universally applicable."[1] Appropriately, Texas hospitals have discretion over the development and implementation of charity care policies under current state law.

A hospital also has discretion over which data it will use to support an eligibility determination for charity care. Such data may include but are not limited to: individual or family income, net worth, employment status, credit scores, amount and frequency of health care bills and eligibility for public assistance. A hospital may determine that charity-eligible patients can qualify according to whether they are financially indigent, medically indigent or both. Data may be self-reported by the patient or patient's representative, or queried from external sources. Hospitals may require a patient to demonstrate charity eligibility at time of service, or – recognizing that patients' circumstances and ability to pay may change – allow a patient to demonstrate eligibility during a defined time frame tied to the time of service.

INSET 1: **CHARITY CARE VS. BAD DEBT**

Charity care and bad debt are two types of uncompensated care recorded on Worksheet S-10. They must be clearly distinguished.

Charity care is provided to patients at reduced or no charge based on the patient demonstrating financial hardship according to the criteria in the hospital's charity care or financial assistance policy.

Bad debt expense relates to uncollected amounts from patients who received services but did not qualify for charity care under the hospital's policy.

Charges are the basis for charity care record-keeping purposes, while costs are the primary reporting unit for valuing charity care. HFMA Statement 15 reads: "[C]harity care is not to be reported in revenue or receivables. However, it is often not known whether services will meet charity care criteria at the time the services are rendered, so there is no alternative to keeping records for charity care in the same manner as for any other service. ... The use of separate accounts for a charity care provision and the related allowance is usually necessary." For this reason, hospitals may employ varied record-keeping practices for charity care based on their policies.

Governmental and non-governmental accounting standards related to revenue recognition also differ. Governmental hospitals may record services in revenue and receivables for all patients based on full charges until charity care eligibility is determined, with consideration given to adjustments that may need to be made to gross charges based on the estimate of collectability. Amounts eligible for charity care are written off immediately from revenue and receivables if a charity determination is possible at the

[1] **See HFMA Principles & Practices Board Statement 15.**

time care is delivered, or may be written off later after the charity care eligibility determination is made. Non-governmental entities record revenue based on what they expect to receive. If a patient is not yet qualified for charity care, the expectation is to receive much less than gross charges. Gross charges may be tracked in the general ledger with adjustments made based on estimates of collectability, but revenue is not technically recognized due to the implicit price concession of providing care to an uninsured patient who has qualified, or is likely to qualify, for charity care.

Finally, all hospitals will have processes to differentiate charity care from other unpaid dollar amounts, such as courtesy discounts, payment shortfalls and bad debt. The practical exercise of making such distinctions can be complex, but charity care is distinguished by a patient's demonstrated inability to pay according to hospital policies. Ensuring the hospital's record-keeping accurately differentiates charity care from other uncompensated care is essential for many purposes, including supplemental reimbursement.

COST-TO-CHARGE RATIO

While charges are the basis for charity care record-keeping, there is variation among hospitals' charges, and thus minimal comparability. A cost-to-charge ratio is used in Worksheet S-10 to standardize charity care amounts by converting charges to costs. Charity care amounts should be expressed as costs to avoid misleading inferences about the value of charity care provided.

The cost-to-charge ratio (CCR) populated in Worksheet S-10, Part I, line 1 is computed by dividing total Medicare-allowable costs (Worksheet C, Part I, line 202, column 3) by total charges (Worksheet C, Part I, line 202, column 8) for the hospital and hospital complex.[2] Providers with no charge structure enter their CCR as calculated in accordance with CMS Pub. 15-1, chapter 22, §2208. The result is an overall CCR for the entire hospital or hospital complex derived from all inpatient, outpatient, ancillary, special purpose and other cost centers.

Worksheet S-10, Part I estimates Medicaid, uninsured charity, and state and local indigent care costs for the hospital complex by multiplying the CCR by the charges for those patients. CMS's instructions do not offer discretion on methods used to derive the CCR on S-10. The overall CCR on line 1 is used to estimate all cost outputs in the remainder of Worksheet S-10.

The overall CCR is derived from all cost centers, without regard for which departmental cost centers contain concentrated shares of Medicaid or charity care volume. Departmental CCRs are calculated by dividing the total costs attributable to a department by charges incurred within that department.

[2] **For the CCR populated in Worksheet S-10, Part II, line 1, the same methods are used, but costs and charges associated with non-hospital services are removed.**

While the overall CCR is used exclusively for cost estimation on S-10, in Texas hospitals, Medicaid and uninsured charity care patient volumes tend to be highest in certain cost centers corresponding to patient populations most likely to demonstrate eligibility for charity care or public programs. These include labor and delivery, emergency department, and outpatient clinic settings. **Department-specific CCRs for service lines with high Medicaid and uninsured volumes may differ significantly from the overall CCR of the hospital or hospital complex.**

To illustrate the variance, we provide cost report data from 10 de-identified Texas hospitals from varying geographic regions, population centers (urban/rural) and bed sizes. ***Figure 1*** shows there can be high variance in a hospital's overall CCR and its departmental CCRs with the largest Medicaid and uninsured volume. The variance does not exhibit uniform direction – the hospital's overall CCR may be lower or higher than its departmental CCRs. In some cases, the departmental CCRs are greater than 1.00, indicating costs exceed billed charges.

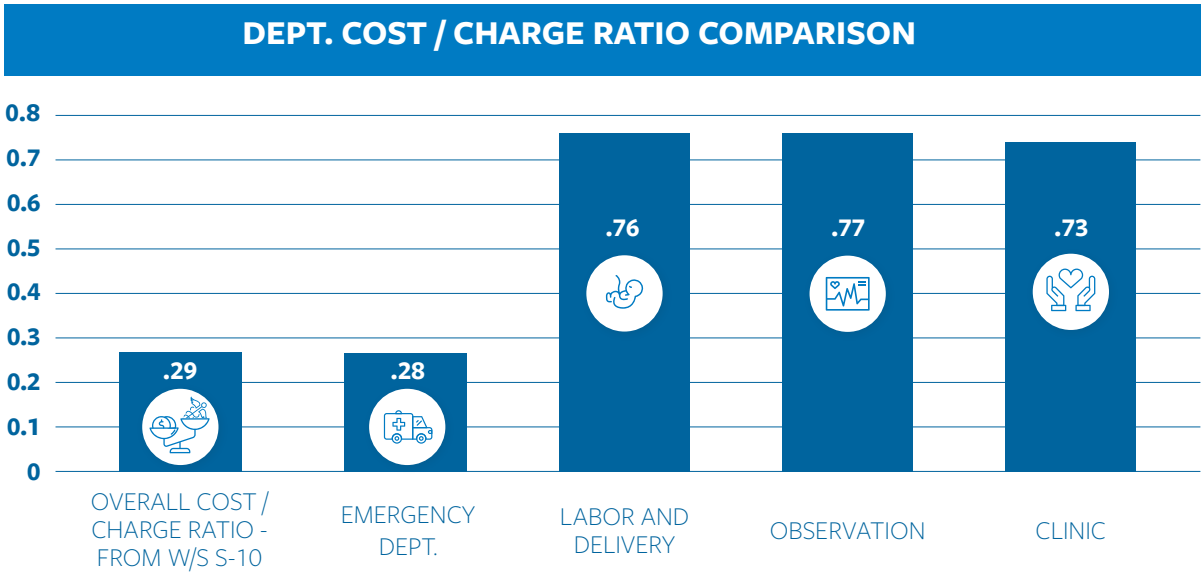
Figure 2 plots the average overall and departmental CCRs of the 10 selected hospitals. On average, the sample hospitals' emergency department CCR and overall CCR are similar. However, the labor and delivery, observation and clinic CCRs are uniformly higher.

Taken together, figures 1 and 2 demonstrate CCRs in cost centers most relevant to uninsured care do not usually mirror the hospital's overall CCR. Therefore, using the overall CCR to reduce charges to costs generally leads to estimation error for hospitals' uncompensated care cost estimates on Worksheet S-10.

Figure 1. Variance between overall and departmental CCRs with highest Medicaid and uninsured volume for 10 selected Texas hospitals

HOSPITAL ID	OVERALL COST / CHARGE RATIO - FROM W/S S-10	EMERGENCY DEPT	LABOR AND DELIVERY	OBSERVATION	CLINIC
HOSPITAL **A**	0.595314	0.809475	0.674697	1.151046	1.645333
HOSPITAL **B**	0.245064	0.173741	0.935223	1.003279	0.225371
HOSPITAL **C**	0.280097	0.309249	0.863765	0.707093	0.453328
HOSPITAL **D**	0.250048	0.268932	0.371562	0.552568	0.540014
HOSPITAL **E**	0.219523	0.134123	0.313335	0.528267	1.292345
HOSPITAL **F**	0.336013	0.534191	1.875795	1.817965	0.73235
HOSPITAL **G**	0.366482	0.11724	1.17398	0.712347	0.792776
HOSPITAL **H**	0.182127	0.172827	0.500037	0.432579	0.979497
HOSPITAL **I**	0.284252	0.176659	0.399134	0.568095	0.557298
HOSPITAL **J**	0.119419	0.097083	0.52332	0.200708	0.104898
AVERAGE	**0.2878339**	**0.279352**	**0.7630848**	**0.7673947**	**0.732321**

Figure 2. Average of 10 selected Texas hospitals' overall and departmental CCRs



In accordance with Medicare reimbursement principles, costs not directly related to patient care are not reimbursable under the program. These are referred to as "non-allowable" costs. Costs not related to patient care are still real, significant and necessary to the operation of the hospital and safe care delivery. Such costs include physician professional fees and overhead related to non-reimbursable cost centers, such as administrative and general expenses, capital costs and employee benefits. Medicare non-allowable costs that account for a significant portion of a hospital's overall costs are definitionally excluded from the overall CCR as an artifact of Medicare's reimbursement formula. Figure 3 shows the magnitude of cost underreporting is, on average, 10-12% for Texas hospitals in each of the non-reimbursable cost centers presented.

Figure 3. Percentage of non-allowable overhead cost removed from overall CCR from 10 selected Texas hospitals

HOSPITAL ID	CAPITAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL
HOSPITAL **A**	5.456%	3.155%	4.880%
HOSPITAL **B**	3.886%	4.954%	11.160%
HOSPITAL **C**	17.834%	41.656%	26.264%
HOSPITAL **D**	2.510%	2.557%	5.776%
HOSPITAL **E**	13.202%	13.268%	12.648%
HOSPITAL **F**	36.069%	2.366%	11.457%
HOSPITAL **G**	11.372%	16.249%	14.274%
HOSPITAL **H**	20.686%	16.336%	14.221%
HOSPITAL **I**	3.815%	3.827%	4.648%
HOSPITAL **J**	1.634%	2.050%	19.309%
AVERAGE	**11.646%**	**10.642%**	**12.464%**

SECTION 2:
SUGGESTED REPORTING CONVENTIONS FOR PREPARERS

SECTION 2: SUGGESTED REPORTING CONVENTIONS FOR PREPARERS

A hospital's Worksheet S-10 is prepared to be internally consistent with the hospital's own financial records, reconciling back to an audited financial statement and subject to audit by Medicare administrative contractors. However, its Worksheet S-10 may not be (and is not required to be) externally consistent with the preparation methods of other hospitals filing Medicare cost reports. CMS's general instructions on completion of Worksheet S-10 and hospitals' varied recordkeeping methods give rise to a range of acceptable reporting practices. Inconsistencies in preparation can undermine efforts to use Worksheet S-10 data in activities of regulatory and legislative significance.

Given increasing external reliance on publicly reported Worksheet S-10 data to assess Texas hospitals' unreimbursed Medicaid, uninsured charity and indigent care costs, a greater degree of consistency and clarity in financial reporting practices will promote a more accurate backdrop for regulatory and policy decisions affecting Texas hospitals. This document offers suggestions and options intended to promote consistency in Texas hospitals' preparation of Worksheet S-10. The document also provides a comprehensive discussion of areas where variation in reporting is inevitable and appropriate. We encourage preparers of Worksheet S-10 to reference this document as a guide where suitable for your hospital, system or client.

Suggested reporting conventions in this guide are not meant to homogenize S-10 reporting statewide or discourage hospitals from completing Worksheet S-10 in the manner recommended by its own accounting and regulatory advisors. Consultation with certified public accountants and regulatory advisors is highly recommended in preparation of Worksheet S-10.

MEDICAID (LINES 2-8)

Texas hospitals operate within a unique Medicaid payment environment. Multiple supplemental and directed payment programs are used to augment base payments.[3] Base payments are financed with state general revenue, while the nonfederal share of supplemental and directed payments is self-financed by hospitals. Certain Medicaid payment programs – such as Disproportionate Share Hospital (DSH) and uncompensated care (UC) pool payments – are not payments for Medicaid patient care, but contribute to overall Medicaid revenues recorded on Worksheet S-10. Supplemental payment programs change from year to year in amount, purpose and timing. Consequently, supplemental payments drive fluctuation in Medicaid payment data recorded on Worksheet S-10.

[3] **Texas Health and Human Services Commission. (2024). Medicaid supplemental and directed payment programs. https://www.hhs.texas.gov/providers/medicaid-business-resources/medicaid-supplemental-payment-directed-payment-programs**

The character, method and financing of each Medicaid payment leads to diversity of practice in cost reporting. Notable sources of variation are addressed below with suggestions for preparers.

ALLOCATING NET REVENUE FROM MEDICAID SUPPLEMENTAL PAYMENTS BETWEEN LINES 2 AND 5. In general, Texas hospitals use lines 2 and 5 to record supplemental payment revenue. CMS's instructions provide guidance but permit some discretion on which supplemental payments are allocated to each line.

CMS instructions support recording supplemental or directed payments made on Medicaid managed care claims on line 2, and recording supplemental or directed payments not paid on managed care claims in line 5. Directed payments for physician and professional services should be excluded entirely. Specifically, CMS's instructions indicate that payments be recorded in line 5 if "separately identifiable" and that physician and professional service costs should be omitted (see Inset 2). Under this suggested reporting convention, Texas' Medicaid supplemental payment programs would be allocated on Worksheet S-10, Part I as listed in Table 1.

INSET 2: **CMS INSTRUCTIONS FOR COMPLETING WORKSHEET S-10, LINES 2 AND 5**

Line 2 records net revenue received or expected from Medicaid inpatient and outpatient services during the cost reporting period. Line 2 revenue includes payments for all covered services except physician or other professional services, and payments received from Medicaid managed care programs. If not separately identifiable, disproportionate share hospital (DSH) and supplemental payments are included in line 2. For these payments, providers report amounts received or expected for the cost reporting period net of associated provider taxes or assessments.

Line 5 records separately identifiable DSH and/or Medicaid supplemental payments the hospital received or expects during the cost reporting period not recorded in Line 2, net of associated provider taxes or assessments.

Table 1. Suggested placement of FY 2023 Texas Medicaid supplemental payments on Worksheet S-10, Part I

PROGRAM	LINE
COMPREHENSIVE HOSPITAL INCREASE REIMBURSEMENT PROGRAM (CHIRP)	2
• *UNIFORM HOSPITAL RATE INCREASE PROGRAM (UHRIP)*	2
• *AVERAGE COMMERCIAL INCENTIVE AWARD (ACIA)*	2
TEXAS INCENTIVES FOR PHYSICIAN AND PROFESSIONAL SERVICES (TIPPS)	EXCLUDE
RURAL ACCESS TO PRIMARY AND PREVENTIVE SERVICES (RAPPS)	2
GRADUATE MEDICAL EDUCATION (GME)	5
HOSPITAL AUGMENTED REIMBURSEMENT PROGRAM (HARP)	5
DISPROPORTIONATE SHARE HOSPITAL (DSH)	5
UNCOMPENSATED CARE (UC)	5
NETWORK ACCESS IMPROVEMENT PROGRAM (NAIP)	5

In the measurement of net revenue from Medicaid in line 2, preparers should consider all Medicaid supplemental payment sources and the charges related to the costs those supplemental payments are designed to cover.

RECORDING REVENUES ON CASH VS. ACCRUAL BASIS. Supplemental payments included as net revenue from Medicaid in lines 2 and 5 should be recognized on an accrual basis of accounting, which would include retroactive payments and changes in estimates related to the difference between amounts expected to be received and amounts actually received.

NETTING PROVIDER ASSESSMENTS AND IGT FROM REVENUE. All provider taxes, assessments or intergovernmental transfers (IGTs) that support Medicaid funding should be offset from net revenue from Medicaid supplemental payments in lines 2 and 5. These include payments made by private hospitals to a local provider participation fund (LPPF).[4]

Hospitals demonstrate diversity of practice around netting LPPF assessments or IGTs against revenue received from supplemental programs. Some record these payments as expenses elsewhere on their statements, and it is not always intuitive to net the assessments and IGTs from the Medicaid payments recorded on S-10. Medicaid losses look artificially small on Worksheet S-10 unless provider taxes are offset from Medicaid net revenue.

[4] To finance the nonfederal share of certain Medicaid payments, Texas accepts voluntary funds transfers from local governmental entities. These include cities, counties and public hospital districts. Twenty-nine cities and counties in Texas operate local provider participation funds (LPPFs), which impose mandatory assessments on private hospitals in their jurisdiction to generate Medicaid financing.

TREATMENT OF UNCOMPENSATED CARE (UC) POOL PAYMENTS. Texas' UC pool payments are *Medicaid* payments earned by providing charity care to *uninsured* patients who demonstrate financial need. Partial reimbursement for each hospital participating in the UC pool is calculated based on uninsured charity care costs incurred two fiscal years prior to the payment. UC pool payments draw prior uninsured charges and costs into current Medicaid revenues, making these payments difficult to reconcile with CMS cost report instructions.

This guide recommends UC pool payments be recorded on line 5 due to their character as separately identifiable Medicaid waiver payments.

We note this convention results in the appearance of a reduced loss from Medicaid on line 8 when UC pool payments are included in Medicaid revenue. Medicaid margins derived from Worksheet S-10 can thus appear artificially high. This occurs because:

- Medicaid charges in line 6 do not include the charges associated with charity care accounts on which UC pool payments are calculated.
- Medicaid charges from the current cost reporting period are reduced to costs in line 7.
- Medicaid costs in line 7 are netted from Medicaid net revenue in line 8. Medicaid net revenue is calculated as the sum of lines 2 and 5, on which a UC payment may be recorded.
- Line 8 reflects the hospital's Medicaid loss in the cost reporting period. Total revenue from Medicaid, which includes UC pool payments recorded on lines 2 and 5, will be compared against costs that exclude patient accounts funded by UC pool payments.

We also note that the above discussion applies to any portion of a hospital's DSH payment attributable to uninsured charity care, although these amounts are smaller in magnitude and create less distortion in Medicaid margins.

MEDICAID NONPAID CLAIMS. Texas has a 30-day inpatient spell of illness limitation and a $200,000 individual annual limit on inpatient services applicable to fee-for-service patients and non-adults in managed care. The spell-of-illness limitation requirement leads to certain claims being non-covered and nonpaid. Medicare cost report instructions state that non-covered charges for days exceeding a length-of-stay limit for covered Medicaid services can be reported on line 20, column 2 and also line 25. Charges associated with these days should not be recorded on line 6. See the Uncompensated Care section of this guide for further discussion.

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (LINES 13-16)

Under Texas law, counties (or hospital districts in counties where they exist) bear legal responsibility for indigent care to residents who do not qualify for other state or federal health care programs. There is variation in the types and extent of indigent care support. Preparers should consider all charges and funding received from state, county and local indigent care programs in reporting this support on line 13. Line 14 should include charges related to patients whose services are covered by any indigent care program.

UNCOMPENSATED CARE (LINES 20-31)

The uncompensated care cost lines of Worksheet S-10 derive valuations of unreimbursed care from charges associated with insured *and* uninsured patient accounts. Uncompensated care from charity care and bad debt are distinguished. Bad debt occurs when an expected payment is not made and the amount is deemed uncollectible, while amounts recorded as charity care carry no expectation of payment.

Bad debt and charity care are nonstandard inputs with variability across the hospital industry. The former is influenced by the hospital's billing and collection practices; the latter is influenced by the hospital's individual charity care or financial assistance policy (see page 8, Inset 1).

Sources of variation in charity care policies, which translate to variation in charity care charges and costs, are discussed in Section 1.

NON-COVERED CHARGES. Non-covered charges for insured patients are reported on line 25. Line 25 consolidates into line 20, column 2 and is reduced by the CCR on line 21. Medicaid non-covered charges can be included as uninsured charges in column 1 of line 20 if this provision is included as a component of the hospital's charity care policy.

In 2022, CMS introduced Transmittal 18, which required identification of certain non-covered charity charges in a new line, 25.01. Specifically, line 25.01 reflects any medically necessary insured liability amount that was not related to the insured's deductible, copayment or coinsurance amount. Line 25.01 also consolidates into line 20, column 2. These amounts are reduced by the CCR, similar to line 20, column 1, but reported under column 2. This new requirement created large fluctuations for cost reporting periods beginning on or after Oct. 1, 2022, in amounts previously reported on line 20, column 1 and now reported on line 20, column 2.

Amounts on line 20, column 2 should represent the insured patient's deductible, copayment and coinsurance amount written off to charity. Hospitals should consider including language in their charity care policy to address how remaining balances on medically necessary care are considered for financial assistance. Line 20, column 2 amounts, less amounts recorded on lines 25 and 25.01, are not reduced by the CCR. These amounts are subject to a higher level of scrutiny during audit, since the cost directly impacts line 30.

Preparers must consider how line 20, columns 1 and 2; line 25 and line 25.01 will be audited in the future. Since line 25 and line 25.01 data is now consolidated on line 20, column 2, hospitals should closely monitor their reporting and auditing practices. Different types of non-covered charges and associated lines are described in Table 2.

Table 2. Placement of Non-covered charges on Worksheet S-10, Part I

LINE	NON-COVERED CHARGE
25	MEDICAID EXHAUSTED BENEFITS DUE TO LENGTH OF STAY
25.01	INSURED NON-COVERED AMOUNTS
20, column 2	INSURED DEDUCTIBLE, COPAYMENT AND COINSURANCE AMOUNTS APPROVED FOR CHARITY CARE*

**Lines 25 and 25.01 consolidate into line 20, column 2. Insured deductible, copayment and coinsurance amounts approved for charity care can be isolated by subtracting charges in lines 25 and 25.01 from line 20, column 2.*

SECTION 3:
IMPLICATIONS FOR DATA USERS

SECTION 3: IMPLICATIONS FOR DATA USERS

This guide aims to promote an understanding of Worksheet S-10's usefulness, limitations and sources of measurement error, and is intended to support informed decision-making about using Worksheet S-10 data in policy contexts. It discusses activities, inferences or conclusions that may or may not be supported by its use. We encourage users of Worksheet S-10 data to reference this section to ensure data are applied and interpreted with appropriate context. Support and evidence for statements in this discussion are presented in the preceding two sections.

For Medicare cost report years prior to publication of this guide, data users should be aware of the diversity in reporting practices throughout the hospital industry. Prospectively, this guide identifies and attempts to increase use of identified best practices for recording Medicaid payments on Worksheet S-10. However, no hospital or preparer is bound by the suggested conventions in this guide, and data users cannot assume uniformity in subsequent years.

Worksheet S-10 data reflect hospitals' unique charity care policies and safety-net payment opportunities.

1. **Variation in charity care amounts between hospitals – even similar hospitals – is normal and expected.** Different charity care policies lead to differences between hospitals in estimated charity care costs as reported on Worksheet S-10. Individual hospitals have appropriate reasons for maintaining individualized charity care policies, which is discussed in detail on pages 4-5. Therefore, patients eligible for free or discounted care in one hospital would not be expected to be eligible in all hospitals. Patient accounts classified as charity care in one hospital could be recorded as bad debt expense in another hospital. Hospitals serving communities with comparable social and economic profiles may deliver different amounts of charity care, and systems comprised of multiple hospitals may also report an overall valuation of charity care that is not uniformly distributed between component facilities. To the extent Worksheet S-10 data conveys such variance, it should be considered a normal output intrinsic to charity care delivery and record-keeping.

2. **Hospitals' charity care percentages must be presented in context.** One common practice to standardize and compare charity care amounts is to express a hospital's annual gross charges associated with services rendered to patients who qualify for charity care as a percentage of total annual gross patient revenue. Another common practice, used in Texas regulatory contexts, is to express annual charity care costs as a percentage of total net patient revenue.[5]

[5] **This method corresponds to the charity care percentage in Texas Health and Safety Code §311.045 as measured by the Annual Statement of Community Benefit Standard administered to nonprofit hospitals.**

Charity care percentages are used in policy contexts to draw inferences about charity care sufficiency by comparing hospitals to each other or to an external benchmark. However, even when charity care values are standardized, the usefulness of comparisons between hospitals can be diminished by dissimilarity in charity care policies, communities served, ownership type and services offered. In general, a hospital's charity care percentage is an output unique to that hospital. Comparing a hospital to itself to demonstrate change over time may carry more validity than comparisons between hospitals.

3. **All types of Texas hospitals – not just nonprofits – benefit from delivering charity care according to their policies.** There is little incentive to forego charity discounts to patients in financial hardship. When a patient owes a balance they have not paid or cannot pay, hospitals either incur expenses related to pursuit of the debt or bear the full cost of an uncollectible debt. Conversely, a hospital incurs no collection costs on the discounted portion of a charity care patient's bill. Further, Texas Medicaid computes the 1115 waiver UC pool payment based only on uninsured charity care cost; bad debt cannot be claimed for UC pool reimbursement. Non-duplicated uninsured charity care costs can also be reimbursed through Texas' Medicaid disproportionate share hospital (DSH) payment formula. Therefore, Texas hospitals *with and without* charitable missions are incentivized to:

    - Set charity care policies that apply broadly to patients who demonstrate financial hardship;
    - Correctly identify charity-eligible patients when they present for care;
    - Ensure charity-eligible patients receive the full discount available under the policy; and
    - Record charity costs comprehensively on Worksheet S-10.

Proper recording of charity care limits the cost of collection activities, reduces bad debt and increases available reimbursement remedies. For nonprofits, these benefits also encompass tax exemptions maintained by delivering legally required charity care.

The overall cost-to-charge ratio contributes to imprecision in Worksheet S-10 data.

1. **Use of the overall CCR creates measurement error.** The CCR used in Worksheet S-10 is a simple and standardizable conversion factor. Its calculation methods, however, introduce predictable sources of measurement error. In the case of non-allowable costs, the error is directional and systematically underreports aggregate Medicaid, indigent care and uncompensated care costs. These costs include physician professional fees and overhead to non-reimbursable cost centers like employee benefits, capital costs and administrative expense.

This guide does not dispute CMS's cost report procedures or allocations. However, it emphasizes reasons the CCR can lack precision in determining a hospital's true Medicaid and uncompensated care costs. Taken together, the limitations of the overall CCR and the known costs it excludes reduce its accuracy. This has implications for regulatory and legislative activities using Worksheet S-10 data.

2. **CCRs for charity-heavy departments can differ meaningfully from the overall CCR.** In Texas hospitals, Medicaid and uninsured charity care patient volumes tend to be highest in certain cost centers corresponding to patient populations most likely to demonstrate eligibility for charity care or public programs. These include labor and delivery, emergency department and outpatient clinic settings. Department-specific CCRs for service lines with high Medicaid and uninsured volumes may differ significantly from the overall CCR of the hospital or hospital complex.

   Using the overall CCR when costs and charges in the most relevant cost centers are known to share a different ratio will affect individual hospitals' uncompensated care cost estimates on Worksheet S-10.

   Data users should be aware of the extent to which the overall CCR introduces error into a hospital's estimated uncompensated care cost. The error will be proportional to the difference between the hospital's overall CCR and the departmental CCRs of its Medicaid- and uninsured-heavy cost centers.

   We note that some existing regulatory applications of Worksheet S-10 data *do* employ departmental CCRs for more precise cost estimation. An example is Texas' Medicaid DSH and UC pool payments, which calculate cost by cost center and use cost center-specific CCRs. Our comments and cautions here pertain to analyses and regulatory activities that **do not** use departmental CCRs.

3. **Exclusion of non-allowable costs underestimates hospitals' true cost of care.** The overall CCR does not produce a true reflection of the overall cost incurred to provide care, but rather reflects the allowable costs incurred to provide care. Costs in the CCR numerator exclude Medicare non-allowable costs that comprise a significant portion of a hospital's overall costs. Excluding these costs lowers the CCR and contributes to systematic underreporting of the true costs of uncompensated and indigent care on Worksheet S-10. In three such cost centers – capital, employee benefits and administrative and general costs – the magnitude of cost underreporting is 10-12% on average in each cost center. Even if the overall CCR is not used in a particular Medicaid reimbursement, as is the case with Texas Medicaid DSH and UC payments, the departmental CCRs

also do not reflect non-allowable Medicare costs. Supplemental payments calculated based on Worksheet S-10 estimates of uncompensated and indigent care values are, therefore, likely to under-reimburse providers' true costs proportional to the difference between total costs and Medicare-allowable costs.

Data users should bear in mind that the cost inputs in the CCR are aligned to CMS's use of Worksheet S-10 specifically to calculate Medicare disproportionate share hospital reimbursement. The exclusion of Medicare-disallowed costs in this singular context does not mean those costs are insignificant to hospitals or that they should necessarily be discounted in other policy activities where Worksheet S-10 data are used.

Worksheet S-10 data must be presented in context of the Texas Medicaid payment environment.

1. **Medicaid losses can appear artificially reduced due to charity care pools and self-financed amounts.** Texas disburses billions of dollars to hospitals for care of Medicaid and non-Medicaid patients in base rates and across multiple supplemental Medicaid programs. To the extent Texas hospitals' Medicaid business does not result in substantial losses on Worksheet S-10, it is an artifact of Texas' Medicaid programs and financing, not underlying profitability of payments for care.

Two features of Worksheet S-10 distort the losses (or gains) Texas hospitals record in Medicaid:

- Payments for uninsured charity care that flow through Texas' UC pool and a portion of the DSH program are appropriately recorded as Medicaid payments.
- Hospitals self-finance the non-federal share (about 40%) of Texas' hospital supplemental payments through IGTs and local provider assessments. Hospitals demonstrate diversity of practice in netting IGTs and provider assessments from their recorded Medicaid payments, with many recording them as a cost elsewhere on the cost report. Hospitals that have made a historical practice of not netting out their IGT or provider assessments are recording more net revenue, including a self-financed portion, than those who net out their assessments.

Texas' directed payment programs can augment Medicaid base rates up to 90% of average commercial rates, and comprise the largest pools of gross supplemental dollars. However, directed payments are not the primary driver of high Medicaid net revenue in Worksheet S-10 data. Medicaid directed payments pay Texas hospitals about 80-90% of what Medicare would have paid for the same services when provider tax amounts are removed, as CMS instructs.[6]

[6] **Policy options for improving the transparency of Medicaid financing. (MACPAC, 2024).**

Data users must interpret Medicaid payment data with care to avoid misleading inferences about Medicaid revenues, adequacy of base payments, cost growth and margins.

2. **Worksheet S-10 lacks detail on Medicaid supplemental payments.** Each hospital is eligible for and receives different supplemental payments. Each preparer records supplemental payment amounts differently based on choices available under the CMS instructions. Aside from total net revenue, no reliable inferences can be made about how supplemental payments are characterized.

3. **Medicaid supplemental payments can vary considerably from year to year.** State actions to modify Medicaid base rates are infrequent, but supplemental Medicaid payments can change considerably from year to year in amount, purpose and timing. When interpreting Worksheet S-10 data, it is important to understand which Medicaid supplemental payments were in place for any given cost reporting period and which hospital classes received them. Hospitals' cost reporting periods differ from state fiscal years, meaning two sets of supplemental payments could be represented in a single cost report. This guide recommends using multi-year averages, as available, to account for annual fluctuation in Medicaid payment changes.

4. **Nonpaid Medicaid claims and insured non-covered amounts written off as charity are a form of uncompensated care.** Medicaid can be loss-making in several ways, including payment rate shortfalls and nonpaid claims. Many nonpaid claims arise from Texas' restrictive spell-of-illness limitation, previously discussed in the Medicaid portion of Section 2. Therefore, not all Medicaid losses are apparent in the Medicaid lines of Worksheet S-10, as charges related to non-covered and nonpaid Medicaid claims are recorded in line 25 under uncompensated care.

   We recommend that insured non-covered charge amounts recorded on line 20, column 2 (inclusive of amounts on lines 25 and 25.01) should be incorporated in definitions of charity care for regulatory purposes and supplemental payment calculations. Insured non-covered charges – such as Medicaid exhausted benefits and patient cost-sharing written off as charity care in accordance with a provider's financial assistance policy – are a form of charity care CMS clearly recognizes and separately identifies on Worksheet S-10. An example of an exercise where this is appropriate is the UC pool size determination.

   Data users should be cognizant of changes to reporting of non-covered charity amounts following the introduction of Transmittal 18 for cost reporting periods on or after Oct. 1, 2022.

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