CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

January 11, 2021

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314-G
Washington, D.C. 20201

***Subject: Proposed Changes to CMS 2552-10 Hospital and Health Care Complex Cost Report (OMB Control Number 0938–0050)***

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) is pleased to submit comments on the proposed changes to the Hospital and Health Care Complex Cost Report. CHA appreciates the intent of the proposed changes and strongly supports efforts to further standardize data collected via patient logs and improve the accuracy of data reported to the Centers for Medicare & Medicaid Services (CMS).

However, as discussed in detail below, CHA is concerned that many of the proposed changes will unnecessarily increase administrative burden while creating additional ambiguity related to how certain data elements should be submitted to CMS as part of a cost report filing. CMS estimates these changes will increase the time required to file a cost report by 21 hours (from 673 to 694 hours). **CHA believes CMS greatly underestimates the additional unnecessary burden added by worksheet S-12 and the new data fields added to schedules that support the disproportionate share hospital (DSH) calculation and uncompensated care reported on worksheet S-10. CHA estimates that worksheet S-12 alone will cost hospitals nationally $111 million per year to prepare and respond to anticipated Medicare administrative contractor (MAC) audits of this data.**

To reduce the administrative burden on hospitals and improve the accuracy of data collected by the Medicare cost report, CHA asks that CMS change its proposals for the following worksheets:

- S-12: At a minimum, delay implementation of worksheet S-12 for two years to complete impact modeling and resolve technical issues associated with consistently and accurately collecting Medicare Advantage (MA) MS-DRG payer-specific negotiated charges from hospitals
- S-2: Eliminate unnecessary new data elements
- S-10: Remove verbiage from instructions that will cause confusion at audits and modify the worksheet to improve the accuracy of the calculation of bad debt expense
- Exhibits 2A (Listing of Medicare Bad Debts), 3A (Listing of Medicaid Eligible Days for DSH Eligible Hospitals), 3B (Charity Care Listing), and 3C (Listing of Total Bad Debts): Eliminate unnecessary data elements that have been added

499 So. Capitol Street SW, Suite 410, Washington, DC 20003 • *Telephone:* 202.488.3740 • *Facsimile:* 202.488.4418
1215 K Street, Suite 800, Sacramento, CA 95814 • *Telephone:* 916.443.7401 • *Facsimile:* 916.552.7596 • www.calhospital.org
*Corporate Members:* Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

- D-4: Clarify key terms

Below, please find CHA's specific concerns and recommendations.

## Worksheet S-12

CMS adds worksheet S-12 to facilitate the collection of hospitals' median MA MS-DRG payer-specific negotiated charges with the stated intent of using the data to rebase Medicare fee-for-service MS-DRG weights starting in federal fiscal year (FFY) 2024. **As discussed in our comments on the FFY 2021 inpatient prospective payment system (IPPS) proposed rule, CHA strongly opposes this requirement.** CMS has not studied nor provided a serious rationale for requiring hospitals to report the median negotiated charge data, apart from potentially changing the manner in which MS-DRG weights are established. This change in the methodology is not supported by the Medicare Act. A data request from hospitals of this size and magnitude to facilitate a significant policy change that is neither proven to be valid payment policy nor supported by statute is counter to the goals of the Paperwork Reduction Act and CMS' Patients Over Paperwork Initiative.

Additionally, this is just one of three requirements CMS is making of hospitals and health plans related to price transparency. The two others are:

- *Hospitals*: Effective January 1, 2021, hospitals are required to make their third-party payer-specific negotiated charges for items and services publicly available online in a comprehensive machine-readable file that includes standard charges for all hospital items and services, and post a searchable display of standard charges for at least 300 "shoppable" services. Standard charges are defined as the gross charge, payer-specific negotiated charge, de-identified minimum and maximum negotiated charges, and discounted cash price.

- *Health plans:* For plan years starting on or after January 1, 2022, health plans are required to make available to the public three separate machine-readable files that provide detailed price information. The first file contains detailed price information — including the negotiated rates — for all covered items and services for all in-network providers. The second file includes historical payments to out-of-network providers. The third file includes in-network negotiated rates for all covered prescription drugs at the pharmacy location level. Additionally, starting in plan year 2023, CMS is requiring health plans to make personalized out-of-pocket cost information (which includes the underlying negotiated rate) for 500 shoppable items and services available via an internet-based, self-service tool (or by request). The remainder of all items and services will be required for these self-service tools for plan years that begin on or after January 1, 2024.

CMS' stated intent in pursuing these three separate policies is to provide price data to inform patient decision making about where they should receive care. However, each of these requirements involves different definitions of price that will be made available to the public on different implementation time frames.

Given the lack of public education about these initiatives, CHA is deeply concerned that making different types of "prices" available to the public on separate time frames with no education about what these data elements represent and how best to use them will create more confusion for the public and make

it less likely that consumers and patients will use price data to make value-based choices about where to receive their care. For example, currently there is little appreciable effort on CMS' part to pair price data from health plans with quality data. **Therefore, CHA asks again that CMS withdraw its requirement that hospitals report median payer-specific negotiated charges by MS-DRG for MA plans on the cost report and delete the proposed worksheet S-12 from the revised cost report package.**

This requirement, on top of the price transparency requirements effective January 1, 2021, is duplicative and administratively burdensome for hospitals at a time when all available administrative and clinical resources should be focused on responding to the COVID-19 public health emergency (PHE). CMS has not provided any evidence that this change will result in more accurate Medicare IPPS payments to support this diversion of resources from the PHE. Furthermore, the median MA payer-specific negotiated charges that will be available through the public release of the Healthcare Cost Reporting Information System (HCRIS) files on a quarterly basis will not provide meaningful information to the average consumer attempting to make a value-based decision about where to receive their care. Rather, it will cause significant confusion and misinformation among those unfamiliar with this data set who attempt to merge it with other publicly available data.

CMS should take steps to minimize the risk of confusing the public and ensuring that the price data made available through its various initiatives has the desired impact and delay implementation of both the hospital and health plan transparency initiatives. The pause would allow CMS to work with relevant stakeholders (hospitals, health plans, consumers, and data aggregators) to develop an integrated strategy for educating the public and other data users about this incredibly complex information.

If CMS does implement this unsuitable policy to rebase Medicare FFS MS-DRG weights using median MA payer-specific negotiated charges, CHA believes the agency must, at a minimum, delay implementation for at least two years.

**The purpose of a delay is two-fold. First, CMS must use the time afforded by the delay to understand the payment impact of transitioning to MS-DRG weights based on median MA payer-specific negotiated charges on hospital payments for Medicare inpatient services.** And, as discussed below in point one, there are faster, less administratively burdensome ways for CMS to cost-effectively secure the data necessary for modeling this policy change than waiting to collect it from hospitals. **Second, CMS must use the delay to convene a workgroup to advise it on data definitions and collection methodology for the purposes of Medicare FFS MS-DRG weight setting.** The current instructions for this collection effort only address how to report data for MA inpatient services paid based on MS-DRGs. Given the lack of clarity in the current instructions and the wide variety of contract terms for inpatient services between hospitals and MA plans (discussed below in point two) CMS risks collecting inconsistently reported, unusable data. Below is a detailed discussion of what CMS will gain by delaying the implementation of worksheet S-12 for at least two years.

1) **CMS must understand the payment impact of transitioning to MS-DRG weights based on median MA payer-specific negotiated charges on hospital payments for Medicare inpatient services:** CHA believes CMS must model the impact of replacing the current system of cost-based MS-DRG weights with weights based on median MA payer-specific negotiated charges *before* taking on a costly nationwide data collection effort. Given that this policy change is clearly contrary to Section 1886(d)(4)(B) of the Social Security Act, which requires the Secretary

to establish MS-DRG weights based on relative resources used to treat patients, CMS must fully explore and understand the potential for arbitrary redistribution of IPPS payments, make the results of this modeling available for public comment, demonstrate how this new methodology is more accurate than the current methodology and comports with the Medicare statute, and does not inadvertently redistribute payments causing harm to already fragile hospital finances.

Importantly, CMS does not need to collect the data from hospitals to model this change in policy. MA claims data are widely available to the agency as evidenced by the studies referenced in the FFY 2021 IPPS final rule. **CHA strongly recommends that CMS obtain data from a reliable third-party entity or require MA plans to report claims data to CMS to facilitate the study and inform the stakeholder workgroup described in point two.** Obtaining these data from a reliable third-party entity or MA plans will allow CMS to begin modeling this policy immediately. Otherwise, given this reporting requirement applies to cost reporting periods ending on or after January 1, 2021, CMS will not have the data necessary to model this policy until the June 30, 2022, update of the HCRIS, at the earliest. Additionally, any data in the June or September updates of the HCRIS collected from worksheet S-12 will be unaudited.

Given this is a new requirement for hospitals, and CMS has provided limited instructions for the completion of worksheet S-12 (additional detailed comments and examples below), it is likely these data will need to be audited to ensure they are reported consistently across hospitals. This will be a costly and time-consuming effort. The agency and its contractors have few resources to ensure that data are valid and reported consistently. **A nationwide collection effort should be undertaken only when additional information is known about the appropriateness and viability of using median MA MS-DRG payer-specific negotiated charge data to set FFS MS-DRG weights; anything less would be a misuse of taxpayer and limited provider resources. At this time, the utility of this information for weight setting is completely unknown.**

Additionally, CHA believes it is more cost effective for the program and minimizes the administrative burden on hospitals if CMS acquires the data for modeling this new methodology for weight setting from either a reliable third-party entity or the MA plans. In the FFY 2021 IPPS final rule, CMS estimates that this requirement will cost hospitals approximately $4.3 million nationally to comply.

In the FFY 2021 IPPS final rule, CMS minimizes the administrative burden of the requirement to report median MA payer-specific MS-DRG negotiated charges by stating that hospitals can use the data they have aggregated to comply with CMS' hospital price transparency final rule requirements that are effective on January 1, 2021. CHA believes CMS significantly understates the true cost of reporting data that will be used for rate setting.

CMS is correct in noting that, as part of the price transparency mandate, hospitals are required to update, at least annually, the posted payer-specific negotiated charge information. However, unless a hospital continually updates the files that are publicly available — which would significantly and unnecessarily increase the administrative burden and cost of complying with CMS' hospital price transparency requirement — hospitals will need to run a specific analysis of their MA claims volume and the contractual rates for each separate contract in effect for the dates of service in question. As CMS is aware, MA contracts between hospitals and health plans

are not static. They typically have annual updates to negotiated rates to account for input cost inflation and other changes in resource use. The timing of these updates is unique to each MA plan/contract and will occur throughout the course of a hospital's fiscal year. Therefore, hospitals will need to replicate the analysis necessary to create the price transparency files in order to accurately complete worksheet S-12 when the Medicare cost report is prepared.

This will require hospitals to map each MA beneficiary discharge back to the payer-specific negotiated charge contractually in effect at the time of discharge for each MA contract. For contracts that are not based on MS-DRGs, hospitals will further need to determine the appropriate payer-specific negotiated charge to report and map that amount to the corresponding MS-DRG. Therefore, much of the cost associated with developing and updating the machine-readable file of payer-specific negotiated charges for the price transparency mandate will need to be re-incurred if a hospital is to complete worksheet S-12. Many hospitals outsourced the creation of the standard charge files necessary to comply with the hospital price transparency mandate to external consultants due to the complexity of the data analysis required. CHA estimates that this component of the price transparency requirement costs $8,000 per hospital. Given the data analysis necessary to report the data requested on worksheet S-12 is similar, CHA anticipates that hospitals will outsource the creation of MA MS-DRG median payer-specific negotiated charge files. **Based on the cost to create the standard price transparency file, this will cost $25.5 million per year nationally.**

Additionally, given that CMS' stated intent is to use the data to set MS-DRG weights, it is imperative that it is reliable and valid. This will require MACs to audit the data to ensure accuracy. Given the dearth of detailed instructions for the proposed worksheet S-12, CHA is concerned there will be significant, unintentional variance in how this worksheet is completed. Normalizing these variances, if possible, will greatly increase the administrative burden on hospitals and require additional MAC audit resources that are already stretched thin. Even with some normalization at audit, it will still require the commitment of significant time and effort on the part of CMS' analysts to minimize the impact of data anomalies when attempting to develop MS-DRG weights based on median MA payer-specific negotiated charges.

CHA believes the best analog for the potential resources required by hospitals to respond to audits of the data that will be submitted on worksheet S-12 is the recent experience with worksheet S-10. CHA estimates that current audits of worksheet S-10 cost an average of $27,000 (including staff time and external consultant support) per hospital. Applying this cost to the 3,189 hospitals subject to reporting data on worksheet S-12 results in an estimated audit cost nationally of $85.6 million per year. When added to the estimated cost per year for hospitals to prepare worksheet S-12, the total national cost of this data collection effort is $111 million annually. Given hospitals' limited resources and the magnitude of the current pandemic, these funds would be better spent responding to the COVID-19 PHE. Additionally, as discussed above, there are faster, more cost-efficient ways for CMS to acquire the data necessary to model this policy than mandating that hospitals submit it as part of their Medicare cost report. **Because of the considerable, unnecessary administrative cost associated with this requirement, CHA strongly recommends that CMS delay the implementation of worksheet S-12 and explore collecting these data from a reliable third-party entity or require MA plans to report the data to CMS so it can model this policy change.**

2) **Convene a workgroup to advise CMS on data for the purposes of Medicare FFS MS-DRG weight setting:** If CMS persists in implementing MS-DRG weight setting based on MA payer-specific negotiated charges, it should convene a workgroup that includes relevant staff from CMS, Medicare IPPS and MA payment policy experts, and representatives from hospitals who have subject matter expertise in financial operations, Medicare cost reporting, and MA contracting. The workgroup must identify the best source (or sources) for these data and then develop standardized instructions for collecting the data to ensure the MA MS-DRG median payer-specific negotiated charge is reported and aggregated accurately.

   **To ensure the reliability and validity of the data, CMS must consult with the workgroup and provide additional examples of how health plans and hospitals currently contract for inpatient services in order for hospitals to accurately and consistently determine the median MA payer-specific negotiated charge.** It is unclear from the current, limited instructions how the following types of payment models/methodologies would be captured and reported.

   - *Percent of charge contracts*: **For MA plans that use a percent of charge methodology to pay for inpatient services, how should discharges be incorporated into the median calculation and reported to CMS? CHA recommends that CMS calculate the average payment amount for each MS-DRG for discharges that occur during the reporting period in question.** The average amount would then be added to the list used to derive the median amount, along with the negotiated amounts from other payers.

   - *Per diem contracts*: **For MA plans that use a per diem methodology to pay for inpatient services, how should discharges be incorporated into the median calculation and reported to CMS? CHA recommends that CMS calculate the average payment amount for each MS-DRG for discharges that occur during the reporting period in question.** The average amount would then be added to the list used to derive the median amount, along with the negotiated amounts from other payers.

   - *MS-DRG contracts with quality adjustments/add-on payments*: Many hospitals' MA contracts that pay for inpatient services based on MS-DRGs also include programs that adjust the base payment rate for various quality metrics. These adjustments are similar to the Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and hospital-acquired condition penalty. These contracts may also have policy-based add-on payments analogous to disproportionate share and indirect medical education adjustments.

     **Should quality adjustments and add-on payments be included in the amounts used to calculate and report the median MS-DRG MA payer-specific negotiated charge to CMS? CHA believes this is a key question that CMS must resolve when it models the payment impact of rebasing MS-DRG weights on median MA payer-specific negotiated charges**.

     - *Shared risk contracts*: Some hospitals participate in shared risk contracts with MA plans. While these shared risk contracts include a mechanism to pay for acute, inpatient services, they are based on the total cost of care for all services provided by the

hospital. Following is a high-level summary of a common shared risk contracting model for inpatient services between an MA plan and a hospital:

*An MA plan pays the hospital a percentage (e.g., between 50% and 75%) of the Medicare FFS MS-DRG payment when the patient is discharged. This payment may or may not have add-on payments and quality adjustments as described above. At the end of the contract year, there is a reconciliation between the MA plan and provider. If the MA plan achieves savings relative to an overall target for the population of patients who received services from the hospital or were attributed to the accountable care organization (ACO) in which the hospital participated, there is a lump sum shared savings payment from the MA plan to the hospital or ACO. If the contract includes two-sided risk, there could be a lump sum payment from the ACO to the MA plan if the total cost of care for the attributed population exceeds the benchmark. Given that this lump sum payment is for all services provided by the hospital or ACO in which the hospital participates, allocating any shared savings or loss to an individual patient discharge or encounter will be extremely difficult to do with any degree of accuracy from a resource utilization perspective.*

**CHA recommends that CMS clarify the instructions for shared risk contracts that are conceptually similar to the one described above by requiring hospitals to report 100% of the payer-specific MS-DRG negotiated charge**. **CHA believes this will be less burdensome administratively and will more accurately reflect the resources required to deliver inpatient acute care.**

**CHA notes that this list of issues is not intended to be exhaustive but is provided to illustrate the complex technical issues that must be resolved before data related to median MS-DRG MA payer-specific negotiated charges can be reliably collected.** It is likely the workgroup, through its discussions, will surface additional technical issues related to payment mechanisms and reporting formats that need to be addressed to ensure the accuracy of the data CMS intends to use to rebase MS-DRG weights starting in FY 2024.

**Once all technical issues are resolved, CHA believes that CMS must allow for a significant period of education for the stakeholders who will be required to report data prior to the initial data submission deadline. Furthermore, CHA strongly encourages CMS to proactively provide meaningful education related to this change.** As demonstrated by the issues discussed above, vehicles like the Paperwork Reduction Act are not sufficient enough for the type of dialogue to successfully implement a change as significant as switching the data source used for rebasing MS-DRG weights. Timely and repeated stakeholder engagement is needed to ensure that any data collected are reliable and valid for the purposes of weight setting.

### Worksheet S-2

CHA is concerned with the following proposed changes to worksheet S-2:

**Lines 24 (Acute Medicaid Days) and 25 (Inpatient Rehabilitation Facility Medicaid Days):** The instructions for lines 24 and 25 instruct hospitals to separately report Medicaid FFS in-state paid days,

Medicaid FFS in-state eligible unpaid days, Medicaid out-of-state days paid, Medicaid put-of-state ineligible days unpaid, Medicaid HMO days, and Medicaid other in columns 1-6.

While this has been a longstanding reporting requirement, CHA questions why hospitals are asked to report separately on these items. **CHA asks CMS to simplify reporting and reduce administrative burden by consolidating the columns reported on worksheet S-2, lines 24/25 and in Exhibit 3A into one column for all Medicaid days**. **If CMS does not adopt this proposed change, CHA asks CMS to clarify where out-of-state HMO days and HMO eligible but unpaid days should be reported.**

**Line 89, column 2 (TEFRA Adjustment Date):** Given that approval for many of the permanent adjustments to the TEFRA targets were granted a decade or more ago, CHA is concerned there may be some hospitals that no longer know the specific date on which the permanent adjustment was granted. In many instances, the individuals who are familiar with the circumstances of how and when the hospital received the adjustment left the organization years ago and when they did, the institutional knowledge was lost. Furthermore, CMS already has this information. **Therefore, CHA asks CMS to delete column 2 on line 89 on worksheet S-2. If CMS does not delete this column, we ask that it require the MACs to provide hospitals with a copy of this documentation.**

**Line 123 (Purchased Administrative Services): CHA questions the need for this newly added line and believes it adds significant administrative burden without improving the quality of data collected by the cost report to set Medicare payment rates for services delivered by hospitals and their sub-providers.** Almost all hospitals use purchased legal, accounting, tax preparation, bookkeeping, payroll, and management consulting services. Hospitals do not track the percentage of services that are "purchased from an unrelated organization located in a CBSA outside of the main hospital CBSA." Furthermore, even determining this percentage is a complex undertaking. Many firms that provide these services are either regional or national. While a regional or national firm that a hospital engages for services may have a "local office" in the hospital's CBSA that the hospital "contracts with," in many instances — due to the complexity of tax, accounting, and regulatory rules impacting hospitals and health systems — the staff that will work on a given project may not be based entirely in the local office. This adds significant complexity to determining what percentage of a hospital's purchased administrative services from unrelated organizations are procured from outside of the hospital's CBSA.

Additionally, this question appears to be informational in nature, and CMS does not provide any rationale for collecting this data. **Given the burden required to answer this question and its informational nature, CHA strongly opposes the addition of line 123 and asks CMS to remove this question from worksheet S-2.**

### Worksheet S10: Hospital Uncompensated Care and Indigent Care Data

CHA has concerns with several of the changes CMS proposes to the opening text and definitions for worksheet S-10.

**Opening paragraph**: CMS adds the following sentence to the first paragraph of the instructions for worksheet S-10:

> *CMS does not mandate the eligibility criteria that a hospital uses under its financial assistance policy.*

CHA appreciates and supports the added language, however, this statement is insufficient. **CHA strongly recommends CMS add clear language to the S-10 instructions to affirmatively state that hospitals may qualify individuals as being eligible for their charity care/financial assistance policies using a presumptive eligibility tool, if the use of that tool is specifically referenced in the hospital's charity care/financial assistance policy.**

Many hospitals use tools based on publicly available and proprietary data to determine if a patient qualifies to receive charity care under the hospital's charity care/financial assistance policy. The use of these tools reduces the administrative burden on both the hospital and patient. It also increases the accuracy of charity care determinations, as many patients who are eligible for charity care do not apply, or if they do apply, are unable to provide the required documentation despite multiple attempts by providers to educate patients on both the availability of charity care/financial assistance and process for applying.

**Revised definitions**: CMS revises the definitions of charity care and uninsured discounts to include the phrase "*medically necessary health care."* **CHA strongly opposes the addition of this language and asks that CMS delete it from the revised worksheet S-10 definitions and subsequent instructions (line 20, parts A, C; Line 25.01; Exhibit 3B – Cols 6, 16).** CHA is deeply concerned that this will result in charity care/financial assistance being disallowed due to a difference of opinion between a MAC auditor (who will not know the particular details of a clinical situation and likely not have a clinical background) and the hospital as to what constitutes "medically necessary health care services." Few, if any, hospitals' charity care/financial assistance policies provide relief for health care that is not medically necessary (e.g., plastic surgery undertaken for purely cosmetic reasons not related to a disfiguring disease or traumatic accident). Therefore, we do not believe the addition of this language is necessary, and it could lead to arbitrary disallowances of charity care/financial assistance claimed on worksheet S-10 in accordance with its policy.

**Line 20 (Charity care charges and uninsured discounts): CHA asks CMS to strike all instances of the phrase "*if such inclusion is specified in the hospital's charity care policy or FAP"* from worksheet S-10 and Exhibit 3B instructions.** CHA is deeply concerned that this language could be erroneously interpreted and extended to other similar situations as described in the instructions for line 20. Should this occur, it would require hospitals to describe a wide variety of clinical/insurance coverage scenarios in their policies to ensure that a patient who meets the financial criteria to receive charity care/financial assistance can be included in the amounts claimed on worksheet S-10 line 20. **CHA believes the important fact in the determination of whether a patient's amount should be included on line 20 is that the patient has an outstanding balance related to services rendered and meets the financial criteria set forth in the hospital's financial assistance/charity care policy, not that the balance was the result of a payer's administrative policy.** Failing to remedy this increases hospitals' administrative burden and could result in arbitrary disallowances of eligible charity care from worksheet S-10 stemming from an auditor taking an expansive interpretation of the instructions for line 20.

Finally, CHA believes that CMS could simplify reporting on line 20 by redefining column 1 (Uninsured Patients) and column 2 (Insured Patients). Column 2 is currently defined to include deductibles, copayments, and coinsurances for insured patients as well as non-covered charges for days exceeding

length of stay (LOS) limits for Medicaid and other indigent care programs, and charges other than deductibles and coinsurance, and co-payment amounts that represent the insured patient's liability.

**CHA asks that CMS redefine column 1 as gross charges written off to charity care for uninsured individuals, insured individuals with charges for non-covered services or days that exceed a LOS limit, and gross charges other than cost sharing. Column 2 should be redefined as cost sharing (deductibles, copayments, and coinsurances) for insured patients. Redefining these columns will simplify cost report preparation and reduce the likelihood of error.** CHA also notes there is no known reporting standard for the determination of amounts that are charges "other than deductible, coinsurance, copayment" amounts. CHA recommends CMS propose a threshold to determine when an insured charity amount is likely charity copayment, coinsurance, or copayment as compared to other charity charges for the insured patient. For instance, CMS may consider a threshold for auditing any reported amounts on line 20, column 2 that are greater than 25% of total hospital charges. **If CMS accepts this change, it should also delete lines 24–25.01 from worksheet S-10.**

**Line 29 (Cost of non-Medicare and non-reimbursable Medicare bad debt expense)**: While CMS updates the instruction text for lines 26–27.01, the proposed changes do not address a material flaw in the calculation of the cost of non-Medicare and non-reimbursable bad debt expense.

Line 26 of worksheet S-10 includes charges for patients for whom the full balance was written off to bad debt expense, as well as for patients where only cost sharing was written off to bad debt expense. Line 27 captures reimbursable Medicare bad debts. Line 27.01 captures Medicare allowable bad debts.

For cost reporting periods beginning on or after October 1, 2013, line 28 calculates non-Medicare bad debt expense by subtracting line 27.01 from line 26. This amount is then multiplied on line 29 by the hospital's cost-to-charge ratio (CCR) on line 1 and added to the difference between lines 27 and 27.01 to calculate the cost of non-Medicare and non-reimbursable Medicare bad debt expense.

First, applying a hospital's CCR to the amount on line 28 as part of the calculation of line 29 will calculate an amount materially less than the cost of providing the care. It is technically incorrect, as it mixes "apples and oranges." The CCR is the relationship between a hospital's cost and its charges in a given cost reporting period. It can be used to arrive at a proxy for a hospital's cost of services provided to a patient if it is multiplied by the hospital's gross charges from that same period. For instance, a hospital's ratio may reduce $1 of gross charges to $0.20 of cost. However, deductibles, coinsurances, and copayments are not marked up to reflect the gross charge amount. Therefore, it is inappropriate to attempt to arrive at the cost of bad debt expense by multiplying uncollectible deductibles and coinsurance based on the payment rate times a hospital's CCR. Doing so understates the true expense of forgone revenue resulting from uncollectible accounts. Given the increased cost sharing many insured individuals currently face, a growing portion of a hospital's bad debt is related to deductibles, coinsurance, and copayments.

**CHA asks CMS to create separate columns for insured and uninsured patients on lines 26 through 29. The column for uninsured patients should be multiplied by a hospital's CCR to arrive at the cost of bad debt. The column for insured patients (which will consist of deductibles, copayments, and co-insurance) should not by multiplied by the CCR.** This approach is similar to the one taken by CMS on worksheet S-10, lines 20-23, for charity care/financial assistance.

**Finally, if CMS accepts the proposed redefinitions discussed above for worksheet S-10, line 20, columns 1 and 2, CHA recommends that CMS define the newly created bad debt columns similarly. Column 1 should include amounts written off to bad debt at gross charges, and column 2 should include cost sharing for insured patients (deductibles, coinsurance, and copayments).**

### Exhibit 2A (Listing of Medicare Bad Debts)

In the FFY 2021 IPPS final rule, CMS amended the Medicare regulations to state that Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts (bad debts or, under the new Accounting Standards Update Topic 606 terminology, implicit price concessions). This change is effective for cost reporting periods beginning on or after October 1, 2020. **CHA asks that CMS acknowledge this change in Exhibit 2A and make necessary modifications to the instructions to clarify how this change will impact reporting for Medicare bad debts.**

**Column 7 (Medicaid Number):** The instructions require the Medicare beneficiary's Medicaid number if the beneficiary is dually eligible. In instances where the dually eligible beneficiary is covered by a Medicaid managed care organization (MCO), a hospital may not have the beneficiary's Medicaid ID number, as many MCOs have their own HIC or insurance ID number. **CHA asks CMS to clarify in the instructions that if a hospital does not have a dually eligible beneficiary's Medicaid ID number, it can report the MCO's HIC or insurance ID number. Furthermore, CHA asks CMS to make a conforming clarification in the instructions for Exhibit 2, line 4.**

**Column 16 (Collection Effort Cease Date):** CHA questions the need for column 16 on Exhibit 2A. The instructions for column 16 state, "*Enter the date all collection efforts ceased, both internal and external, including efforts to collect from Medicaid and/or from a state for its cost sharing liability.*" This date — in many instances — is the same date that will be reported in column 15 (Return Date from Collection Agency) and/or column 17 (Medicare Write Off Date). **Therefore, CHA asks that CMS eliminate this column. If CMS does not eliminate this column, the instructions must be clarified that it is acceptable for the date reported in column 16 to be the same as the dates in columns 15 and 17.**

### Exhibit 3A (Listing of Medicaid Eligible Days for DSH Eligible Hospital)

As discussed above in comments on Worksheet S-2 lines 24 and 25, CHA questions why hospitals report separately for Medicaid FFS in-state paid days, Medicaid FFS in-state eligible unpaid days, Medicaid out-of-state days paid, Medicaid out-of-state ineligible days unpaid, Medicaid HMO days, and Medicaid other. **CHA recommends CMS could simplify reporting and reduce administrative burden by consolidating the columns reported on worksheet S-2 lines 24/25 and requiring hospitals to complete only one Exhibit 3A. If CMS does not adopt this proposed change, CHA asks CMS to clarify where out-of-state HMO days and HMO eligible but unpaid days should be reported.**

**Additionally, hospitals are unable to get data from Medi-Cal until 13 months after the end of the year. This includes information on Medicaid eligible but paid days. Therefore, CHA asks that CMS clearly state in the instructions that hospitals may update the Medicaid days reported on Exhibit 3A, worksheet S-2, lines 24 and 25, and worksheet S-3 part 1, column 7 prior to the Medicare cost report audit.**

**Column 5 (Medicaid Number):** The revised instructions ask for the Medicaid recipient identification number in column 5. For Medicaid recipients covered by MCOs, the hospital may not have the Medicaid ID number, as MCOs frequently use their own their own HIC or insurance ID number. **CHA asks CMS to clarify in the instructions that if a hospital does not have a Medicaid recipient's ID number, it can report the MCO's HIC or insurance ID number in column 5 instead.**

**Column 10 (State Eligibility Code):** The instructions for column 10 state, "*Enter the applicable State plan eligibility code number.*"

**Hospitals are unable to get data from Medi-Cal until 13 months after the end of the year. This includes information on the beneficiary's plan eligibility code. First, CHA asks that CMS make this column optional when the Medicare cost report is filed for hospitals that cannot get this code from their state Medicaid program or Medicaid MCO(s). Second, CHA asks that CMS clearly state in the revised instructions that hospitals may update the Medicaid days reported on Exhibit 3A, worksheet S-2, lines 24 and 25, and worksheet S-3 Part 1, column 7 prior to the Medicare cost report audit.**

Medicaid recipients can have multiple state plan eligibility codes during the course of one inpatient admission when they have continuous Medicaid coverage. **CHA asks CMS to clarify in its instructions for column 10 how the plan eligibility code should be reported for inpatient stays when the patient has multiple eligibility codes for one stay.**

**Column 13 (Primary Payer) and Column 14 (Secondary Payer):** CMS instructs hospitals to include the names of the patient's primary and secondary insurance coverage in lines 13 and 14. **CHA questions the need for these columns and asks CMS to remove them from Exhibit 3A.** Inclusion in Exhibit 3A is predicated on the patient being Medicaid eligible. Furthermore, CMS captures Medicare eligibility in columns 15–17, which will allow it to identify any days during the patient stay that should be excluded from the DSH calculation due to Medicare eligibility.

**New Columns A (Presumptive Eligibility Baby) and B (Mother's Account or Control Number):** Currently there is no discussion of how presumptive eligibility for babies born to Medicaid-eligible mothers should be linked to their mothers' eligibility. **CHA recommends CMS add fields to indicate that a baby is covered under presumptive eligibility and report the account or control number for the babies' mothers.**

### Exhibits 3B (Charity Care) and 3C (Bad Debt)

Overall, and as supported by the details below, CHA recommends CMS continue using the current Figliozzi and Company schedules during audits instead of attempting to replace them with the proposed Exhibits 3B and 3C.

### Exhibit 3B (Charity Care Listing)

CHA is concerned the proposed Exhibit 3B is overly complex and attempts to capture a significant amount of extraneous information that will significantly increase hospitals' administrative burden when preparing this schedule. Additionally, CHA notes that the data provided in Exhibit 3B (or similar schedules currently in use) represent a snapshot in time of the patient account's status when the schedule was prepared. Any schedule filed with a Medicare cost report will need to be updated at audit to reflect changes in a patient's insurance coverage that impact charity care and financial assistance**.**

**CHA asks that CMS' instructions for Exhibit 3B include language that allows for updating this schedule to reflect subsequent changes in a patient's insurance status prior to an audit.**

**CHA believes that CMS should simplify the data submitted on Exhibit 3B when the cost report is filed.** The revised Exhibit 3B should be limited to the following fields when the cost report is submitted. We ask that CMS only require fields 1 through 4 only if they are necessary due to a potential HIPAA risk.

- 1: Last Name[1]
- 2: First Name[2]
- 3: Date of Admission[3]
- 4: Date of Discharge[4]
- 5: Patient Account Number
- 7: Name of Insurer
- 8: MBI
- 9: Medicaid Number
- 24: Total Charity Care Amount
- 25: Write Off Date
- 27: Payments Received

When the charity care or financial assistance claimed on a cost report is audited, there is an existing schedule in use by Figliozzi and Company to capture similar data. Hospitals have experience preparing these schedules. CHA also believes the Figliozzi and Company schedules related to uncompensated care provide more relevant data. This allows hospital staff and auditors to trace the various transactions (e.g., insurance payments, contractual allowances, patient payments, self-pay discount, charity care discount or financial assistance) that occur on a patient account and verify the accuracy of charity care or financial assistance included on worksheet S-10 line, 20. **Therefore, CHA recommends that CMS continue using the current Figliozzi and Company schedules during audits instead of attempting to replace them with the proposed Exhibit 3B.**

In addition to being overly burdensome for hospitals, Exhibit 3B as currently constructed has significant flaws. If CMS does not adopt the approach recommended above by CHA, it must address the issues with this exhibit that are discussed in the following pages.

**Column 6 (UI/INC):** The instructions for column 6 state:

> *Use this column when completing the charity care listing for uninsured patients to indicate if the patient was uninsured (UI) or insured but not covered (INC). Do not complete this column for insured patients. Enter UI if the patient did not have any insurance coverage. Enter INC if the patient –*
>
> - *had insurance coverage through an insurance company with which you do not have a contractual relationship,*

[1] Only if necessary, otherwise providing this data to MAC provides an additional HIPPA risk.
[2] Only if necessary, otherwise providing this data to MAC provides an additional HIPPA risk.
[3] Only if necessary, otherwise providing this data to MAC provides an additional HIPPA risk.
[4] Only if necessary, otherwise providing this data to MAC provides an additional HIPPA risk.

- *had insurance coverage and the services provided were medically necessary but not covered, or*
- *had insurance coverage and the patient had exhausted their benefits.*

CHA is concerned that column 6 will require some hospitals to manually capture this information for all of their uninsured accounts. In hospital patient accounting systems, this field is not universally populated, so completing it may require manual data entry for some providers. It is also unclear how providing these data will improve the accuracy of charity care reporting and the allocation of uncompensated care (UC) DSH payments. Summing the amounts for patients reported as insured but not covered will not tie into line 25.01 on worksheet S-10. Charges for patients who have coverage through an insurance company the hospital does not have a contractual relationship with are reported on line 20, column 1, which does not flow into line 25.01. Finally, CHA notes that this field is not currently captured in the current Charity Care Reporting schedule used by Figliozzi and Company during S-10 audits. **Therefore, CHA requests that CMS delete column 6 from Exhibit 3B given that the administrative effort required to collect this data far outstrips its value to CMS to improve the allocation of UC DSH payments.**

**Column 7 (NAME OF INSURER)**: **CHA recommends CMS issue clarification on the level of payer detail to report in this field.** For instance, many providers can simply classify payers between commercial, Medicare FFS, commercial Medicare, Medicaid FFS, Medicaid commercial, self-pay, and other. CHA asks CMS to confirm that this level of payer reporting is sufficient.

**Additionally, for column 7 CHA asks CMS to clarify in the instructions how hospitals should report patients who, during an inpatient admission, have multiple primary insurers.**

**Column 10 (Charity Care Determination – Approved):** CHA questions the need for column 10. If a patient is listed on Exhibit 3B, the hospital has already identified them as eligible for their charity care or financial assistance policy. **Therefore, this column is redundant, and CHA asks it to be removed. Completing the column creates unnecessary administrative burden for hospitals without providing CMS with useful additional information.**

**Column 11 (Charity Care Determination – Policy Under Which Approved):** While there may be some hospitals with separate charity care and financial assistance policies, the hospital industry uses the terms "charity care policy" and "financial assistance policy" interchangeably to refer to the documents detailing how a hospital will forgive or reduce charges for care provided to an individual who meets certain financial criteria. **Therefore, CHA recommends CMS delete this column as it adds administrative burden without improving the quality of data reported to CMS.**

**Column 13 (Deductible/Coinsurance/Copayment):** Many hospitals do not capture the amount owed by the patient for deductibles, coinsurances, and copayments in their patient accounting systems in a separate field. Hospitals have also reported different interpretations as to what constitutes a patient's "deductible;" in some cases a patient's deductible can be as much as $16,300 for a family for ACA-compliant plans[5]. This data element is currently not standard hospital reporting and subject to interpretation. This will result in administrative and operational difficulties involving manual

[5] https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

intervention to ensure the data are input correctly. It is also unclear from the proposed instructions for Exhibit 3B how this column is used. It currently does not feed into any subsequent calculation on Exhibit 3B and will not tie into worksheet S-10, column 2, line 20, given that a patient may receive partial charity care/financial assistance for their deductible, co-insurance, or copayment. Finally, CHA notes that this field is not currently captured in the current Charity Care Reporting schedule used by Figliozzi and Company during S-10 audits. **CHA recommends CMS delete this column, as it adds administrative burden without providing CMS with useful information.**

**Column 16 (Non-Covered Charges): Given CHA's previous comments about globally deleting references to "medically necessary health care services" in worksheet S-10 and this exhibit, CHA asks CMS to revise the instructions for this column to read as follows, "Enter gross charges not covered/not allowable under charity care/FAP."**

**Column 17 (Uninsured Discount): CHA asks that CMS clarify the instructions for column 17 by adding the following sentences: "*Do not report charity care or financial assistance granted to uninsured patients in column 17. Amounts for charity care or financial assistance should be reported in column 21*."** If CMS does not include this clarification in the instructions, CHA is concerned that some hospitals may accidentally report amounts related to charity care and financial assistance on this line. Doing so would, based on CHA's interpretation of the current instructions, inappropriately co-mingle self-pay discount amounts with amounts granted to the patient as charity care or financial assistance based on the hospital's policy.

**Column 18 (Contractual Allowance): CHA asks CMS to clarify in the instructions that it intends for all contractual adjustments to be included.** For example, some hospitals have a contractual adjustment code for the Medicare sequestration amount. Should amounts related to the contractual adjustment for sequestration be included in line 18 as well? Additionally, how should hospitals report contractual allowances when a payment is received from primary and secondary payers on a patient's account. It is presumed that both the primary and secondary payer contractual allowance should be reported in column 18. **CHA asks CMS to clarify these points in the revised instructions.**

**Column 20 (Gross Charges Net of Reductions):** CHA has multiple concerns with this column. First, there does not appear to be a column for gross charges for insured patients. **CHA recommends CMS add a column for reporting gross charges for insured patients or clarify in the instructions for column 12 that it can be used for both insured and uninsured patients, depending on which worksheet (insured or uninsured) the hospital is completing**.

Second, the instructions for column 15 could be interpreted to require that professional fees be excluded from column 12. However, the professional fees reported in column 15 are subtracted from column 12 in the column 20 calculation. If a hospital interprets the instructions in column 15 as requiring professional fees to be excluded from column 12, the instructions inappropriately remove professional fees from gross charges twice. **CHA asks that CMS clarify the instructions by deleting the sentence, "*Exclude these charges from gross charges in column 12*" from the instructions on column 15.**

Third, column 18 for insured patients' contractual allowances is subtracted out, but there is no place to report gross charges for insured patients. **CHA recommends CMS add a column for reporting gross charges for insured patients or clarify in the instructions for column 12 that it can be used for both**

**insured and uninsured patients, depending on which worksheet (insured or uninsured) the hospital is completing**.

**Column 21 (Allowable Charity Care Charges)**: **CHA asks CMS to clarify in the instructions that only amounts for charity care or financial assistance should be reported on line 21 by adding the following sentences: "*Do not report uninsured or self-pay discount amounts in column 21. These amounts should be reported in column 17.*"**

**Column 22 (Charity Care Approved Ratio): CHA questions why CMS needs this column and, therefore, requests it be deleted.** We do not believe the value of the information provided by this column will be worth the administrative burden. If CMS includes this column in Exhibit 3B, it will either need to clarify that this column is for uninsured patients only (as the instructions for column 12 currently only capture gross charges for the uninsured), or CMS must make the changes to column 12 recommended by CHA.

**Column 25 (Write-Off Date): CHA asks CMS to clarify in the instructions how hospitals should report accounts that have multiple write-off dates.** Due to the time required to determine if a patient is eligible for charity care or financial assistance, the uninsured discount is frequently granted to the patient first. And then, once the patient is determined eligible for charity care or financial assistance, the amount the patient is eligible for based on the hospital's policy is subsequently written off.

Furthermore, a patient may have multiple charity care or financial assistance write-off amounts for the same account that are written off and reversed over multiple fiscal years. This results in account balances for a given year that do not reflect the true account balance over the entire life of an account. For instance, a patient may be determined to be eligible for only a partial charity care or financial assistance write-off. However, due to additional information provided by the patient or a change in their clinical or financial circumstances, the patient may subsequently qualify to have the entire amount (remainder of the account balance) written off as charity care or financial assistance.

**Column 26 (Patient Responsibility Charges): CHA asks that CMS explicitly state in the instructions and on Exhibit 3B that column 26 contains "Patient Responsibility Charges for Uninsured Patients Only." Otherwise, CMS will need to make the changes to column 12 recommended above in the discussion of line 20 to incorporate charges for insured patients in the calculation of line 20, as recommended by CHA.**

### Exhibit 3C (Listing of Total Bad Debts)

In the FFY 2021 IPPS final rule, CMS amended the Medicare regulations to state that Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts (bad debts or, under the new Accounting Standards Update Topic 606 terminology, implicit price concessions). This change is effective for cost reporting periods beginning on or after October 1, 2020. **CHA asks that CMS acknowledge this change in Exhibit 3C and make necessary modifications to the instructions to clarify how this change will impact reporting on total bad debts.**

**Column 7 (Primary Payer) and Column 8 (Secondary Payer):** The instructions for columns 7 and 8 state that the hospital is to enter the patient's primary and secondary payer at the time of service.

It is not uncommon for patient accounts to be in collections for five or more years before they are finally written off and claimed on Worksheet S-10 line 26 as bad debt. Given the age of these accounts, it may be difficult for the hospital to report the patient's primary and secondary payer. For example, if the hospital implemented a new accounts receivable system, the information related to primary and secondary payer may no longer be available. **Therefore, CHA asks that CMS revise the instructions for columns 7 and 8 by making these fields optional to report.**

**Column 12 (Total Patient Payments):** Often, when a patient has multiple accounts with outstanding balances for services received from the hospital or one of its sub-providers, they will send a payment to the hospital without indicating which account/date of service the payment should be applied to. **CHA recommends that, in these instances, CMS clarify in the Exhibit 3C instructions that hospitals apply any funds received to the oldest date(s) of service first as is recommended in the Health Care Financial Management Association's *Best Practices for Resolution of Medical Accounts Receivable*[6].**

**Column 15 (Contractual Allowance/Other Amount)**: **CHA asks that CMS revise the instructions for column 15 and provide additional examples of what would constitute "other amounts."** For example, if a hospital offers a discount to all self-pay patients (e.g., uninsured discount) regardless of whether they qualify for a charity care or financial assistance discount, would that be reported in column 15?

**Column 16 (A/R Write Off Date):** Historically, many hospitals have written an account off on their financial statements as a bad debt when the account is transferred to a collections agency so that amounts owed to the hospital can be pursued using the collections process. In these instances, the date the account is written off the hospital's financial statement is not the date on which attempts to collect on the account cease. **CHA asks CMS to clarify in the instructions that the date reported in column 16 is the date the account is written off the hospital's financial accounting system (and financial statements) and not the date that all collections activities cease.**

**Column 17 (Patient Bad Debt Write Off Amount):** Column 17 will not always calculate the bad debt amount accurately as CMS intends. This is particularly true for Medicare cross-over bad debt for dual-eligible patients. Additionally, the format of Exhibit 3B is not designed to accurately capture and reflect bad debt reversals (which are frequent occurrences) based on the current formula. Cost reporting instructions require hospitals to report bad debts net of recoveries, however, there is no field for recoveries in this Exhibit. Additionally, CHA notes the current schedule used by Figliozzi and Company to capture the necessary account level detail for total hospital bad debts for S-10 audits does not attempt to calculate the patient bad debt write off as CMS intends in column 17. Instead, hospitals report the amount of bad debt written off from their patient accounting and financial systems. **CHA asks that CMS revise the instructions for column 17 to direct hospitals to report, instead of calculating, the patient bad debt write-off amount. CHA believes this change will improve the accuracy of amounts reported in column 17, as it accommodates bad debt reversals and discrepancies in data collected in columns 12 through 15 that result from normal account activity (e.g., Medicare crossover claims for dual eligible beneficiaries).**

### Worksheet D-4, Parts III and IV

**Line 63.01**: The instructions for line 63.01 state:

[6] Best Practices for Resolution of Medical Accounts (hfma.org)

*Effective for dates of service on or after January 1, 2021, enter the number of MA usable kidneys that are included on line 62. MA usable kidneys include:*

- *Kidneys transplanted into MA beneficiaries for dates of service on or after January 1, 2021*
- *Kidneys transplanted into MA beneficiaries with partial payment by a primary insurer in addition to MA for dates of service on or after January 1, 2021*

**CHA asks CMS to clarify the phrase "dates of service on or after January 1, 2021." For the transition year, does CMS intend for hospitals to report kidneys based on the patient's admission date, discharge date, or the organ transplantation date?**

CHA appreciates the opportunity to share our comments on the proposed changes to the CMS 2552-10 Hospital and Health Care Complex Cost Report. If you have any questions, please contact me at (202) 270-2143 or cmulvany@calhospital.org.

Sincerely,
/s/
Chad Mulvany
Vice President, Federal Policy