Ascension

William N. Parham III
Director
Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

July 22, 2022

Submitted electronically via: www.reginfo.gov/public/do/PRAMain

RE: Proposed Changes to CMS 2552-10 Hospital and Health Care Complex Cost Report (OMB Control Number 0938–0050)

Dear Director Parham:

Ascension appreciates the opportunity to submit comments in response to the proposed reinstatement with change of a previously approved collection, *Hospital and Hospital Health Care Complex Cost Report (Form Number: CMS-2552-10 (OMB control number: 0938-0050))*[1].

Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. As one of the leading non-profit and Catholic health systems in the U.S., Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. In FY2021, Ascension provided $2.3 billion in care of persons living in poverty and other community benefit programs. Ascension includes more than 150,000 associates and 40,000 aligned providers. The national health system operates more than 2,600 sites of care – including 143 hospitals and more than 40 senior living facilities – in 19 states and the District of Columbia.

As an overarching comment, we appreciate that the Centers for Medicare & Medicaid Services (CMS) has taken into consideration and acted upon a number of comments and recommendations offered in response to the agency's earlier proposed changes to the Hospital and Hospital Health Care Complex Cost Report ("the Cost Report"). Many of CMS's adopted changes will improve the utility of the Cost Report going forward. However, we remain concerned that several of the proposed changes, as well as the requirement to file the S-10 listing at the time of filing, will create additional administrative burden and redundancies at the time of audit, when we anticipate having to resend documentation to the Medicare Administrative Contractors (MACs). We encourage CMS to continue evaluating opportunities to limit administrative burden and filing redundancies, particularly in light of the ongoing workforce challenges that hospitals and health systems continue to navigate, and offer the following additional recommendations with those goals in mind. We appreciate CMS's consideration of these comments.

[1] 87 Fed. Reg. 37338 (June 22, 2022).

Worksheet S-2

In this Paperwork Reduction Act (PRA) package, the Form CMS-2552-10 is amended to revise Worksheet S-2, Part I to add Exhibit 3A, Listing of Medicaid Eligible Days for [Disproportionate Share Hospital (DSH)] Eligible Hospital, and instructions to §4004.1 to facilitate compliance with acceptable Cost Report submission requirements in 42 CFR 413.24(f)(5)(i)(C) for DSH eligible Medicaid days reported on Worksheet S-2, Part I, lines 24 and 25.

In reviewing line 24 and 25, we believe there is an opportunity for CMS to significantly simplify reporting and reduce administrative burden for both hospitals and MACs by eliminating the six columns currently required and creating a single column, which would be used to report DSH eligible days (titled, e.g., *Total DSH Medicaid Eligible Days*). We note that separating the DSH eligible days across the six delineated columns does not ultimately impact the Medicare DSH calculation. However, requiring this data to be collected and broken out across multiple sub-categories adds significant administrative burden when preparing the Cost Report. We thus encourage CMS to streamline this data collection. We also note our support for continued separate reporting of Acute and Rehab days on Lines 24 and 25.

Form CMS-2552-10 is further amended to add line 123, "to report certain purchased services." Specifically, CMS would require hospitals to report if a majority of professional expenses (>50%) are purchased from any unrelated organization(s) and, if so, whether those services were purchased from unrelated organization(s) located in a Core-Based Statistical Areas (CBSA) outside of the main hospital CBSA. We are concerned that the level of detail CMS is proposing to collect would create significant complexity and administrative burden without meeting a demonstrated need or providing clear value to CMS or the Medicare program. We encourage CMS to refrain from incorporating this line as proposed.

Exhibit 2A – Listing of Medicare Bad Debts

Similar to the comments above, Ascension is concerned Exhibit 2A will significantly increase hospitals' administrative burden when preparing the Medicare Bad Debt listing. The current Medicare Bad Debt schedule (Exhibit 2) requires a hospital to populate 10 columns, while the proposed new Medicare Bad Debt schedule (Exhibit 2A), required for a cost reporting period beginning on or after October 1, 2022, would require a hospital to complete 25 columns. We are again concerned that the additional new required data elements–and the granular level of detail requested by CMS–will prove extremely complex to collect and report, and represents data that CMS has not presented a meaningful need for in support of hospitals' claiming of Medicare Bad Debt.

We note that hospitals have created processes to standardize their Medicare Bad Debt logs to meet the current Exhibit 2 format and data reporting requirements. A change to these hospital processes will result in additional cost and administration burden, and could potentially result in higher error rates from reporting new data to new fields–further adding to the complexity and administrative burden associated with the Cost Report process. We encourage CMS to maintain the existing, reliable exhibit that is already in place in support of Medicare Bad Debt claims. In the alternative, we would strongly recommend CMS eliminate at least the following columns from Exhibit 2A, which we believe could help strike a balance between creating undue burden on hospitals and allowing CMS to gather additional data:

- **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. As this date is not used to report the bad debt, and the write-off date is included in another

column, we believe CMS could eliminate Column 10 to help ease the additional time and burden that the hospital will need to complete the bad debt exhibit.

- **Column 12 (Beneficiary Responsibility Amount)** – It appears this column may be redundant with Columns 20 and 21; if this is not accurate, we encourage CMS to more expressly clarify the data requested under Column 12.
- **Column 19 (Recoveries Only: Fiscal Year End Date)** – Because CMS states this column is optional, we ask that the column be eliminated to avoid confusion and inconsistency. If the hospital wishes to report this information, they can do so in Column 25, which allows for additional comments.
- **Column 23 (Current Year Payments Received Source)** – We are concerned that obtaining this information accurately and completely will be extremely resource intensive, if not impossible, while providing no clear support for the amount of bad debt claims, and thus encourage CMS to eliminate this column.

At the same time, we support the removal of all HIPAA related patient health information (PHI) during the cost reporting submission for Exhibits 2A, 3A, 3B, and 3C. During the desk review audit, hospitals can provide additional patient data—including PHI, as needed—directly to the assigned auditor. We appreciate CMS's recognition of the potential risks and costs associated with maintaining and transmitting this information as part of the Cost Report filing and support finalizing the removal of such PHI data.

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

As discussed above, with respect to Worksheet S-2 Lines 24 and 25, we encourage CMS to move away from requiring hospitals to report their DSH days in six separate columns and ask that this data collection be consolidated into one single column. We are also concerned that CMS is requiring hospitals to submit one exhibit per CMS Certification Number (CCN). We note that there are patient populations comprising a hospital's DSH eligible days whose data will be audited based on differing criteria. As such, we believe hospitals should be allowed to report on these patients separately, so they are subsequently sampled with similar types of patient days. We caution CMS against putting hospitals in situations where a sample is selected containing patients that require multiple levels of documentation support (*e.g.*, emergency, waiver days, etc.) with patients that require only a UB claim form to document their stays. As currently proposed by CMS, an auditor would sample these patients as one population, which is neither reasonable for audit purposes nor aligned with current industry standards. We therefore encourage CMS to allow hospitals the flexibility to separate out similarly situated patient populations across different schedules. Additionally, we offer the following comments regarding specific proposed columns within Exhibit 3A:

- **Column 6 (Medical Record Number)** – We encourage CMS to remove this column given that reporting the Medical Record Number (MRN) is redundant, 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, whereas 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. From a practical perspective, only the patient account number will be used by both the hospital and the MAC.

- **Column 7 (Medicaid Number)** – We agree with CMS's instruction to refrain from reporting the patient's date of birth and social security number and encourage CMS to also remove this column for reasons similar to those stated by CMS in the instructions for Column 18. Not only would this proposed Column 7 contain confidential patient information, but we note that not all states use or require the Medicaid number to perform the DSH eligibility matching process. We encourage CMS to remove this column to avoid confusion and potential data privacy concerns.

- **Column 12 (Newborn Baby Days)** – We encourage CMS to remove this proposed column to prevent redundancy with Column 10 and confusion for hospitals. It is unclear what the intended purpose or benefit is to appropriate these days as proposed and we ask that hospitals be allowed to claim newborn days similarly to any other patient day, where the full stay is included within one line.

- **Columns 13 (Primary Insurance Payer) and 14 (Secondary Insurance Payer)** – We encourage CMS to remove these proposed columns as they will create additional data collection and reporting burden without providing demonstrably necessary data. While the proposed directions require the insurance company or other payer with the primary responsibility of paying the claim be reported, these columns would merely show *which* insurance had or has a responsibility to pay, not *whether* any payment was actually made–the latter being the key relevant data.

- **Columns 15 (A/B Indicator), 16 (Start Date), and 17 (End Date)** – Because eligibility for Medicare Part B has no impact on a patient being claimed on the DSH exhibit, we encourage CMS to limit or eliminate these columns for Part B patients.

Worksheet S-10

As a general matter, we strongly encourage CMS to provide greater clarity in the Exhibit 3B instructions to avoid inconsistent reporting among providers and differing MAC interpretations. We are grateful that CMS, MACs, and hospitals have collaborated in recent years to ensure alignment in understanding and approaches to the current reporting structure and caution CMS against unnecessarily creating confusion and uncertainty. We also offer the following recommendations related to the reporting of Uncompensated Care (UC) on Worksheet S-10.

Financial Assistance Policies

CMS proposes to add 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." To avoid confusion, Ascension encourages CMS to include additional language confirming that hospitals may use presumptive charity resources (*e.g.*, 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 to require that providers file Worksheet S-10 Part II, for inpatient and outpatient uncompensated care data billable under the hospital CCN. We encourage CMS to remove the new Worksheet S-10 Part II schedule, as we anticipate that carving out acute versus other uncompensated care is likely to be an overly burdensome process. We note that 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 subacute care providers. There is currently no industry standard on how to appropriate these write-off amounts between acute and subacute care. Therefore, hospitals may encounter unique and burdensome hurdles when attempting to produce or calculate the acute care portion of uncompensated care. As such, we recommend that CMS remove Worksheet S-10 Part II to avoid creating additional and unnecessary administrative burden.

Revised Definitions

CMS proposes to revise the definitions of Charity Care and Uninsured Discounts to include the phrase, "*medically necessary health care."* We are concerned that the addition of this language to the definition of Charity Care and Uninsured Discounts will result in improper disallowances at the time of audit for care delivered to low-income patients and strongly encourage CMS to delete this clause from the revised Worksheet S-10 definitions and subsequent instructions. We caution that this language could result in an increase in subjective interpretations related to billing, administrative errors, payment denials from patients that cannot be discharged home, and other unforeseen circumstances. This would in turn result in an inaccurate measurement of unreimbursed care to the low-income population and would likely be subject to MAC audit variation. We also strongly encourage CMS to take into consideration that most auditors are not medical reviewers and thus refrain from inserting new language that could create inconsistent interpretations and improper denials at the time of audit.

Cost Reports on or After October 1, 2022: Line 20, Column 1 (Uninsured Charity)

CMS's proposed instructions instruct hospitals to: "*Enter… total charges, or the portion of total charges for insured patients that were determined uninsured for the entire hospital stay."* We encourage CMS to provide examples of what types of write-offs qualify as "insured patients that were determined uninsured." Questions CMS might consider addressing would include: do these charges include non-covered and denied charges from ***any payor***, as long as the provider's financial assistance policy considers the patient to be "uninsured" in these circumstances? If so, we encourage CMS to clarify the relationship between these data and the S-10 explicitly and separately discussing the reporting of charges for "non-covered services provided to patients eligible for Medicaid or other indigent care programs," if included in the financial assistance policy.

CMS's proposed instructions also instruct hospitals to: *"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…"* and defines an inferred contractual relationship as follows: *"…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)."*

We strongly encourage CMS to consider payments from inferred agreements that are less than the cost of care as a charitable event. For instance, in many cases, workman's compensation funds and automobile insurance payments reimburse only a small portion of the cost of care. We believe Worksheet S-10 Uncompensated Care is an appropriate area to recognize the remaining costs associated with these underpayments as charity care. We therefore encourage CMS to amend this language to account for "charitable events," when providers are reimbursed less than the cost of care.

CMS further indicates that "Hospitals that received HRSA-administered Uninsured Provider Relief Fund (PRF) payments, as authorized by the CARES Act (Pub. L. 116-136), for services provided to uninsured COVID-19 patients, must not include the patient charges for those services. Under the terms and conditions of the PRF, payments are considered payment in full for such care or treatment." We appreciate CMS clarifying these requirements with respect to HRSA Uninsured PRF payments and encourage CMS to further define the appropriate timeframe that a provider must wait before writing unpaid claims off to charity to allow these claims to be included as uninsured charity on S-10, Line 20, Column 1. We note that the PRF terms and conditions do not address how providers must treat outstanding unpaid claims for which no denial has been received. Yet, currently, there are a large number of claims that exceed 270 days but have neither been paid nor denied. We would greatly appreciate guidance from CMS on whether and when such unpaid HRSA Uninsured PRF claims may be written off and claimed as uninsured charity.

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

CMS's proposed instructions require hospitals to: *"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 [financial assistance policy] and the patient meets the hospital's policy criteria (such amounts are subject to the CCR and must be included on line 25);…"* We encourage CMS to consider removing this data element from Worksheet S-10 Line 20, Column 2, as we believe it is redundant given that hospitals already report all other forms of non-covered charges on Worksheet S-10 Line 20, Column 1. It is our understanding that days exceeding a length-of-stay (LOS) limit should fall under the same instruction for Column 1, which instructs that hospitals report "charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs." We are concerned that dedicated reporting of days exceeding a LOS limit, apart from other forms of non-covered Medicaid, could result in confusion and unintended reporting errors and we again encourage CMS to refrain from incorporating this new data element.

Finally, CMS's proposed instructions would require hospitals to: *"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."* We encourage CMS to provide examples of the types of write-offs (other than C+D) that would qualify as "insured patient's liability for medically necessary hospital services." For instance, we would welcome additional clarity on whether 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. We also encourage CMS to consider whether these amounts would most accurately be reported with other uninsured charges on Worksheet S-10, Line 20, Column 1. This would help avoid any unintentional reporting errors, as providers may inadvertently miss reporting these same amounts on Worksheet S-10, Line 25.01.

Exhibit 3B (Charity Care Listing)

As noted above, we often find that we are required to submit – or resubmit – detailed data on charity care during the audit process to accommodate the processes, technology infrastructure, or requests of our MACs. Ascension therefore encourages CMS to consider only collecting detailed charity care during the audit of Worksheet S-10. Producing this detailed information for both the Cost Report filing *and* the audit has proven to be extremely burdensome, duplicative, and ultimately unnecessary. We note, also,

that 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. We thus encourage CMS to provide a reasonable method for reporting certain information on the Cost Report at the time of filing, while allowing more detailed data to be provided during audit. We also offer the following comments on several specific columns and data collection requirements, as proposed:

- **Column 11 (Deductible/Coinsurance/Copayment)** – We encourage CMS to remove Column 11 from Exhibit 3B as there is currently no industry standard related to how deductibles, coinsurances, and copayments (C+D) are captured (or not captured) in patient financial systems and, as a result, this data collection will increase 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 such partial discounts**.**

- **Column 14 (Non-Covered Charges)** – We recommend CMS refrain from incorporating this data element and, as previously stated, we strongly encourage CMS to remove any discussion of "medical necessity" from Worksheet S-10 instructions. We recommend that CMS revise the instructions to state "Enter gross charges not covered and not allowable under charity care/FAP." It is also our understanding that these charges are to be excluded, which would result in this column being consistently populated with $0 if such non-covered charges are removed as instructed.

- **Column 15 (Payments)** – We recommend CMS clarify this Column, particularly in relation to others (*e.g.*, charity care is determined as Column 9 minus Columns 10, 11, 12, 13, 14, 15, and 16, and is reported in Column 17, 18, or 19).

- **Column 19 (Other Allowable Charges)** – We recommend CMS remove this Column from Exhibit 3B as well, as it appears to be redundant. However, if CMS retains this Column for Exhibit 3B, we respectfully request that CMS provide examples of what constitutes "Other Allowable Charges." For instance, CMS might clarify whether this is supposed to represent deduct, coinsurance and copays.

- **Column 20 (Amounts Written Off to Charity Care and Uninsured Discounts)** – We encourage CMS to 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 totaling amounts from Columns 17 through 19.

- **Column 21 (Write-Off Date)** – We encourage CMS to clarify how hospitals should report accounts that have multiple write-off dates. In our experience, it is often the case that patients may have different dates for charity care, self-pay discounts, and non-covered Medicaid. Furthermore, patients can also have subsequent reversals related to amounts written off. We thus recommend that 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).

We offer the following examples in an effort to illustrate our concerns and highlight opportunities for additional clarity from CMS:

EXAMPLE: Exhibit 3B – Charity Care

	Column Number 9	Column Number 10	Column Number 11	Column Number 12	Column Number 13	Column Number 14	Column Number 15
	TOTAL CHARGES FOR CLAIM	PHYSICIAN / PROFES-SIONAL CHARGES	DEDUCT-IBLE / COINSUR / COPAY AMOUNTS	TOTAL THIRD PARTY PAYMENTS	INSURED CONTRAC-TUAL ALLOWANCE AMOUNT	NON-COVERED CHARGES	TOTAL PATIENT PAYMENTS
Example 1	1,000	-	0	400.00	600.00		-

	Column Number 16	Column Number 17	Column Number 18	Column Number 19	Column Number 20	Column Number 21
	AMOUNTS WRITTEN OFF AS BAD DEBT	UNINSURED DISCOUNT AMOUNTS	CHARITY CARE NON-COVERED CHARGES	OTHER CHARITY CARE CHARGES	AMOUNTS WRITTEN OFF TO CHARITY CARE AND UNINSURED DISCOUNTS	WRITE OFF DATE
Example 1	0	-1,000	-	-	-1,000	1/1/2022

Opportunities for Additional Clarification:

- For Exhibit 3B – We encourage CMS to clarify whether amounts documented in Columns 10 through 20 are intended to all be positive values.
- For Exhibit 3B – Professional fees documented in Column 10 must be allocated across all adjustments that posted on the account. Hospital's bill total charges incurred for the patient visit, not total charges, less professional fees. The current formula assumes that total charges are net of professional fees before any adjustments are made.
- We encourage CMS to clarify how administrative adjustments and denial adjustments should be documented.
- For a charity reversal transaction, we are concerned that the formula referenced for Column 17 would result in a $0.00 recovery. See example 1, above, where the charity reversal was $1,000 due to insurance adjudicating the account.
    - Per Column 15 instructions, the following note indicates that charity reported on Line 20 can be a calculated amount (*i.e.*, Charity care is determined as column 9 minus columns 10, 11, 12, 13, 14, 15, and 16, and is reported in column 17, 18, or 19).

EXAMPLE: Exhibit 3C – Bad Debt

	Column Number 10	Column Number 11	Column Number 12	Column Number 13	Column Number 14	Column Number 15	Column Number 16	Column Number 17
	TOTAL CHARGES FOR CLAIM	PHYSICIAN / PROFES-SIONAL CHARGES	TOTAL PATIENT PAYMENTS	TOTAL THIRD PARTY PAYMENTS	PATIENT CHARITY CARE AMOUNT	CONTRAC TUAL ALLOWAN CE/OTHER AMOUNT	A/R WRITE OF DATE	PATIENT BAD DEBT WRITE OFF AMOUNT
Example 1	5,000	-	1,000	-	-	-	1/1/2022	4,000

Opportunities for Additional Clarification:

- For Exhibit 3C – We encourage CMS to clarify whether amounts documented in Columns 10 through 15 and Column 17 are intended to all be positive values.
- For Exhibit 3C – Professional fees documented in Column 11 must be allocated across all adjustments that posted on the account. Hospital's bill total charges incurred for the patient visit, not total charges, less professional fees. The current formula assumes that total charges are net of professional fees before any adjustments are made.
- We encourage CMS to clarify how administrative adjustments and denial adjustments should be documented.
- For a Bad Debt recovery transaction, the formula referenced for Column 17 would result in a $0.00 recovery. See example 1, above, where total patient payments on the account are $1,000, which posted in the cost reporting period. Under this example, $5,000 had been written off to bad debt and reported on Line 26 in the prior year's Worksheet S-10. The formula in Exhibit 3C calculates bad debt as $4,000, which would be incorrect.

Exhibit 3C (Listing of Total Bad Debts)

Finally, we offer the following comments on two specific columns and data collection requirements, as proposed for Exhibit 3C:

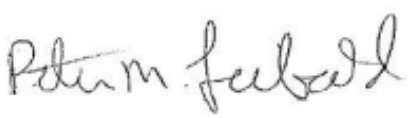
- **Column 16 (A/R Write Off Date)** – We encourage CMS to clarify in the instructions that the date reported in Column 16 is the date the account is written off the hospital's financial accounting system (and financial statements) and not the date that all collections activities cease. For instance, 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 thus 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)** – We encourage CMS to revise Column 17 so that the bad debt write-off amount is directly reported, and not calculated from other fields in Exhibit 3C. We are concerned that Column 17, as proposed, will not always calculate the bad debt amount as accurately as CMS intends, due to other adjustments including, but not limited to, reversals and recoveries.

Conclusion

We appreciate your consideration of these comments. If you have any questions, or if there is any additional information we can provide, please contact Mark Hayes, Senior Vice President for Policy and Advocacy for Ascension, at 202-898-4683 or mark.hayes@ascension.org.

Sincerely,



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