American Hospital Association

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February 13, 2023

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

Re: CMS–855A, Agency Information Collection: Medicare Enrollment Application for Institutional Providers (Vol. 87, No. 240), December 15, 2022.

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, 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) information collection request regarding the revision of the Medicare Enrollment Application for Institutional Providers (CMS-855A).

There are several areas of proposed changes to the enrollment application with which the AHA has concerns. These include:

- Section 2A's proposed elimination of the physician-owned hospital (POH) question;
- Section 4A regarding whether practice locations are provider-based, and if so, the type of provider-based department (PBD);
- Section 4C2 about the electronic storage of patient medical records; and
- Section 5A asking whether an organization is itself owned by any other organization or individual.

Section 2A: Physician-owned Hospitals

The AHA opposes CMS' proposal to eliminate POH reporting in the CMS-855A. We urge the agency to maintain use of question 2A3, which captures whether an organization is a POH. This information is necessary to track these organizations and capture statutorily required data elements. Additionally, we urge the agency to issue

additional forms and/or questions regarding POHs to comply with the reporting requirements mandated in the Affordable Care Act (ACA).

Indeed, for more than two decades, community hospitals, policymakers, the business community and governmental advisory bodies have grappled with overutilization and higher health care costs caused by self-referral to POHs. Conflicts of interest are inherent in these arrangements, whereby physicians refer their patients to hospitals in which they have an ownership interest.

In 2010, after a decade of studies and congressional hearings showing the adverse impact of these arrangements, Congress acted to protect the Medicare and Medicaid programs, and the taxpayers who fund them, by imposing a ban on self-referral to new POHs. Section 6001 of the ACA prohibited the creation of new POHs that can bill Medicare and Medicaid, and generally prohibited expansion of POH facility capacity unless certain exception criteria are met for community needs or high Medicaid services. Existing POHs could continue operating and admitting Medicare and Medicaid patients.

Legislation also required the reporting of physician ownership information on an annual basis. Therefore, in 2011, CMS added an attachment to the CMS-855A to capture ownership and investment information. This was removed from the form in 2013 under the pretense the agency would create a separate CMS-855POH form to be completed on an annual basis. The CMS-855POH was approved by the Office of Management and Budget in 2013; however, CMS announced in 2015 that reporting using the CMS-855POH and Attachment 1 would be suspended until further notice citing concerns about data accuracy. Eight years later, the agency is still not in compliance with Section 6001 requirements.

This means that the current question in the CMS Form 855A is the only way to identify POHs. If it is eliminated, it is unclear how POHs will be identified and tracked, and as such, how compliance would be assured for requirements set forth in section 6001 of the ACA. **For these reasons, the AHA requests continued use of question 2A3 and updates on the status of implementation for the 855POH.**

Section 4A: Provider-based Practice Locations

The AHA urges CMS *not* to finalize its proposed provider-based practice location questions on the Form 855A, as they are redundant with data already available to the agency. If CMS declines to do so, we recommend that the agency significantly increase the burden estimates included in its Paperwork Reduction Act (PRA) submission to indicate a more realistic time estimate for providing this information.

Specifically, CMS proposes several additions to Section 4A: Practice Location Information, including a question about the date the first Medicare patient was/will be

seen at a practice location and new check boxes to indicate whether the location being changed, added or removed is provider-based and what type of PBD it is. It is clear from the substance of the questions, the agency's supporting statement for the PRA submission and the CMS-855A application revisions justifications[1] that the intention is to assist CMS in identifying PBDs that are subject to the site-neutral payment reductions under Sec. 603 of the Bipartisan Budget Act of 2015.

However, the AHA is concerned that these changes will significantly increase provider burden, far more than the 15 minutes per provider estimated in the agency's PRA submission. First, this is not merely a matter of entering a date and checking boxes; it will require that providers carefully research the various sections of the regulations cited in the form and also likely would require review of CMS interpretive guidance to ensure that the questions are correctly answered. Further, for providers with more than one off-campus practice location, this new section will necessitate that they review and, as appropriate, change/add/remove such data for each of these practice locations. Such an endeavor could take multiple hours as many individuals may need to research the regulations, which are complex.

Moreover, CMS already has ready access to information about which PBDs are excepted or non-excepted. For several years the agency has required that hospitals with off-campus PBDs attach the "PO" modifier (required on services furnished in an excepted off-campus PBD) and the "PN" modifier (required on services furnished in a non-excepted off-campus PBD) to indicate the status of each service on a claim. The use of these modifiers has been widely operationalized by the hospitals and health systems and can be relied upon to indicate the status of each service and PBD. Further, the location in which a service is furnished is available because the hospital claim form reports the address of the specific location in which the service took place (e.g., on the paper UB-04 form, this would be the FL01 field).

For these reasons, the AHA urges CMS not to finalize these burdensome, and redundant, additions to the 855A form.

Section 4C2: Medicare Beneficiary Medical Records Storage Address – Electronic Storage

In Section 4C2, CMS proposes to add a new section regarding whether beneficiary medical records are stored electronically and, if so, where/how these records are stored. The new section notes that "This must be an electronic storage site that can be accessed by CMS or its designees if necessary." We are concerned about this question given the increased targeting of hospitals and health systems by cyber adversaries.

[1] "Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), enacted on November 2, 2015, amended section 1833(t) of the Act and relates to payment for certain items and services furnished by off-campus provider-based departments of a hospital. Requires that we correctly identify off-campus providers and those excepted. New practice location choice added. Reduces provider burden of having to explain this circumstance in section 4D3 (Comments/Special Circumstances)."

Indeed, hospitals are obligated to defend against and remain vigilant about the security of their networks and electronic health information to prevent attempts to steal patient data and disrupt health care delivery.

We do not understand the circumstances under which the electronic location of these records would be accessed by CMS, which "designees" would have access to this information, and, if access is granted, how the location and the electronic data would be protected against breaches. Due to the sensitive nature of the proposed question 4C2 itself, and until the agency can provide an explanation of how it intends to protect access to and use this provider enrollment information, we urge CMS not to finalize these changes. Finally, we strongly recommend that CMS review these plans with the Department of Homeland Security and the Federal Bureau of Investigation, which have been working closely with hospitals and health systems to defend against cyber intrusion and protect the confidentiality of our patients' data.

Section 5A: Organizations with Ownership Interest and/or Managing Control — Identification Information

In Section 5A, for all ownership roles listed, CMS adds the question, "Is this organization itself owned by any other organization or by any individual?" The agency notes that this was added at the request of the Department of Health and Human Services Assistant Secretary for Planning and Evaluation "to identify organizations, such as SNFs or hospitals, with the same ultimate parent," and would facilitate investigating whether a program integrity issue found in one provider was prevalent in other providers under the same ultimate parent.

The AHA strongly supports efforts to reduce fraud and abuse in the Medicare program. However, we are concerned about this question simply being a precursor to additional administratively burdensome disclosures. Specifically, it would enable implementation of a 2019 CMS final rule on program integrity enhancements to the provider enrollment process about which we expressed deep concerns. This 2019 final rule contained overly burdensome and unworkable provisions that will set providers up for failure and possible enforcement actions.

Therefore, we urge the agency to postpone adoption of this question until it can better assess the ability of providers and suppliers to comply with it, as well as with the 2019 rule. At the very least, the agency should expressly state why it is adding this question and demonstrate that it is not connected with the flawed 2019 rule. We recommend that CMS implement a more reasonable and less burdensome approach to enhance program integrity.

The AHA appreciates the opportunity to comment on this information collection. If you have any questions concerning our comments, please feel free to contact Roslyne Schulman, AHA's director for policy, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development