July 21, 2022

Chiquita Brooks-LaSure
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 Brooks-LaSure:

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 just one hour (from 673 to 674 hours). **CHA believes CMS greatly underestimates the additional unnecessary burden added by the expanded S-10, new data fields added to schedules and new schedules that support the disproportionate share hospital (DSH) calculation and uncompensated care reported on worksheet S-10, and worksheet D-6 to compute cellular therapy acquisition costs.**

Due to the COVID-19 public health emergency and related early retirements, California's hospitals are currently facing a shortage of qualified reimbursement staff to prepare Medicare cost reports. CHA asks CMS to reduce the administrative burden on hospitals and improve the accuracy of data collected by the Medicare cost report, making the following changes to the proposed worksheets:

- S-2: Eliminate unnecessary new data elements
- S-10: Remove language from instructions that will cause confusion at audits, modify the worksheet to improve the accuracy of the calculation of bad debt expense, and delete Part II

- 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 the unnecessary data elements that have been added
- Worksheets A–C: Clarify the instructions related to lines 77 (allogenic hematopoietic stem cell transplants – HSCT) and 78 (CAR T-Cell Immunotherapy)
- Worksheet D-6: Clarify instructions to ensure costs are appropriately transferred to worksheet E, Part B

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

References to Removed Worksheet S-12

CHA supports providing the information necessary to empower patients to make value-based decisions about where to receive their care. However, as noted in our prior comment letters in response to the 2020 inpatient prospective payment systems (IPPS) proposed rule and December 2020 cost report Paperwork Reduction Act (PRA) package, CHA is strongly opposed to such mandates — like requiring hospitals to report their median negotiated Medicare Advantage rates for inpatient services. We greatly appreciate that CMS realized that reporting these data did not advance the cause of empowering consumers, even as it required more of providers at a time when reimbursement staffing resources have never been more taxed. As a result, the agency rescinded this requirement and eliminated worksheet S-12 from the current cost reporting package. **However, CHA notes that there are still vestiges of this requirement that remain in the cost report instructions. Therefore, we respectfully ask CMS to remove the acronym for MPS - median payer specific from page 40-10 (p. 10). Further, we ask that CMS also remove the reference to the deleted worksheet S-12 from page 40-22 (pg. 22).**

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 fee-for-service (FFS) in-state paid days, Medicaid FFS in-state eligible unpaid days, Medicaid out-of-state days paid, Medicaid out-of-state eligible days unpaid, Medicaid HMO days, and Medicaid other in columns 1-6. Also, the revisions of the definitions for columns 1–4 clarify that hospitals should only report Section 1115(a)(2) Medicaid waiver days if the patient is eligible for inpatient benefits or regarded as such.

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 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.**

As noted in CHA's comment letter in response to the federal fiscal year (FFY) 2022 IPPS proposed rule,[1] CHA strongly opposes CMS' clarification that only Section 1115(a)(2) waiver days where the patient is eligible for inpatient care or regarded as such are eligible to be included in the DSH calculation. Multiple court rulings have found that this is an impermissible interpretation of the Medicare statute. **Therefore,**

[1] https://calhospital.org/cha-issues-draft-comments-on-ffy-2023-ipps-proposed-rule/

we ask CMS not to finalize this requirement and remove the phrase "*eligible for inpatient benefits, or regarded as such*" from the instructions for lines 24 and 25, columns 1–4.

Line 89, column 2 (Tax Equity and Fiscal Responsibility Act (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. **CHA appreciates that CMS has added "if available" to the instructions for column 2. However, CHA continues to ask CMS to delete column 2 on line 89 on worksheet S-2. Further, if CMS does not delete column 2, we continue to ask the agency to require the Medicare administrative contractors (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 core-based statistical area (CBSA) outside of the main hospital CBSA." Furthermore, even determining this percentage is a complex undertaking that may not be possible. 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 firm's subject matter experts that will work on a given project may not be based 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.

An example of this might be a hospital that purchases tax advisory services from a national firm with a local office in the hospital's CBSA. The engagement partner who leads the engagement is based in the advisory firm's office in the hospital's CBSA. However, the manager who does the bulk of the work on the project is based in one of the advisory firm's offices in another CBSA. In this example, the hospital that retained the firm contracted on a flat fee basis for the project in question. Therefore, they are not privy to the billable hours charged for the project by the engagement partner and the manager.

Additionally, this question appears to be informational in nature, and CMS does not provide any rationale for collecting these 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. If CMS persists in retaining this requirement, it must provide detailed examples of how hospitals are to report purchased services that use both in-CBSA and out-of-CBSA labor to complete the project.**

Worksheet S10: Hospital Uncompensated Care and Indigent Care Data

The proposed revisions to the instructions and forms separate worksheet S-10 into two parts. Part I instructs hospitals to report their uncompensated and indigent care data for the entire hospital complex. This includes any sub-providers associated with the hospital. worksheet S-10, Part II collects only

uncompensated care data for the hospital CMS certification number in question. For Part II, hospitals are instructed not to complete lines 2–19 (collecting data on indigent care shortfalls related to Medicaid, Children's Health Insurance Program, state and local programs, and other grants).

Thus far, CMS has not provided a rationale justifying the additional, considerable hospital effort — at a time when resources are limited following two years of pandemic — of having to complete both Part I of S-10 and Part II, which provides a subset of the uncompensated care data. **Given the reimbursement staffing issues hospitals are currently facing, CHA asks CMS to delete the forms and instructions related to worksheet S-10, Part II and only require hospitals to report on uncompensated care for the entire hospital complex, as has been the requirement.**

CHA notes that some hospitals do not have their revenue cycle systems configured to easily separate out and report separately on charity care and bad debt for the acute hospital and any sub-providers. **Therefore, CHA respectfully asks that if CMS persists in requiring hospitals to complete the onerous Part II of worksheet S-10, the agency delay the requirement for two years.** Delaying the requirement until cost reporting periods beginning on or after October 1, 2024, will allow hospitals to reconfigure their revenue cycle systems and more efficiently address this unnecessary requirement.

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 allows hospitals to provide more charity care to those eligible: many patients who are eligible do not apply, or if they do apply, they 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 assist them in the process of applying.

Revised definitions for Parts I and Parts II: 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 – columns 6, 16).** CHA is deeply concerned that this will result in charity care/financial assistance being disallowed due to a difference of opinion between the hospital and a MAC auditor (who will not know the particular details of a clinical

situation and likely not have the clinical background necessary to make a clinical determination) about 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). Further, many health plans inappropriately deny medically necessary care for administrative reasons. 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 a hospital's policy.

CMS has an opportunity to provide clarity and to clearly define roles and responsibilities by deleting the phase "medically necessary health care," not only in the area of charity care, but in general throughout the Medicare regulations as to who is the correct professional to make medically necessary determinations. It is not a MAC's financial auditor.

This is another example of encroachment by unqualified auditors on medical decisions. It is a difference of opinion between a financial auditor who is unqualified to render a clinical opinion about the appropriateness of care and a highly trained medical professional. Medical necessity can only be determined by licensed medical professionals. To allow financial auditors such latitude is an egregious and inappropriate expansion of their role. This could not possibly have been the intent of Congress in passing the legislation and definitively should not be allowed by CMS.

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 financial assistance policies (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 factor 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 charity care policy or FAP, not that the balance was the result of a payer's administrative policy.** Failing to remedy this strains hospitals' limited resources 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 a 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 25 (Medicaid/Indigent Care Program Charges beyond Length of Stay Limit Included): The updated instructions for line 25 add the phrase, “if such inclusion is specified in the hospital’s charity care policy or FAP and the patient meets the hospital's policy criteria.” **CHA believes the important fact in the determination of whether a patient’s amount should be included on line 25 is that the patient has an outstanding balance related to services rendered and meets the financial criteria set forth in the hospital’s charity care policy or FAP, not that the balance was the result of a Medicaid or indigent care program’s administrative policy. Therefore, we ask CMS to strike the following portion of the added language, “if such inclusion is specified in the hospital’s charity care policy or FAP and.”** Doing this will reduce the additional requirements that providers will face from having to include every conceivable scenario in their financial assistance policy and simplify it for both patients who may be eligible for financial assistance to understand and hospitals and health systems to administer.

Lines 26 to 29 (Total Bad Debts/Allowable Medicare Bad Debt/Reimbursable Medicare Bad Debt): CHA asks CMS to clarify the relationship of bad debt amounts on line 26 to the amounts on lines 27 and 27.01. Lines 27 and 27.01 are based on CMS’ policy for amounts assigned to an outside collection agency (OCA). Therefore, all collection activities must have ceased and the account returned from the OCA before they can be claimed as a Medicare bad debt.

The instructions for line 26 indicate that all bad debt amounts, including Medicare, should be included based on write-off date. As discussed in the comment for exhibit 3C, column 16 (below, page 14), the write-off date for A/R purposes is frequently when the bad debt was “sent to” the OCA. **Does CMS expect the Medicare (and non-Medicare?) bad debt amounts included on line 26 to follow the same criteria as lines 27 and 27.01 (all collection activities ceased), or is the agency allowing a timing difference (e.g., a Medicare account gets reported on line 26 in one year and on lines 27 and 27.01 in a subsequent year)?**

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 with a CCR of .2 will reduce $1 of gross charges to $0.20 of cost. However, deductibles, coinsurances, and copayments — which are included in line 28 — 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 lines 26 through 29. The first column would include all amounts written off at gross charges (e.g., uninsured individuals, insured individuals with charges for non-covered services or days that exceed a LOS limit, and gross charges other than cost sharing). The second column should include cost sharing (deductibles, copayments, and coinsurances) for insured patients. The column for amounts written off at gross charges 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 coinsurance) should not be 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.

CHA notes the instructions for the lines hospitals are to complete for Part II of worksheet S-10 are the same as in Part 1. **Therefore, if CMS does not eliminate Part II of worksheet S-10, CHA asks that CMS also apply the recommendations discussed above to the applicable lines of worksheet S-10, Part II.**

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 health insurance claim (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.**

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)
CHA appreciates that in the 2022 updates of the 2020 cost report package CMS has removed the requirement that hospitals complete separate Exhibits 3A for Medicaid FFS in-state paid days, Medicaid FFS in-state eligible unpaid days, Medicaid out-of-state days paid, Medicaid out-of-state eligible days unpaid, Medicaid health maintenance organization (HMO) days, and Medicaid other.

Column 7 (Medicaid Number): The revised instructions ask for the Medicaid recipient ID number in column 7. 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 7 instead.**

Column 8 (State Eligibility Code): The instructions for column 8 state, "*Enter the applicable State plan eligibility code number, if available. To report more than one code, report the additional State plan eligibility codes in column 18.*"

CHA thanks CMS for making column 8 optional if the state plan eligibility code is unavailable. We also appreciate CMS clarifying that when a Medicaid beneficiary has multiple state plan eligibility codes for the same inpatient stay, additional codes may be captured in column 18. **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. We also ask the agency to provide guidance on how hospitals should treat unpaid but eligible patient days when the hospital does not have the state plan eligibility code.**

Column 9 (WKST S-2, Part I Column Number): The instructions for column 9 state, *"For each entry in columns 10 and 12, or column 11, enter the Worksheet S-2, Part I, column number where the days were reported."*

As discussed above in comments on Worksheet S-2 lines 24 and 25, CHA questions why hospitals need to identify Medicaid FFS in-state paid days, Medicaid FFS in-state eligible unpaid days, Medicaid out-of-state days paid, Medicaid out-of-state eligible 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 deleting column 9. 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.**

Column 12 (Newborn Baby Days): CMS instructs hospitals to, "*Enter the number of newborn baby days occurring prior to the Medicaid eligible mother's date of discharge for a baby born to a Medicaid eligible mother. These newborn baby days are in addition to the mother's days reported in column 10. If the Medicaid eligible mother was discharged and the newborn baby remained in the hospital, do not report the newborn baby days occurring after the date of the mother's discharge in this column; report the days on a separate line in column 10.*"

CMS has not articulated why it needs hospitals to separately report newborn baby days that overlap with the mother's stay. Hospital medical records do not currently segregate newborn baby days based on those days that overlap with the mother and those where the baby remains in the hospital beyond the mother's discharge date. Breaking those days out for separate reporting will either require manual calculation or reprogramming of the electronic medical record to automate this process. Further, this breakout is not required to calculate the Medicaid share of the DSH percentage. Any additional value that CMS might derive out of this information is clearly outweighed by the administrative cost to hospitals and health systems. **Therefore, CHA asks that CMS delete this column and require hospitals to report newborn baby days in column 10.**

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.**

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 5 only if they are necessary due to a potential Health Insurance Portability and Accountability Act (HIPAA) risk.

- 1: Last Name[2]
- 2: First Name[3]
- 3: Date of Admission[4]
- 4: Date of Discharge[5]

[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.
[5] Only if necessary, otherwise providing this data to MAC provides an additional HIPPA risk.

- 5: Patient Account Number
- 6: Insurance Status
- 7: Name of Primary Insurer (if applicable)
- 8: Name of Secondary Insurer (if applicable)
- 20: Amounts Written Off to Charity Care and Uninsured Discounts
- 21: Write Off Date
- A: Total Payments Received (From Insurance and Patient)

In addition to being overly burdensome for hospitals, Exhibit 3B as currently constructed has significant flaws. CHA respectfully asks CMS to address the issues with this exhibit that are discussed in the following pages.

Column 6 (Insurance Status): The instructions for column 6 state:

Enter 1, 2, or 3, to indicate the patient's insurance status at the time services were provided, as follows:
- *Enter 1 to indicate the patient was uninsured (did not have any insurance coverage).*
- *Enter 2 to indicate the patient was insured but not covered when the patient:*
    - *had insurance coverage through an insurance company with which you do not have a contractual relationship,*
    - *had insurance coverage and the services provided were medically necessary but not covered,*
    - *had insurance coverage and the patient had exhausted their benefits, or*
    - *had general coverage through Medicaid but was not covered for this particular stay due to exhausted benefits or noncoverage.*
- *Enter 3 to indicate the patient was insured.*

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 Parts I and II. 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. These data do not flow into line 25.01 Parts I or II. 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 effort required to collect these data far outstrips its value to CMS to improve the allocation of UC DSH payments.**

Column 11 (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 $17,400 for a family for ACA-compliant plans[6]. This data element is currently not standard hospital reporting and subject to interpretation. This will result in administrative and operational difficulties involving manual intervention

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

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, coinsurance, 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 does not provide CMS with useful information.**

Column 13 (Insured Contractual Allowance Amount): 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 13 as well?

Column 14 (Non-Covered Charges): Given CHA's previous comments about globally deleting references to "medically necessary" 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 and not allowable under charity care/FAP."

Column 17 (Uninsured Discount Amounts): For line 17 CMS instructs hospitals to "*…Enter the amount of the uninsured discount given to the uninsured patient pursuant to the hospital's written charity care policy or FAP.*" CHA questions why CMS needs the amount of written off charity care to be broken out by type. Based on the current instructions for this line, the amount entered here will not match the amount reported on worksheet S-10 Part I or II Line 20, column 1. **Therefore, we ask CMS to delete column 17.**

Column 18 (Charity Care Non-Covered Charges): For line 18, CMS instructs hospitals that, "*For insured patients, enter the portion of the medically necessary non-covered charges considered for charity care, if such inclusion is specified in the hospital's written charity care policy or FAP and the patient meets the hospital's policy criteria, as follows…*" CHA questions why CMS needs the amount of written off charity care to be broken out by type. Based on the instructions for this line, the amount entered here will not match the amount reported on worksheet S-10 Part I or II Line 20, column 2, even if added to Exhibit 3B column 19. **Therefore, we ask CMS to reduce the requirement of hospitals by deleting column 18.**

Column 19 (Other Charity Care Charges): For line 19, CMS instructs hospitals to, "*Enter any other allowable charges (not reported in column 17 or column 18) and written off as charity care pursuant to the provider's written charity care policy or FAP.*" CHA questions why CMS needs the amount of written off charity care to be broken out by type. Based on the instructions for this line, the amount entered here will not match the amount reported on worksheet S-10 Part I or II Line 20, column 2, even if added to Exhibit 3B column 18. **Therefore, we ask CMS to reduce the requirement of hospitals by deleting column 19.**

Column 20 (Amounts Written Off to Charity Care and Uninsured Discounts): CMS instructs hospitals to, "*Enter the sum of the amounts in columns 17, 18, and 19.*" Based on the comments for columns 17–18, CHA strongly recommends that CMS revise the instructions for this column. Instead of summing columns 17–19 (which CHA believes should be deleted), CHA asks CMS to instruct hospitals to enter any amounts related to charity care provided to insured and uninsured patients as specified in the hospital's FAP or discounts provided to insured or uninsured patients as specified in the hospital's FAP.

Column 21 (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.

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***[7]**.**

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?

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

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. Additionally, the format of Exhibit 3C 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.**

Worksheets A–C, Lines 77: HSCT Acquisition Costs/Charges

CHA appreciates the clarity CMS has added to the line 77 instructions. Because of the complexities around donor acquisition costs for allogeneic stem cell transplants, CHA asks that the instructions explicitly mention direct costs and time studies, which help hospitals capture costs devoted to donors as defined at 42 CFR 412.113(e).

We also ask that instructions for worksheet C reference the appropriate patient care gross charges for line 77. That is, line 77 should have patient charges for purchased donor services. Line 77 should not include charges for donor services furnished by departments, since these charges are included in each respective department's gross patient revenue lines and are used to calculate donor costs of furnished services in worksheet D-6. There are, however, gross charges for purchased donor services that are appropriate for line 77 — it will be important that CMS' instructions reference these charges.

Worksheets A and C, Line 78: CAR T-Cell Immunology

CHA appreciates CMS' revised instructions for worksheet A, line 78. It is now clear that this line is for the direct and purchased cost of procuring, storing, and processing chimeric antigen receptor T-cells and acquiring the biologic from the manufacturer. CMS does not use the terms autologous or allogeneic, so our understanding is that this cost center would be used for costs of both types of cell therapy once allogeneic therapies are FDA approved.

CHA requests that CMS add the words "cell collection" to "procuring, storing, and processing chimeric antigen receptor T-cells…" because cells are collected by centers more often than procured by an outside entity or other hospital. We also ask CMS to include in its instructions that this will require reclassification of the direct and purchased service costs in other cost centers to this line 78. In addition, CMS should specify that the gross patient charges for these services and the CAR-T biologic should be added to worksheet C for this line.

Worksheet D-6: Computation of Cellular Therapy Costs

CMS proposes to use the new worksheet D-6 to calculate donor-search and cell-acquisition costs associated with donor services rendered to support Medicare recipient transplants, including transplants that are cancelled. CHA supports the revisions to this worksheet to enable cost finding for donor costs for inpatient and outpatient transplants for all patients and that the Medicare share will appropriately transfer to Worksheet D-1, Part II, line 48.01 for TEFRA inpatient and to Worksheet E, part B, line 2 outpatient with the modifications CMS has made.

CHA asks that CMS explicitly state in section 4029.8 Part III that PPS-exempt cancer hospital-outpatient costs require transfer to worksheet E, part B, line 2. CMS has appropriately and explicitly stated that this is required and included relevant instructions in the revision to worksheet E, part B, line 2, but not in the Worksheet D-6 instructions. Including these instructions in Worksheet D-6 line 10 would ensure that there is no confusion for cost report preparers and MACs. We, therefore, recommend adding this into the instructions for worksheet D-6 line 10, so that it is listed just as the "TEFRA hospital – inpatient transfer to WS D-1, Part II, line 48.01" is listed. It should state "TEFRA hospital – outpatient transfer to WS E, part B, line 2."

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