

January 11, 2021

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***Re: Agency Information Collection Activities: Proposed Collection; Comment Request (Proposed Changes to Hospital and Hospital Health Care Complex Cost Report); (Vol. 85, No. 218), November 10, 2020.***

Dear Administrator Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the hospital and hospital health care complex cost report. The AHA appreciates CMS' efforts to improve the quality of the data being reported and eliminate the collection of outdated information. However, we have substantial concerns that many of the proposed changes increase hospitals' regulatory burden, without benefit. **While our detailed comments on the proposed modifications to the cost report follow, we also, at a higher level, urge CMS to do a thorough review and simplify and/or eliminate its requirements to the greatest extent possible.**

### **HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA – WORKSHEET S-2, PART I**

In this worksheet, lines 24 and 25 specify that hospitals separately report six different types of Medicaid days:

- 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 ineligible days unpaid;
- Medicaid health maintenance organization (HMO) days; and
- Other Medicaid days.

While this has been a longstanding reporting requirement, the need for six different Medicaid days categories is not clear. Similarly, CMS has proposed a new line 123, which requests information on the extent to which a hospital has purchased legal, accounting, tax preparation, bookkeeping, payroll or management consulting services from an outside organization. We do not understand the purpose of this line. **As such, we urge CMS to either clarify why these data are needed, or, preferably, simplify reporting and reduce administrative burden by consolidating the columns and removing line 123.**

## **HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA – WORKSHEET S-2, PART II**

Worksheet S-2, Part II requires submission of Exhibit 2A, which includes data to support bad debt being claimed. However, CMS is proposing to more than double the amount of data elements that must be reported. This again introduces more administrative burden to hospitals – even the most sophisticated enterprises will need to make significant changes to their systems to be able to capture this information; the burden will be much higher for small and/or rural hospitals. **We urge CMS to streamline and simplify this exhibit to the greatest extent possible.**

As a specific matter, we are concerned about the requirement to provide Medicare beneficiaries' Medicaid number, where applicable, in column 7. It is not always possible for a hospital to obtain this number, particularly for beneficiaries enrolled in Medicaid Managed Care plans. **CMS should allow hospitals to record a beneficiary's social security number, or health insurance claim number when their Medicaid number is not available.**

## **HOSPITAL UNCOMPENSATED CARE DATA – WORKSHEET S-10**

The AHA is concerned with several of the changes CMS proposes to the opening text and definitions for Worksheet S-10. For example, 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." While we appreciate the added language, more is needed. **Specifically, we urge CMS to add clear language to the S-10 instructions affirmatively stating 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 as a method to qualify individuals for charity care/financial assistance 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.

In addition, CMS proposes to revise the definitions of charity care and uninsured discounts to include the phrase "medically necessary health care." The first sentence of the definition would read as, "Charity care and uninsured discounts result from a hospital's policy to provide all or a portion of medically necessary health care services free of charge to patients who meet the hospital's charity care policy or FAP." **The AHA strongly opposes the addition of this language and asks that CMS remove it.** We are deeply concerned that this will result in charity care/financial assistance being disallowed due to a difference of opinion between a Medicare Administrative Contractor (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." Therefore, we believe the addition of this language is unnecessary and could lead to arbitrary disallowances of charity care/financial assistance claimed on Worksheet S-10 in accordance with its policy.

Regarding Worksheet S-10 line 20, we have concerns with regard to the submission of supporting information. That is, CMS says cost reports will be rejected if detail charity care listings are not submitted in support of the data in this line. However, we urge CMS to clarify that sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs) paid on their hospital-specific rate (and therefore not receiving DSH uncompensated care payments based on this information) are not subject to this requirement. **Doing so would avoid administrative burden for hospitals and MACs alike.**

Finally, we remain concerned about the calculation of hospitals' bad debt expense in lines 26 through 29. Specifically, CMS continues to multiply non-Medicare bad debt expense (line 28) by the hospital's cost-to-charge ratio (CCR) (line 29) as a step in calculating total bad debt expense. However, this is a mathematically incorrect calculation because line 28 includes deductibles, coinsurance and copayment bad debt amounts. These are not charges that can or should be reduced to a hospital's cost. They are, in and of themselves, absolute dollar amounts that a hospital reasonably expected a patient to pay. **As such, we urge CMS to modify the form and instructions so that only bad debt charges, and not bad debt deductibles, coinsurance and copayment amounts, are multiplied by the hospital's CCR.**

In addition, Worksheet S-10 requires submission of Exhibits 3A, 3B and 3C, which include data to support various S-10 data elements. Exhibit 3A requires supporting information on hospitals' number of Medicaid disproportionate share hospital (DSH) eligible days. However, we note that many SCHs and MDHs are paid a hospital-specific rate and Medicaid-eligible days have no impact on their reimbursement. Indeed, CMS in the past has clarified that hospitals such as these do not need to submit the "supporting information" mentioned above. **As such, we ask that CMS also add this clarification to the instructions here, to avoid administrative burden for hospitals and MACs alike.**

Regarding Exhibit 3B, many of the data elements requested are either not in the same format or not the same elements as the recent S-10 audit data request. This raises the possibility that hospitals will need to provide a different iteration of these data when the MACs conduct their audits – which is not appropriate. We urge CMS to align the data on this Exhibit with that which the MAC needs to conduct their audits. **Doing so would avoid administrative burden for hospitals and MACs alike.**

Lastly, while CMS specifies that failure to submit Exhibits 3A and 3B would result in cost report rejection, it does not specify the same for Exhibit 3C. **We urge CMS to clarify whether this exhibit is required for successful cost report submission.**

## **MEDIAN PAYER-SPECIFIC NEGOTIATED CHARGE DATA – WORKSHEET S-12**

We have substantial concerns about the Worksheet S-12, which does not provide sufficient guidance to allow hospitals to consistently and accurately report their median payer-specific negotiated rates. In addition, unlike most of the proposed changes, which have a much longer timeline, CMS would require completion of Worksheet S-12 for cost reporting periods ending on or after Jan. 1, 2021. **As such, we urge CMS to both clarify the worksheet instructions to address the issues set forth below and also to either delay the adoption of Worksheet S-12 and the collection of median payer-specific negotiated rates for Medicare Advantage Organizations (MAOs) or delay the filing date deadline.**

The S-12 is a brand-new worksheet, which requests incredibly difficult-to-calculate data points. Hospitals have many questions that they need to have answered before they can accurately provide the data required. Yet, with an implementation date that is so soon, we are concerned that there will not be an adequate amount of time between when CMS provides these answers by revising the cost report instructions and the due date for these cost reports. For example, cost reports for periods ending Jan. 31 are due on June 30 – if CMS provides finalized instructions in May, hospitals will have less than two months to ensure they are able to report accurately. **As such, we urge CMS to ensure there are at least 90 days from the finalization of its instructions and the due date for Worksheet S-12. This could be accomplished either by delaying the**

**effective date of this worksheet all together, or by delaying the filing date of the cost report.**

The questions/clarifications we have are outlined below. We ask CMS to provide answers in its finalized instructions for Worksheet S-12.

- We urge CMS to clarify that these data should be provided for discharges that occur during the cost report year (rather than for payments during the cost report year). The instructions state that median rate data is to be determined from “each MAO-paid discharge in the cost reporting period,” which suggests that CMS is requesting that the median amount be determined for discharges that *occurred* during the cost reporting period (regardless of the date of payment) rather than for discharges that were *paid* during the cost reporting period (regardless of the date of discharge). We would appreciate clarification, as reporting based on date of payment would increase the complexity of reporting.
- We urge CMS to allow hospitals to report either expected or actual payments. Specifically, the instructions rely on the undefined term “basis of payment” to explain how the provider is to determine the median payer-specific negotiated rate for each MS-DRG. However, it is unclear what the “basis of payment” is and how it should be reasonably determined. Expected payments are often available at time of billing and their reporting can include all patients; thus, their use facilitates timely filing of the cost report. If, instead, actual payments must be reported, hospitals may need additional time in filing to ensure all payments have been received and exclude those that have not been fully paid.
- The proposed instructions indicate that data should only be provided for “each MAO-paid discharge.” We urge CMS to clarify this term to include only discharges of beneficiaries covered by an in-network MAO where the MAO actually made payment on an inpatient basis. Thus, MAO discharges that were not fully paid (e.g., not paid at the inpatient rate) or for which the MAO denied payment should be excluded.
- It is our understanding that median payer-specific negotiated rates include MAO members’ cost-sharing amounts (e.g., copayments and deductible amounts), but we ask that CMS clarify the instructions to affirmatively state as much. This will ensure that the median payer-specific negotiated rate reported on Worksheet S-12 includes the full negotiated MAO rate.
- We urge CMS to revise and clarify Worksheet S-12, Part II, Line 1 to address exclusion of capitated, out-of-network (non-negotiated) rates. The instructions for Worksheet S-12, Part II, Line 1 require an attestation that “the provider had zero MAO discharges (for any MAO payer) for each MS-DRG without a [median payer-specific] negotiated charge amount in Part I.” It is unclear whether the broad reference to “any MAO payer” encompasses MAOs that pay on a fully or partially capitated basis and out-of-network MAOs with which the hospital does not have a negotiated rate. Both capitated and out-of-network MAO rates appear to be excluded from Part I of Worksheet S-12 (the former are expressly excluded

in the instructions, and the latter are excluded by the use of the term “negotiated” rates), so a provider might have a mix of MS-DRGs without a median payer specific negotiated rate amount in Part I where some MS-DRGs. It is not clear how a provider that had zero MAO discharges for one MS-DRG and only excluded MAO discharges for another MS-DRG should complete Part II.

- The instructions assume that the each MAO contract uses an MS-DRG payment methodology for all inpatient discharges and does not provide any guidance for the range of alternative payment methodologies that may be applied by MAOs. For example, some MAOs may negotiate payment based on a percentage of charges methodology or a per diem methodology. It is unclear how a hospital should crosswalk from this rate information to any payer-specific negotiated charge for an MS-DRG or whether data for such discharges should be excluded (and, if so, how the hospital should complete Part II of Worksheet S-12). We urge CMS to provide guidance on this issue. Without it, hospitals will be unable to consistently calculate a median payer-specific negotiated rate for each MS-DRG.
- The instructions to Worksheet S-12 indicate that the median payer-specific negotiated rates should exclude rates negotiated on a capitated basis. However, the instructions do not define “capitated basis” or address shared risk contracts more broadly – we urge CMS to provide more clarify on their inclusion or exclusion. Shared risk contracts are different from traditional capitated contracts. For example, an MAO may pay the hospital a percentage of the inpatient PPS-based payment amount upon patient discharge. Then, on an annual basis, the MAO and provider will undertake a reconciliation process, which evaluates the MA plan savings against a target for the entire population of patients that received services from the hospital or were attributed to an accountable care organization (ACO) in which the hospital participated. If additional savings were achieved beyond the target, the payer would make a lump sum shared savings payment to the provider or ACO. In two-sided risk arrangements, if target savings were not achieved, the provider or ACO would provide a lump sum payment to share in the loss. In these cases, it is unclear whether the basis of payment would be the negotiated MS-DRG rate before any withholds or reductions that are part of the shared risk arrangement or some other value.
- The instructions to Worksheet S-12 do not address whether the basis of payment includes or excludes outlier or stop-loss payments negotiated with MAOs. We urge CMS to expressly address this issue.
- The instructions to Worksheet S-12 do not address whether or how MAO-negotiated rates for transfer-adjusted cases should be handled. The instructions should be revised to expressly address these cases.
- Many MAOs negotiate payment methodologies that adjust the base payment rate based on various quality metrics. In some cases, these operate in a similar manner to Medicare’s Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital Acquired Condition

penalty. MAOs also may include add-on payments that might be comparable to DSH and indirect medical education payment adjustments. We urge CMS to revise the instructions for Worksheet S-12 to expressly address the inclusion or exclusion of these adjustments and add-on payments.

- We recommend that CMS to clarify that payments for patients treated in distinct part units – for which care is not paid under the inpatient prospective payment system – are not included in the calculation of the median payer-specific negotiated MAO rate. It is our understanding that the reference to the subsection (d) hospital in the instructions to Worksheet S-12 is intended to exclude a psychiatric or rehabilitation unit of the hospital in accordance with 42 U.S.C. § 1395ww(d)(1)(B), but the broad definition of “items and services” in the instructions creates potential ambiguity on this issue.

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Joanna Hiatt Kim, vice president of payment policy, at [jkim@aha.org](mailto:jkim@aha.org).

Sincerely,

/s/

Ashley Thompson  
Senior Vice President  
Public Policy Analysis and Development