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July 15, 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:

Toyon Associates, Inc. appreciates the opportunity to comment on the proposed changes to the Hospital and Health Care Complex Cost Report. Toyon works with hundreds of hospitals in filing annual Medicare and Medicaid cost reports and is an industry leader in cost report education, teaming with leaders throughout the country to identify best practices for reporting data to federal and state governments. Our comments are listed below in Sections I through VI for each respective schedule of the Medicare cost report with notable proposed changes.

I. Worksheet S-2

Lines 24 and 25 – DSH Eligible Days by Category

Toyon proposes to eliminate the six columns and create one column "Total DSH Medicaid Eligible Days" to report the DSH eligible days.

CMS requires hospitals to report the DSH eligible days in six separate columns:

- Column 1 (In-State Medicaid paid days)
- Column 2 (In-State Medicaid eligible unpaid days)
- Column 3 (Out-of-State Medicaid paid)
- Column 4 (Out-of-State Medicaid eligible unpaid)
- Column 5 (Medicaid HMO days)
- Column 6 (Other Medicaid days)

Toyon asks CMS to simplify reporting to save time for both the hospital and the Medicare Administrative Contractor (MAC). Separating the DSH eligible days into six columns does not impact the Medicare DSH calculation, and only adds to the administrative burden in preparing the cost report. A Medicaid eligible patient day, regardless of whether the day is classified as In-State Medicaid, Out-of-State Medicaid, or Medicaid HMO, is treated the same in respect to the DSH payment calculation. The total DSH eligible days reported in the six columns is the number resulting in the DSH payment. There is no additional benefit reporting whether a Medicaid eligible day is reported in one column vs. another.

Toyon proposes to eliminate the six columns and create one column "Total DSH Medicaid Eligible Days" to report the DSH eligible days. The current reporting on worksheet S-2, Lines 24 and 25 is an administrative burden with no additional benefit. We request CMS use this opportunity to simplify the reporting process. Toyon agrees that Acute and Rehab days should continue to be reported separately on Lines 24 and 25.

Line 89 (Column 2) – TEFRA Adjustment Date

Toyon requests that if applicable and available, the Medicare Administrative Contract (MAC) provide the hospital the TEFRA adjustment date. This will reduce hospital efforts in possibly having to identify proper documentation containing this date, which may be decades old.

Line 123 – Purchased Administrative Services

Toyon requests CMS does not require hospitals to report if a majority of professional expenses (>50%) are purchased from an unrelated organization outside the main hospital's market area. Tracking this information would add an administrative burden to itemize the address of each professional service, and associated expenses, in its recording keeping. There is no know benefit to the additional burden of organizing and collecting this information.

II. Exhibit 2A – Listing of Medicare Bad Debts

Toyon is concerned Exhibit 2A will significantly increase the hospital's administrative burden when preparing the Medicare Bad Debt listing. The current Medicare Bad Debt schedule (Exhibit 2) requires a hospital to complete 10 columns while the new Medicare Bad Debt schedule (Exhibit 2A) requires a hospital to complete 25 columns. The new reporting is overly complex and includes extraneous data fields that are not needed for a hospital to report their Medicare Bad Debt.

Toyon asks why the current Exhibit 2 (10 fields), which is a standardized format and has provided the necessary information for both the hospital and the MAC for over 10 years, needs to be updated? Hospitals have been instructed to follow this exhibit and created processes to standardize their Medicare Bad Debt logs to meet this format. A change to hospital

process will result in an additional administration burden and potentially higher error rate from reporting new data to new fields. We understand the desire for a standard exhibit, but a reliable exhibit is already in place for Medicare Bad Debt (unlike DSH which does not already have a standard format). The exercise of creating an exhibit that changes the required 10 fields to 25 fields is unnecessary and creates a significant burden for hospitals at a time when many hospitals are short-staffed.

(Note: Toyon supports the removal of all HIPAA related patient data during the cost reporting submission for Exhibits 2A, 3A, 3B and 3C. During the desk review audit, the hospital can provide additional patient data directly to the assigned auditor, as necessary. Based on the proposed Exhibit 2A, Columns 1, 2, and 7 (patient name and Medicaid number) would be removed. The transfer unnecessary PHI is an unnecessary HIPAA risk and maintaining this information on IT systems is more costly with rising insurance rates for storing PHI.)

Toyon asks CMS to eliminate the following columns from Exhibit 2A due to both the complexity and administrative burden this will put on hospitals. Hospitals are familiar with the current Medicare Bad Debt (Exhibit 2) and we propose keeping the required data fields closely intact. The additional time hospitals will spend reporting the data fields below heavily outweighs the necessity of including the information.

- **Column 10 (Medicaid Remittance Advice Date)** – Reporting this date is unnecessary as any payment received from Medicaid is removed from the allowable bad debt amount being claimed. We propose Column 22 be included in Exhibit 2A and used to report the payment amount received as that has a direct impact on the allowable bad debt claimed in Column 24. As this date is not used to report the bad debt and the write-off date is included in another column, we identify Column 10 as an example of where CMS can exclude this required field to help ease the additional time and burden that the hospital will need to complete the bad debt exhibit. Toyon requests this exhibit only includes mandatory fields that are used to identify and report Medicare bad debt.
- **Column 11 (Secondary Payer RA Received Date)** – Reporting this date is unnecessary as any payment received from a payer is removed from the allowable bad debt amount being claimed. We propose Column 22 be included in Exhibit 2A and used to report the payment amount received as that has a direct impact on the allowable bad debt claimed in Column 24.
- **Column 12 (Beneficiary Responsibility Amount)** – Columns 20 and 21 reflect the Medicare Coinsurance and Deductible amounts. For a self-pay/ indigent bad debt patient, is the hospital to total Columns 20 and 21 in Column 12? This additional column is unnecessary as the information is already being reported on the exhibit. If CMS is attempting to capture the responsibility for the dual-eligible cost-sharing, it seems this column would only be reported for those instances and is not needed for the self-pay/indigent bad debt patient population.

- **Column 14 (A/R Write Off Date) and Column 15 (Collection Agency Return Date) and Column 16 (Collection Efforts Ceased Date) and Column 17 (Medicare Write Off Date)** – Can CMS provide an example in which a patient would have four different dates reported in these four columns? This will assist the hospital community with their bad debt reporting. It would also help alleviate the concern that the same date will be reported in similar columns for most patients, which leads to the unnecessary burden that hospitals are being asked to complete.
- **Column 15a (Collection Agency Sent Y/N) and Column 15 (Collection Agency Return Date)** – Reporting this information is unnecessary as any payment received is removed from the allowable bad debt amount being claimed. If a hospital follows its policy, whether the account went to an agency or not, collection attempts must take place. Since it does not matter whether a hospital contracts with an agency for the collection process or completes the collection attempts internally, we ask that the two columns be removed. This is part of the effort to reduce the burden of asking hospitals to change from a 10-field exhibit to a 25-field exhibit.
- **Column 19 (Recoveries Only: MCR FYE Date)** – Because CMS states this column is optional, we ask that the column be eliminated. If the hospital wants to report this information, they can do so in Column 25 for comments.
- **Column 20 (Medicare Deductible Amount*) and Column 21 (Medicare Coinsurance Amount*)** – The bottom of exhibit 2A notes "** Report deductible and coinsurance amounts only when the provider billed the patient with the expectation of payment. See column 8 instructions for possible exception*." Dual eligible bad debt is an implicit price concession (per ASC Topic 606) and there is no expectation of payment (in addition, the provider bills Medicaid and not the patient). With this in mind, do hospitals still report these two fields for dual-eligible patient accounts? Also, the reference to column 8 (Deemed Indigent) is misleading as it does not provide an explicit directive for an exception to a hospital including the deductible and coinsurance amounts.
- **Column 23 (Current Year Payments Received Source)** – We do not see the necessity of reporting the payment source. The objective is to report the total unpaid bad debt (Column 24), consisting of the patient responsibility minus payments, which is included and reflected in other columns.

III. Exhibit 3A – Listing of Medicaid Eligible Days for DSH Eligible Hospitals

As discussed above for Worksheet S-2 Line 24 and 25, Toyon believes CMS should move away from requiring hospitals to report their DSH days in six separate columns and ask that this is consolidated into one single column.

Toyon is concerned CMS is requiring hospitals to submit one exhibit per CCN. There are patient populations within the DSH eligible days that will be audited with different criteria. These patients should be separated so they are sampled with similar types of patient days. Hospitals need to avoid audit sampling situations where a sample is selected containing patients that require multiple levels of documentation support (emergency, waiver days, etc.) with a patient that only requires a UB to document their stay. As currently proposed by CMS, an auditor would sample these patients as one population, which is not reasonable, nor should it occur as the current industry standard allows hospitals to separate these different populations knowing the audit requirements differ. Toyon asks CMS to allow hospitals the flexibility to separate patient populations, such as emergency patients, on different schedules. Toyon would place a comment for these patients (Exhibit 3A, Column 18), but as the goal is to standardize, the manual comments stated by hospitals would differ.

(Note: Toyon supports the removal of all HIPAA related PHI during the cost reporting submission for Exhibits 2A, 3A, 3B and 3C. During the desk review audit, the hospital can provide additional patient data directly to the assigned auditor, as necessary. Based on the proposed- Exhibit 3A, Columns 1, 2, and 7 (patient name and Medicaid number) would be removed. The transfer unnecessary PHI is an unnecessary HIPAA risk and maintaining this information on IT systems is more costly with rising insurance rates for storing PHI.)

Toyon asks CMS to eliminate the following columns from Exhibit 3A:

- **Column 6 (Medical Record Number)** – Reporting the Medical Record Number (MRN) is unnecessary as the Patient Account Number is included in Column 5. The patient account number is unique to each hospital visit. For a DSH claim reported in Exhibit 3A, the patient account number is used to identify the single hospital visit. A patient will have the same MRN for multiple hospital visits. An auditor cannot use this field during their review to request sample support as it is not a unique number designated for a singular hospital visit, therefore, only the patient account number will be used by both the hospital and the MAC. There is no known benefit to reporting the MRN.
- **Column 7 (Medicaid Number)** – Toyon agrees with the decision by CMS to remove the requirement to include a patient's date of birth and social security number. We believe CMS should also remove this column. Not only does this column contain confidential patient information, but not all patients are queried and matched to the state using a Medicaid number. There are states that do not use or require the Medicaid number to perform the DSH eligibility matching process. This will eliminate confusion as to whether the Medicaid number on the exhibit was used by the state to identify Medicaid eligibility. Toyon anticipates situations where a patient's Medicaid number would not be included in the exhibit.
- **Column 12 (Newborn Baby Days)** – The reporting instructions for Newborn days is an unnecessary additional burden for providers. Eligibility is provided on a

monthly basis for many states. If a patient is deemed Medicaid eligible for the month of January, any hospital visit during that month is covered for Medicaid services.

Mother – Admission and Discharge Date of 1/1/2022-1/3/2022

Newborn – Admission and Discharge Date of 1/1/2022-1/4/2022

If the mother and newborn are both Medicaid eligible for January, their entire service is covered. Why would the hospital need to report two newborn days in Column 10 and one day in Column 12? Toyon does not see a known purpose or benefit in appropriating these days. A hospital would claim three newborn days as they are Medicaid eligible. A hospital would ask that they claim newborn days similarly to any other patient day, where the full stay is included within one line. We ask that CMS remove Column 12 from Exhibit 3A.

- **Column 13 (Primary Insurance Payer) and Column 14 (Secondary Insurance Payer)** – Reporting these columns, as explained per the instructions, is unnecessary. This leads to the question of what the assigned MAC auditor will use this column for. Eligibility is not based on solely payment information. There are going to be patients eligible from the state that could either be paid or unpaid, and it will not impact the hospital from claiming the patient day as DSH eligible. The directions state to enter the insurance company or other payer with the primary responsibility of paying the claim but these columns would merely show which insurance has a responsibility to pay, not whether any payment was actually made.
- **Column 15 (A/B Indicator) and Column 16 (Start Date) and Column 17 (End Date)** – Medicare Part B has no impact on a patient being claimed on the DSH exhibit. Medicaid determines the patient's Title XIX eligibility status. If a patient does or does not have Medicare Part B coverage, it does not impact the ability to report as Medicaid eligible. We ask that hospitals are not required to indicate whether a patient has Medicare Part B coverage.

IV. Worksheet S-10

Toyon proposes the following related to the reporting of Uncompensated Care (UC) on Worksheet S-10.

Financial Assistance Policies

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."

Toyon proposes CMS include language confirming hospitals may use presumptive charity resources (software, hospital authentication) to qualify patients for financial assistance, provided the method is referenced in the financial assistance policy.

Acute Care Only

For cost reports beginning on or after October 1, 2022 CMS proposes providers file Worksheet S-10, Part II, for inpatient and outpatient uncompensated care data billable under the hospital CCN.

Toyon requests CMS remove the new Worksheet S-10 Part II schedule, as carving out acute care vs. other uncompensated care is anticipated to be an onerous process. Providers have different methods and systems for adjudicating claims. Transaction amounts related to charity care, self-pay discounts, and non-covered Medicaid may be comingled for acute care and sub-acute care providers. There is no industry standard on how to appropriate these write-off amounts between acute and sub-acute care. Therefore, hospitals may encounter unique and burdensome hurdles producing or calculating the acute care portion of uncompensated care. Toyon recommends CMS remove Worksheet S-10 Part II to avoid creating an arduous task in working with patient data that is already large and time consuming to prepare for the entire hospital complex.

Revised Definitions

CMS revises the definitions of Charity Care and Uninsured Discounts to include the phrase, "*medically necessary health care.*"

Toyon opposes the addition of this language to definition of Charity Care and Uninsured Discounts and asks that CMS delete it from the revised worksheet S-10 definitions and subsequent instructions. Toyon is concerned this language will result in care delivered to a low-income patient that is disallowed due to a subjective interpretation involving billing, administrative errors, payment denials from patients that cannot be discharged home, etc. This would result in an inaccurate measurement of unreimbursed care to the low-income population, and would likely be subject to MAC audit variation.

Cost reports on or after October 1, 2022: Line 20, Column 1 (Uninsured Charity)

CMS proposed instructions state:

> "*Enter… total charges, or the portion of total charges for insured patients that were determined uninsured for the entire hospital stay*"

Toyon requests CMS provide examples of what types of write-offs qualify as "insurance patients determined uninsured". Do these charges include non-covered and denied

charges from ***any payor***, as long as the provider's FAP considers the patient to be "uninsured" in these circumstances? If this is true, then why does the S-10 explicitly and separately discuss the reporting of charges for "non-covered services provided to patients eligible for Medicaid or other indigent care programs," if included in the FAP?

CMS proposed instructions also state:

> *"Enter… total charges, or the portion of total charges, for patients with coverage from an entity/insurer that does not have a contractual or inferred contractual relationship with the provider;…"*

CMS defines an Inferred contractual relationship as:

> *"…a contractual relationship between an insurer and a provider will be inferred where a provider accepts an amount from an insurer as payment, or partial payment, on behalf of an insured patient (for example, payments from workman's compensation funds, payments from an automobile insurer for medical benefits, or payments from an insurer for out-of-network services)."*

Toyon requests CMS consider payments from inferred agreement that less than the cost of care as a charitable event. For instance, in many cases, worker's compensation and auto insurance payments reimburse only a small portion of cost. Worksheet S-10 Uncompensated Care is a appropriate area to recognize the cost associated with these underpayments as charity care. Toyon requests CMS amend this language to account for "charitable events," when providers are reimbursed less than the cost of care.

Cost reports on or after October 1, 2022: Line 20, Column 2 (Insured Charity)

CMS proposed instructions state:

> *"Enter… non-covered charges for days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs, if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria (such amounts are subject to the CCR and must be included on line 25);…"*

Toyon proposes this instruction is removed from Worksheet S-10 Line 20, Column 2. Providers already report all other forms of non-covered charges on Worksheet S-10 Line 20, Column 1. Days exceeding a LOS limit fall under the same instruction for Column 1 stating "charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs…". Reporting days exceeding a LOS limit apart from other forms of non-covered Medicaid creates an area of risk, as providers may inadvertently miss reporting these same amounts on Worksheet S-10 Line 25.

CMS proposed instructions state:

> *"Enter… charges, or the portion of charges, other than deductible, coinsurance, and co-payment (C+D) amounts that represent the insured patient's liability for medically necessary hospital services (such amounts are subject to the CCR, and must be included on line 25.01). These charges include a patient's liability from a contractual or inferred contractual relationship between a public program or private insurer and the provider."*

Toyon requests CMS provide examples of what types of write-offs (other than C+D) qualify as "insured patient's liability for medically necessary hospital services." Do these charges include non-covered and denied charges from any payor, as long as the provider's FAP considers the patient to be "uninsured" in these circumstances? Toyon also requests these amounts are reported with other uninsured charges on Worksheet S-10, Line 20, Column 1. This is to avoid any unintentional reporting errors, as providers may inadvertently miss reporting these same amounts on Worksheet S-10 Line 25.01.

Cost reports on or after October 1, 2022: Line 26, Column 1 (Bad Debt)

CMS proposed instructions state:

> *"…enter the amount of Medicare and non-Medicare bad debts/implicit price concessions (pursuant to the Accounting Standards Update, Topic 606) written off during this cost reporting period, net of recoveries, that relate to balances owed by patients, regardless of the date of service, for the entire facility..."*

Toyon requests CMS removes the requirement to include all Medicare bad debts on Line 26. Instead, Toyon recommends the instructions for Line 26 are revised to include bad debts/implicit price concessions for patient responsibilities regardless of the payor.

The bad debts related to Medicare patients that are reported as part of this amount should only include bad debts written off in the provider's financial accounting system during this cost reporting period. This is regardless of whether or when they meet any separate requirements for reimbursement as a Medicare bad debt (e.g., timely billing, returned from collection agency, etc.) elsewhere on the cost report.

Medicare indigent bad debts that are allowable per the FAP and processed as charity in the hospital's accounting system should be reported on Line 20 with other charity care (provided these amounts are not also reported as a bad debt on line 26). Eliminating the need to include all Medicare bad debts on Line 26 will significantly reduce confusion and administrative burden.

Line 27 (Medicare Reimbursable Bad Debts): Line 27.01 (Medicare Allowable Bad Debts), Line 28 (Non-Medicare Bad Debt Amount)

Toyon recommends that CMS remove these lines based on our comments above for Line 26 so that all bad debts are treated equally regardless if they meet the Medicare bad debt criteria. If CMS is concerned with the potential duplication of cost, we recommend that a new line be added to reduce the bad debt expense on Line 26 by 65% of the total Medicare bad debts reported elsewhere in the cost report.

V. Exhibit 3B (Charity Care Listing)

Toyon requests CMS only collect detailed charity care during the audit of Worksheet S-10. Producing this detailed information for the cost report filing AND the audit is burdensome, and unnecessary. The data in Exhibit 3B represents a "snapshot in time," and therefore certain amounts (e.g., contractual allowance) are only as accurate as when the report is run by the hospital. Toyon requests CMS provide a reasonable method for reporting certain information on the filed cost report, and a more detailed listing during audit.

PHI Fields – Toyon recommends CMS remove PHI fields that are not needed to validate uncompensated care cost. The transfer of this information is an unnecessary HIPAA risk, and maintaining this information on IT systems is more costly with rising insurance rates for storing PHI. Toyon recommends the following PHI fields are removed:

1. Last Name
2. First Name
3. Date of Service – From
4. Date of Service – To

Column 6 (Insurance Status) – Toyon requests CMS remove column 6 from Exhibit 3B. This data is reported in total on Worksheet S-10 Line 20, and already broken out between uninsured and insured patients in total. Requiring another level of detail for insurance status creates an undue administrative burden with no known benefit of providing this additional detail.

Column 11 (Deductible/Coinsurance/Copayment) – Toyon requests CMS remove column 11 from Exhibit 3B. There is no industry standard in how deductibles, coinsurances, and copayments (C+D) are captured (or not captured) in patient financial systems and will result in administrative burden to ensure the data is correctly reported. Furthermore, Worksheet S-10 Line 20, Column 2 may include a partial discount C+D, and there is no instruction on how to report these partial discounts**.**

Column 13 (Insured Contractual Allowances) – Toyon requests CMS remove the requirement that providers include insured contractual allowances. The strict definition of *insured contractual allowances* is not often maintained as a separate field in many

patient accounting systems. Additionally, providers may interpret the definition of an insured contractual allowance differently. The inclusion of this information will add confusion and additional administrative burden required to complete the exhibit and will not assist in validating what amounts may qualify as an insured patient's cost sharing (co-pay, coinsurance and deductible) written off to charity for Line 20, Column 2. Instead, the presence of co-pay, coinsurance and deductible in Column 11 should be used to determine what may be reported on Line 20, Column 2.

Furthermore, if Column 13 is a requirement, Toyon requests CMS to clarify what constitutes reporting as a contractual allowance. 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?

Column 14 (Non-Covered Charges) – As previously stated, Toyon recommends CMS remove discussion of "medical necessity" from Worksheet S-10 instructions. Toyon requests CMS to revise the instructions to state "Enter gross charges not covered and not allowable under charity care/FAP."

Column 17 (Uninsured Discount Amounts) – Toyon requests CMS remove column 17 from Exhibit 3B. It is not uncommon for a patient to be deemed insured for a portion of their services, and uninsured for the remaining balance. In these situations, a patient may receive a qualifying write-off for their cost-sharing responsibility AND an uninsured write-off for the portion of their stay that was deemed uninsured. These types of occurrences will create confusion with the reporting of amounts on Column 17, with no known benefit of itemizing these amounts.

Column 18 (Charity Care Non-Covered Charges) – Toyon requests CMS remove column 18 from Exhibit 3B. It is unknown if this amount on Exhibit 3B is meant to reconcile to Worksheet S-10, and this column creates another layer of reporting, which is an administrative burden to providers.

Column 19 (Other Charity Care Charges) – Toyon requests CMS remove column 19 from Exhibit 3B. It is unknown if this amount on Exhibit 3B is meant to reconcile to Worksheet S-10, and this column creates another layer of reporting, which is an administrative burden to providers. If CMS retains this column for Exhibit 3B, we request examples of what constitutes "Other Charity Care Charges."

Column 20 (Amounts Written Off to Charity Care and Uninsured Discounts) – Toyon requests CMS revise this Column so that all charity care and uninsured discounts reported on Worksheet S-10 Line 20 reconcile to this column, without itemizing and total amounts from columns 17 through 19.

Column 21 (Write-Off Date) – Toyon requests CMS clarify how hospitals should report accounts that have multiple write-off dates. Patients will have different dates for charity care, self-pay discounts and non-covered Medicaid. Furthermore, patients will also have subsequent reversals related to amounts written off. Toyon recommends CMS consider collecting a separate "transaction" listing, so that all transactions with their associated write-off dates are available. The data in Exhibit 3B would then be unique to each patient ID (regardless of the number of transactions).

VI. Exhibit 3C (Listing of Total Bad Debts)

Toyon requests CMS only collect detailed bad debt during the audit of Worksheet S-10. Producing this detailed information for the cost report filing AND the audit is burdensome, and unnecessary. The data in Exhibit 3C represents a "snapshot in time," and therefore certain amounts (e.g., contractual allowance) are only as accurate as when the report is run by the hospital. Toyon requests CMS provide a reasonable method for reporting certain information on the filed cost report, and a more detailed listing during audit.

PHI Fields – Toyon recommends CMS remove PHI fields that are not needed to validate uncompensated care cost. The transfer of this information is an unnecessary HIPAA risk, and maintaining this information on IT systems is more costly with rising insurance rates for storing PHI. Toyon recommends the following PHI fields are removed:

1. Last Name
2. First Name
3. Date of Service – From
4. Date of Service – To

Column 7 (Primary Payer) and Column 8 (Secondary Payer) – Toyon requests CMS revise the instructions for columns 7 and 8 by making these fields optional to report, as some patient accounts may be in collections for multiple years (subject to change in staff, patient accounting system conversions, etc.) before being written off.

Column 15 (Contractual Allowance/Other Amount) – Toyon requests CMS provide examples of what would constitute "other amounts."

Column 16 (A/R Write Off Date) – Toyon requests CMS 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. For instance, many hospitals recognize an account as written-off to bad debt when it moves from active A/R status to bad debt A/R status.

Additionally, it is very common for patients to have multiple bad debt write-offs, reversals, or other adjusting entries that impact the bad debt balance in the same reporting period. We ask CMS to clarify how providers should report bad debts for patients with multiple write-offs in the same reporting period.

Column 17 (Patient Bad Debt Write Off Amount) – Toyon requests CMS revise column 17 so that the bad debt write-off amount is directly reported, and not calculated from other fields in Exhibit 3C. Toyon is concerned Column 17 will not always calculate the bad debt amount accurately as CMS intends due to other adjustments including but not limited to reversals and recoveries.

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Thank you for providing Toyon the opportunity to submit our comments. Should you have any questions, please contact Fred Fisher at 888.514.9312 or fred.fisher@toyonassociates.com.

Respectfully,

Toyon Associates, Inc.