TOYON ASSOCIATES, INC.
949 South Coast Drive, Suite 405, Costa Mesa, CA 92626 Office 888.514.9312 www.toyonassociates.com

June 21, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, D.C. 20201

SUBJECT: CMS-1716-P - FFY 2020 Medicare DSH Uncompensated Care Funding[1]

Dear Administrator Verma:

Toyon Associates, Inc. (Toyon) appreciates the opportunity to comment on Federal Fiscal Year (FFY) 2020 Medicare DSH Uncompensated Care (UC) funding. Each year, Toyon assists over 100 hospitals across the country prepare and amend UC information reported on worksheet (WS) S-10. Toyon has previously provided insight on uncompensated care data and we appreciate the opportunity to again comment on WS S-10 reporting and trends. Our goal is to assist providers compliantly and efficiently report uncompensated care to federal and state agencies.

While our detailed comments follow, we respectfully encourage CMS to consider the points below as we move forward in continued reviews of WS S-10.

- **Build infrastructure and look to the field for technology solutions.** Robust technology solutions present an opportunity for the industry to efficiently and consistently with large datasets, such as WS S-10 detail. We believe S-10 presents an opportunity to change industry habits and work in more effective and meaningful ways with data. This effort could produce an industry standard for how data should be prepared and submitted to the MACs and CMS (a new requirement starting in FFY 2021).

[1] As Proposed in CMS-1716-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Rule, Federal Register (Vol. 84, No. 86) May 3, 2019.

- **Educating auditors.** Many auditors have a finance background, but not a patient financial services background. General education on how hospitals implement and record transactions based on their charity care and financial assistance policies would promote shared understanding. In addition, various state and federal law requirements influence how a facility may write and implement its policies, particularly with respect to section 501R of the tax code that imposes requirements related to financial assistance policies on not-profit hospitals. CMS acknowledges and allows for variation of these policies as needed. However, there seems to be a "one size fits all" approach of FAP language that may not be appropriate for WS S-10 reviews.

- **Engaging and educating providers.** So much has been learned through these reviews, and we anticipate that CMS and the MACs may identify best practices for reporting. Toyon encourages the investment of staff resources to develop educational forums and opportunities for ongoing dialogue between CMS, the MACs and hospitals **prior** to the release of substantive revisions to or guidance on cost report instructions. Toyon respectfully suggests CMS release its draft guidance or instructions prior to their adoption, to help bring about shared understanding of expectations and ensure more accurate reporting in the future.

In FFY 2020 CMS proposes to distribute $8.4B in UC funding primarily based on FFY 2015 WS S-10 data (total UC cost from line 30, column 1). CMS also presents an alternative proposal to fund UC payments using UC cost from FFY 2017 WS S-10. We do understand in some cases, CMS continues to use low income data for certain hospital types (e.g., Native American Tribal Providers).

Section I of our comments respectively addresses the integrity of WS S-10 data, particularly with FFY 2015 data.

Section II of our comments focuses on existing cost reporting instructions, subject to interpretation, resulting in variation in hospital reporting.

We also respectfully request:

- If CMS uses FFY 2017 for FFY 2020 UC DSH payments, the Agency use a later version of FFY 2017 HCRIS data. This is to correct the aberrant data identified for potential revision by May 24th, as well as account for any hospital that voluntarily submitted WS S-10 revisions by this date.

- Any hospital subject to an aggressive MAC review of its FFY 2015 UC information be afforded an opportunity for a correction. As discussed in further detail below, some safety net hospitals in both rural and urban areas, were subject to aggressive WS S-10 adjustments, which are vastly inconsistent with the treatment of other reviewed and non-reviewed hospitals. These adjustments will result in large and imbalanced revenue reductions for this subset of hospitals if CMS uses FFY 2015 WS S-10 data for FFY 2020 payments.

I. Integrity of FFY 2015 WS S10 Data

Toyon has identified a number of common mistakes affecting FFY 2015 UC reporting. Over the past two years, Toyon has worked with many hospitals towards amending FFY 2015 WS S-10 amounts to follow guidance released under Transmittal 11. Toyon identified, and corrected, the following reporting errors common among hospitals.

- Charity Care incorrectly reported at transaction amount based on write-off date. This occurs when providers prepared FFY 2015 WS S-10 using amounts from the general ledger (G/L). The G/L is a common source file for financial statement and cost report preparation, providing the same information for reporting charity care on the audited financial statements. While we understand hospitals are provided a separate set of cost reporting instructions for FFY 2015 (to report total charges based on date of service), we have learned this reporting error is widespread in hospital reporting of FFY 2015 information. This issue does not appear prevalent in 2017, as charity care is reported at the write-off amount by write-off date. Toyon has not identified this an issue causing the misreporting of uncompensated care during FFY 2017.

- Charity Care amounts related to coinsurance and deductible (C+D) amounts are overstated for more than 20% of UC DSH hospitals. In some cases, this is attributed to WS S-10 Line 20 Column 2 header "Charity Care for Insured Patients". We have learned this description caused a number of hospitals to inadvertently report other types of charges on this line, commonly non-covered Medicaid. Toyon notes an improvement in reporting charity C+D amounts in FFY 2017 due to increased provider education. As evidence, Toyon flagged 449 DSH hospitals for over-reporting in C+D in FFY 2017, while 520 were flagged (post review) using FFY 2015 data. It is also noted hospitals received letters for aberrant data in FFY 2017 that will likely further improve the number of hospital's over-reporting this information in FFY 2017. Additional information is provided in sections "Public Data Shows Hospitals Overstating FFY 2015 Uncompensated Care Due to Misreporting Co-Insurance and Deductible Amounts" and "Public Data Shows Reporting Improvements in 2017".

- Bad debts reported are in duplication of charity care charges during FFY 2015. This occurs because charity care is reported at the total charge, while bad debt is reported at the write-off amount during FFY 2015. This issue does not appear prevalent in 2017, as charity care is reported using a separate transaction (write-off) amount (as opposed to total charges). Toyon has not identified this an issue causing the over-reporting of uncompensated care during FFY 2017.

We understand approximately 600 hospitals were selected for a review in 2018/2019, and many had to completely resubmit amended data. As participants in dozens of these reviews, as well as education advisors to the healthcare industry, we have learned the reporting errors as discussed above were common in the industry. If this is common for the hospitals selected for review, it is very reasonable to presume these errors are present in the remaining 75% of UC data in FFY 2015 for hospitals not selected for review.

We thank CMS and the MACs for allowing hospitals to resubmit WS S10 information during the reviews. As indicated above, we believe these resubmissions are evidence indicating a larger, wide spread issue present in the industry with the accuracy FFY 2015 uncompensated care data. Due to the change in cost report instructions after 10/1/16, we do not believe these issues are materially present in FFY 2017 data, especially as compared to FFY 2015. In large part, this is because of the change in cost reporting instruction that now requires hospitals to report the amount written off as charity care in FFY 2017 (as opposed to the total hospital charge, which was the instruction in FFY 2015).

We are aware of aggressive and highly disputed adjustments made during the WS FFY 2015 reviews at large safety net hospitals in states like Oklahoma. If FFY 2015 data is used as the sole basis of UC DSH payments, these hospitals will lose millions of dollars in safety net funding, which will go to all other DSH hospitals not subject to review (or to other DSH hospitals subject to much less scrutiny during review). The following items are examples of aggressive adjustments that put these hospitals at great risk of losing significant funding:

- **Harmful interpretation of language in financial assistance policies (FAP)**. In one case at a large inner-city academic medical center, the MAC disallowed the hospital's self-payment discount because it did not approve how self-pay discounts were articulated in the hospital's policy. It is important to note, self-pay discounts are included in the policy - however the MAC disapproved of the *applied* language used in the FAP, resulting in millions of dollars in unrecognized charity care. In this case, the MAC – who may or may not have any experience in patient financial assistance - made a bold subjective interpretation of FAP language, which was not commonplace in our experience with other FFY 2015 WS S-10 reviews. Moreover, precise FAP language, for self-pay discounts or other forms of uncompensated care, is not governed by CMS.

  In this same case, the MAC also disregarded the cost of care, to the most critically vulnerable population – homeless – due to a perceived lack of documentation, even though these patients were subject to the hospital's presumptive eligibility policy in the FAP. The MAC's net adjustment decreased uncompensated care cost by $13M at this safety net hospital, and the corresponding UC payment will be allocated to other DSH hospitals across the country if CMS uses FFY 2015 WS S-10 as the sole basis for Factor 3.

  Going forward, we respectfully request CMS provide examples of acceptable financial assistance policy language regarding charity care and self-pay discounts. This will increase the reliability of hospital reporting and MAC review.

  Using the FFY 2015 data proposed in the FFY 2020 IPPS Rule, the hospital above – and any other hospital subject to an aggressive MAC review of FFY 2015 data – may have a sudden cash-flow emergency, and in some cases look to cut programs. We do not believe this was the intent of the FFY 2015 reviews, and respectfully request CMS to identify these occurrences and come to a fair resolution with the affected hospitals, especially if FFY 2015 data is used for FFY 2020 UC DSH funding. Going forward, Toyon recommends hospitals have the ability to appeal these types of determinations with another third party.

- **Charity Care copayments are being disallowed as charity care**. This is due to the subjective interpretation of cost report instructions discussing "Co-insurance and deductible" amounts. Co-payments are the essentially same thing, yet MACs are disallowing these costs based on a verbatim interpretation of WS S-10 cost reporting instructions.

MACs needed more time for the FFY 2015 reviews. Additional time was necessary to understand the impact of review adjustments have on hospital reimbursement. As an example, in one review under tight deadlines, the MAC had difficulty discerning the bad debt amounts. The MAC's solution was an adjustment disallowing **all** non-Medicare bad debt amounts. It is important to note the aggressive nature of eliminating all bad debt amounts, when bad debt is validated on audited financial statements. Adjustments of this magnitude grossly misstate the true cost of care which is not the intent of the ACA. As previously stated, we believe these adjustments were not the intent of the FFY 2015 reviews, and respectfully request CMS to identify these occurrences and come to a fair resolution with the affected hospitals, especially if FFY 2015 data is used for FFY 2020 UC DSH funding.

Claims sampling, extrapolations and determination of adjustment magnitude were vastly different amongst hospitals subject to a FFY 2015 review. In some cases MACs requested up to 150 accounts with an expectation 100% of the documentation would be timely provided. Some of this information was in hospital archives and can take weeks to access.

In other cases, which were more prevalent in the aggressive reviews, the MACs asked for bank statements. Under one aggressive review in the Midwest, the auditor disallowed (and extrapolated) charity care because probate records to determine if the widowed spouse of a deceased patient were not readily available. The hospitals subject to less aggressive reviews, did not have provide support beyond the patient account history and a sampled charity care determinations.

Toyon also recommends statistical relevance in considered, and applied consistently across all MACs, for WS S-10 review findings. Toyon is aware of MACs prepared to make large review adjustments based on the findings of small sample sizes. Toyon recommends that CMS consider a set standard extrapolation finding thresholds to ensure consistency in the application of those findings across all providers.

A Dispute Process Involving a Third Party is Necessary. Toyon highly respects the job and responsibilities of the MAC. However, with the allocation of $8.4B in funding, given the issues as identified throughout this letter, we respectfully request a third party with experience in patient financial services to mediate a final decision when there is a dispute over the nature of an adjustment.

Because this funding is tied to the ACA, hospitals are not afforded traditional methods of appealing MAC decisions. The intent of the ACA is for a measurement of "amount of uncompensated care" …in proportion to "the aggregate amount of uncompensated care" for all qualifying hospitals… based on appropriate data" or other "alternative data" that is "a better proxy for the costs . . . of treating the uninsured."

In order to meet the intent of the ACA, all hospitals must be treated equally in determining the "aggregate of uncompensated care…based on appropriate data." All hospitals must be treated relatively equally in the determination of the appropriate data to achieve "alternative data that is a better proxy for the costs of treating the uninsured". In other words, Toyon believes disputed review findings can be accomplished through a standard and fair dispute process to ensure all data is treated "equally."

Public Data Shows Hospitals Overstating FFY 2015 Uncompensated Care Due to Misreporting Co-Insurance and Deductible Amounts. A review of HCRIS data from March 2019 shows, even after 2018/2019 WS S-10 reviews, there remain 520 DSH hospitals reporting co-insurance, copay deductible amounts (C+D) greater than 25% of total charity charges. The national amount is ~8% for all DSH hospitals. This is a significant issue, because after the issuance of Transmittal 11 cost report instructions, the cost to charge ratio is no longer reported to C+D amounts.

In our experience in amended WS S-10 amounts to correct this reporting error, we have learned amounts are often misreported on line 20 column 2 due to the name of this column "Charity Care for Insured Patients". This column name suggests – to some – that charges related to insured patients with non-covered Medicaid are to be reported here, causing an overstatement of cost.

Public Data Shows Reporting Improvements in FFY 2017. A review of HCRIS data from March 2019 shows there are less hospitals (449 DSH hospitals) reporting C+D amounts greater than 25% of total charity charges as compared to FFY 2015 (520 hospitals). Moreover, some of these hospitals received letters for "aberrant data" from CMS to verify or correct by March 24, 2019. It is expected the over-reporting of uncompensated care will be less using amended FFY 2017 data as compared to FFY 2015 S-10 data, especially when these combined findings are considered.

Also, in Toyon's experience, **providers have communicated the instructions for reporting uncompensated care cost under FFY 2017 instructions are easier to follow** and report as compared to the instructions in place during FFY 2015. Reports by write-off amounts and write-off date are more commonly available to hospital personnel.

There are fewer complex steps to take using data associated with FFY 2017 instructions, as compared to FFY 2015 instructions. For instance, using FFY 2015 instructions, providers have to be careful, and take additional steps, not to double count charity care and bad debt amounts (as charity care is reported at total hospital charges). This issue is less apparent under FFY 2017 instructions, as these amounts are reported by separate and individual write-off amounts, and therefore less chance of inadvertent duplication of cost.

Reporting Days Exceeding a Medicaid LOS Limit with Charity C+D Causes Erroneous Reporting. This occurs when providers inadvertently do not report these same charges on WS S-10 Line 25 (to ensure the CCR is applied). This instruction appears to be an unnecessary step (unless CMS is capturing this information for other purposes). CMS can correct for this issue by requesting providers to report Medicaid days exceeding LOS limit, with the rest of non-covered Medicaid, on line 20 col 1 to ensure the CCR is applied.

In summary, we identified significant issues remain with FFY 2015 S-10 data, including but not limited to:

- Common identified errors (as discussed throughout this document), that were also present in the FFY 2015 MAC reviews, indicate a wide-spread issue with non-reviewed FFY 2015 UC data.

- Large safety net hospitals were subject to very aggressive review adjustments to their FFY 2015 S-10 data, while other reviewed hospitals were much less scrutinized during the FFY 2015 review process. Moreover, the remaining 75% of DSH hospitals were not subject to any form of scrutiny and will receive revenue from the hospitals that were treated differently, and much more aggressively, during the review process.

- Public data indicates there are fewer reporting errors using FFY 2017 data, as indicated by reporting and identification of aberrant data in recent CMS efforts, notably regarding high amounts of charity care coinsurance and deductible amounts on WS S-10 column 2.

- As reported by cost report experts in across the industry, there is less confusion regarding reporting charity care using the write-off data and write-off amounts in FFY 2017 (as opposed to total hospital charges by date of service in FFY 2015).

II. Unclear WS S-10 Cost Reporting Instructions

We are thankful CMS released Transmittal 11 clarifying a number of existing S-10 cost reporting instructions in question. There are remaining vague areas of instruction, which cause variation in the reporting of uncompensated care across the country. Toyon respectfully requests CMS to clarify these issues in an effort towards compliance and consistency.

Accounting Codification Standard (ACS) Topic 606 changes how providers report bad debt on financial statements, and can cause great S-10 reporting variation. ACS 606, which is applicable to all industries, requires providers to claim implied price concessions as a reduction to revenue. This accounting change may influence the way in which providers report bad debt and charity care on WS S-10; as follows:

- As required by ASC 606, providers determine the likelihood of collecting on accounts. This evaluation results in certain accounts being recorded as a reduction to revenue and other amounts that may end up as uncollectible bad debts on the audited financial statement.

- If certain amounts are no longer considered bad debt by accounting standards, providers may vary on how this information is reported. Hypothetically, variation can result from the reporting of no bad debt to the reporting of bad debt that is now “deemed” to be charity care because it is considered patient financial assistance in the reduction of revenue. Importantly, if accounts previously reported

as bad debt are now reported as charity care, any amount that is C+D will no longer be reduced by the cost to charge ratio. A shift in reporting from bad debt to charity care can therefore cause a great impact in the determination of uncompensated care cost.

- The "deeming" of charity care can occur when ACS 606 revenue reductions are a considered to be a form patient financial assistance (regardless of whether the patient qualifies for traditional charity care according to a public facing financial assistance policy). Currently there is nothing prohibiting providers from establishing internal financial assistance policies to validate these amounts, and other amounts, as charity care. There is currently no known CMS authority to prevent this type of activity.

- Toyon recommends CMS clarify the reporting of ASC 606 amounts for WS S-10 to avoid great variation in hospital reporting.

There is no CMS governance to how charity care is articulated in financial assistance policies. If it is possible for providers to establish financial assistance policy language on the accounting of charity care, then it is entirely possible providers may be incentivized to articulate other forms of cost as uncompensated care. For instance, these costs may include, but are not limited to:

- Accounts subject to ASC 606 implied price concessions as charity care
- The cost of days in excess of the average length of stay for all payers
- The cost of non-covered/denied services for all payers
- The cost associated with "flat-rates" from Medicaid payers; and
- The difference between an out of network settlement amount and charges as "charity care".

Toyon recommends CMS release a clarification to the industry regarding its expectations as to what is charity care as opposed to other costs that may not match the intent or spirit of the program.

Providers have different source information for reporting non-covered Medicaid. Reporting the cost associated with non-covered Medicaid can derive from a couple of sources. These sources are primarily patient transaction detail from hospital records, or from remittance advice (R/A) reports provided by Medicaid Fee for Service (FFS) and Managed Care payers. Toyon has learned each source comes with its limitations, as follows:

- Patient transaction detail. In some cases, the amount written off as non-covered Medicaid charge represents the expected payment (that is unpaid and therefore written-off). Toyon recommends MACs are educated in this occurrence, so that MACs understand any adjustments hospitals take to arrive at the charge amount, as opposed to the expected Medicaid payment. Recognizing the charge is important so that proper cost is calculated when the cost to charge ratio is applied.

- R/A Detail from Medicaid payers. In Toyon's experience in reviewing this information, the MACs, CMS and hospitals should be aware of the following potential issues:

- These reports are not always current. Denied/non-covered amounts on the R/A report may have eventually been paid. If providers are to report non-covered charges from R/A reports, there should be a process to ensure these amounts are net of any payments received during the year.

- We identified an R/A code for duplicate billing. It is obvious these amounts should not be reported as uncompensated care, but a very important review check should be executed to ensure consistency in hospital reporting.

There remains some variation in the interpretation of a bad debt "write-off". Some hospitals consider a "write-off date" the date an account is written-off the G/L and sent to collections. Other hospitals consider a "write-off date" the date the account comes back from collections deemed as uncollectible. It should be noted however, hospitals keep their books open for payment under any scenario. Outside of governmental payers (Medicare and Medicaid), accounts are never truly written-off in the event revenue is received at a later date. While it is true that all bad debt amounts should be net of recovery, without a standard definition of "write-off", hospital accounting practices can lead to variation in the amount of UC cost reported by hospitals.

– – –

Thank you for providing Toyon the opportunity to submit our comments on WS S-10 and Medicare DSH Uncompensated Care funding. Should you have any questions, please contact Fred Fisher at 888.514.9312, fred.fisher@toyonconsultants.com.

Respectfully,

Toyon Associates, Inc.