Federation of American Hospitals®

Charles N. Kahn III
President and CEO

July 22, 2022

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

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

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, D.C and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. The FAH appreciates the opportunity to comment on proposed revisions to the Hospital and Health Care Complex Cost Report, Form CMS-2552-10 (OMB Control Number 0938– 0050), following CMS' Notice, published in the Federal Register on June 22, 2022 (87 Fed. Reg. 37,339).

I. Worksheet S-2, Part I, Lines 24 and 25 and Exhibit 3A (DSH Eligible Medicaid Days)

CMS instructs hospitals to support the Medicaid days on Worksheet S-2, Part I, line 24 or line 25 by completing new Exhibit 3A. The FAH urges CMS to simplify the reporting of Medicaid days by consolidating the six columns in lines 24 and 25 into a single column for all Medicaid days and only require the completion of a single copy of Exhibit 3A for all Medicaid days reported. Although lines 24 and 25 have been included for some time, the FAH questions the necessity of separately reporting on specific categories of Medicaid days in six columns (Medicaid 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 HMO days, and Medicaid other). Refining the Medicaid days data into the six categories for reporting purposes does not further accurate

payment and imposes a significant and unnecessary administrative burden on providers. This administrative burden would be compounded by new Exhibit 3A because many providers do not store claims data broken out by the six categories in columns 1 through 6 of lines 24 and 25.

The FAH, therefore, requests that CMS eliminate the separate columns for lines 24 and 25 to streamline reporting of Medicaid days and to instruct providers to only complete one version of new Exhibit 3A. If CMS maintains the separate columns in lines 24 and 25, the FAH requests that CMS permit providers to complete a single Exhibit 3A that crosswalks each entry to the six columns in lines 24 and 25. The FAH also asks that CMS clarify that column 5 (Medicaid HMO days) includes both in-state and out-of-state Medicaid HMO days and includes both paid and HMO-eligible but unpaid Medicaid HMO days.

Additionally, the FAH makes the following recommendations regarding new Exhibit 3A:

- **Patient Name (Columns 1-2).** Exhibit 3A requires hospitals to separately report the patient's last name in column 1 and first name in column 2. Some providers, however, maintain claims data showing the patient's full name in a single field. Although CMS' response to stakeholder comments that it declined to combine these columns in order to promote consistency among various proposed exhibits, the FAH asks CMS to clarify whether a provider can provide a listing of Medicaid eligible days that alters the presentation and order of data by combining the patient name into a single field. Having to break the field into two columns would be an administrative burden for these providers.

- **Medicaid Recipient ID Number (Column 7).** The instructions for new Exhibit 3A ask for the Medicaid recipient identification number in column 5. However, hospitals may not have Medicaid identification numbers for Medicaid recipients. For example, Medicaid recipients covered by Medicaid managed care organizations (MCOs) may not have an identification number because MCOs frequently use their own HIC or insurance identification number. ***The FAH therefore asks CMS to clarify that a hospital may report any alternative identification number used by the Medicaid MCO in the absence of a Medicaid beneficiary identification number.*** In addition, the FAH is concerned that hospitals in some states may be unable to fully complete Exhibit 3A because some state Medicaid plans do not return recipients' Medicaid identification numbers to providers, and this data will not be available to providers in the event that a recipient does not provide their Medicaid identification number. Because eligibility matches can be (and, in past audits, have been) completed using social security numbers and birth dates—***the FAH requests that CMS permit the reporting of alternative data (including social security numbers or birth dates) in column 5 where the Medicaid recipient identification number is not available***. In the alternative, the FAH requests that CMS require state Medicaid plans to provide Medicaid identification numbers to providers.

- **State Plan Eligibility Code (Column 8).** The instructions for column 8 require hospitals to enter the applicable state plan eligibility code number (if available) and to report additional eligibility codes in column 18, but this information is

burdensome to supply and provides no apparent value. In fact, because eligibility codes are variable between states, this data would not even be standardized across providers. ***Therefore, the FAH urges CMS to delete column 8 from Exhibit 3A as unnecessarily burdensome.***

- **Newborn Baby Days (Column 12).** Many babies have complications with birth that result in a stay with a concurrent and non-concurrent portion. The instructions specify that, for a newborn baby born to a Medicaid eligible mother, the number of newborn baby days occurring prior to the mother's date of discharge (the concurrent portion of the stay) is reported in column 12, and that the newborn baby days occurring after the mother's discharge (the non-concurrent portion of the stay) is reported on a separate line in column 10. The FAH is concerned that reporting the concurrent and non-concurrent days separately in two lines would create a significant administrative burden for providers and increases the risk of errors (*e.g.*, duplication of days or total eligible days exceeding the total length of stay). Rather, the FAH urges CMS to instruct providers to report the entire stay of the newborn baby (both the concurrent and non-concurrent portions) in one number in column 12 and to create a separate column to identify the newborn baby days from the non-concurrent portion of the stay. Determining and reporting the total newborn baby days and the number of non-concurrent newborn baby days in a single column provides the same information, but in a manner that reduces unnecessary burden and decreases the risk of errors.

- **Primary Payer (Column 13) and Secondary Payer (Column 14).** The instructions for columns 13 and 14 require hospitals to enter the name of the patient's primary and secondary insurer or other payer. This data is not necessary to confirm Medicaid eligible days, and the ***FAH recommends that CMS reduce the regulatory burden associated with Exhibit 3A by removing these unnecessary columns.*** If CMS does not remove these columns, the FAH seeks clarification as to whether these columns include information for payers that failed to make payment for the stay.

II. Worksheet S-2, Part I, Lines 88-89 (TEFRA Adjustment Date)

CMS proposes to add lines 88 and 89, including column 2 to line 89, which requests the effective date for the provider's permanent adjustment to the target amount per discharge under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). ***The FAH requests that CMS delete column 2 from new line 89*** because some hospitals may not know the specific date on which the permanent adjustment was granted and CMS already has this information. The proposed instructions for line 89 specify that the requested date is for the cost reporting beginning date for which the permanent adjustment was effective. In many cases, the permanent adjustments to the TEFRA targets were granted more than a decade ago. Those individuals familiar with the circumstances of how and when the hospital received the adjustment have left the organization. Meanwhile, because CMS has this information, the inclusion of column 2, line 89 is unnecessary. ***In the alternative, CMS should require that the MAC provide the information requested in line 89 to any requesting provider.***

III. Worksheet S-2, Part I, Line 123 (Purchased Administrative Services)

The FAH urges CMS to remove proposed line 123 from Worksheet S-2, Part I because this addition to the cost report would impose a significant and unnecessary administrative burden on providers without providing data necessary for determining the amount of payments due the provider. As modified, line 123 would require providers to report whether the majority of professional services expenses were purchased from an unrelated organization located in a core-based statistical area (CBSA) outside of the main hospital CBSA. Hospitals widely use purchased legal, accounting, tax preparation, bookkeeping, payroll, and management consulting services and do not track the percentage of services that are purchased from unrelated organizations, let alone whether the unrelated organization is in the main hospital's CBSA. It is also unclear when an unrelated organization would be considered to be located in the main hospital CBSA for purposes of proposed line 123—in many instances, organizations providing these services may have a local office in the main hospital's CBSA but, in light of the complexity of the tax, accounting, and legal rules applicable to providers, will leverage staff resources outside the CBSA to provide the requisite level of expertise on individual projects.

Overall, the costs imposed by this data element (even with the modification to report whether the proportion is more or less than half instead of the exact percentage) would be vastly disproportionate to the value of the data collected. As such, the FAH strongly opposes the addition of line 123 and urges CMS to remove it from Worksheet S-2.

IV. Worksheet S-2, Part II, Exhibit 2A (Listing of Medicare Bad Debts)

A. Flexibility, Beneficiary Name (Columns 1 & 2) and Medicaid number (Column 7)

The FAH requests the CMS permit providers flexibility to alter the presentation and order of data reported in Exhibit 2A and to include additional information and data elements where appropriate. Updating provider templates to present these data elements in the exact order and with identical wording would be administratively burdensome and impose unnecessary costs on providers. For example, some providers normally have recoveries listed in a separate tab, and if they are required to conform to the format of Exhibit 2A, columns 18 and 19 on the new template may have missing information if years have passed since the provider claimed the initial bad debt. In addition, updating current templates that are not separated by inpatient and outpatient would be burdensome, and the FAH requests confirmation as to whether providers have the ability to report Medicare bad debts without separate listings for inpatient and outpatient services.

Along these lines, the FAH notes that Exhibit 2A does not include columns for reporting non-allowable portions, which need to be taken into consideration in order to compute the amount of the patient responsibility. The Exhibit does not include columns for non-covered items and services, such as self-administered drugs and professional fees. Additional patient payments may be proportionally applied to these items, but without this information, and this data would aid in substantiating the allowable bad debt amount in these situations. The flexibility to modify the form and fields of Exhibit 2A, as described above, would enable providers to report this information where appropriate.

For the same reasons explained above with respect to Exhibit 3A, ***the FAH requests CMS clarification that a provider may combine the patient name into a single field and furnish the alternative identification number used by the Medicaid MCO in the absence of a Medicaid beneficiary identification number.*** Likewise, the FAH requests that CMS make a corresponding change to the instructions to Exhibit 2, column 4 so that alternative identifiers may be used where no Medicaid identification number is available.

B. Collection Effort Ceased Date (Column 16)

Column 16 on new Exhibit 2A requires reporting of 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." ***The FAH urges CMS to remove this column as unnecessary.*** In many instances, this date is the same date that will be reported in column 15 (return date from collection agency) and/or column 17 (Medicare write off date), making column 16 largely redundant. In addition, because providers do not currently report on the Medicaid denial date, reporting in column 16 will necessitate another burdensome process change to gather and provide this information.

C. Medicare Bad Debt Write-Off Date (Column 17)

It is the FAH's understanding that the write-off date cannot be earlier than the latest date reported in columns 14, 15, or 16, but the FAH requests that CMS clarify in the instructions that a provider is not otherwise limited in the write-off date (*i.e.*, the Medicare bad debt write-off date may be later than the dates reporting in columns 14, 15, and 16). ***In addition, the FAH requests that CMS address differences in the write-off date and write-off effective date for correct MAC misunderstandings of hospital operations and accounting.*** In some cases, a provider might have a Medicare year end of December 31 with a post-close period through January 4. Bad debts written off in this post-close period would still have an expense effective date of December 31, which is the actual write off date recorded on the general ledger for the provider cost reporting period in question, and the bad debt in these situations should still be allowed in the period that the expense is realized.

D. Current Year Payments Received (Columns 22 & 23)

Exhibit 2A includes new data fields on the amount and source of any deductible or coinsurance payments received from or on behalf of the Medicare beneficiary during the cost reporting period, before the account was written off. ***The FAH requests the elimination of these columns because payments related to the Medicare beneficiary deductible and coinsurance balance will often occur in prior year(s) and the separate reporting of prior and current year payments adds complexity and administrative burden without providing commensurate value.***[1] Instead, the FAH recommends replacing this column with a field to report the unpaid deductible and coinsurance amounts at the time of the Medicare write-off date reported in column 24. During an audit, the MAC would still be able to properly validate the unpaid deductible and

[1] In addition, the FAH requests a corresponding change to strike "less any payments in columns 18 and 22" from the instructions for Allowable Bad Debts reported in column 24.

coinsurance balance against the detailed payment history as part of the normal audit review process for bad debt amounts.

II. Worksheet S-10

A. Introduction

The FAH supports CMS' addition to the first paragraph of the instructions for Worksheet S-10 of a sentence clarifying that "CMS does not mandate the eligibility criteria that a hospital uses under its financial assistance policy."

B. Medical Necessity (definition of charity care and uninsured discounts, line 20, line 25.01, and Exhibit 3B columns 6, 14 and 18)

The revised definition of "Charity Care and Uninsured Discounts" includes a reference to medical necessity that invites confusion and potential arbitrary disallowances, and similar references are included in the instructions for lines 20 and 25.01 as well as columns 6, 14, and 18 of Exhibit B. ***The FAH requests that CMS strike the addition of "medically necessary" from the definition and other instructions***. Under the revised definition, charity care and uninsured discounts must 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 hospitals charity care policy or financial assistance policy, and the notion of medical necessity is incorporated in other instructions. As a general matter, ***Medicare cost report auditors are not clinicians and will not know the underlying clinical details of a case, and the FAH is concerned that these new references to medical necessity may give rise to inappropriate reviews of medical necessity, diverting both hospital and auditor resources without improving the accuracy of the data reported in Worksheet S-10.***

C. "If Such Inclusion is Specified" (lines 20 & 25, and Exhibit 3B)

The revisions to the instructions for Worksheet S-10 also includes the qualification that charges can only be included in particular fields "if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria." ***The FAH requests that CMS remove this ambiguous language from the instructions for lines 20 and 25 and Exhibit 3B to reduce the risk of arbitrary disallowances and unnecessary administrative burdens.*** As written, this language could prompt some auditors to erroneously interpret and extend this language to require unreasonably specific and granular provisions in charity care and financial assistance policies. An overly stringent interpretation of this term could result in the particularized description of a wide variety of clinical and coverage scenarios in hospital policies to ensure that each patient who meets the financial criteria to receive charity care or financial assistance can be included in the charity care charges and uninsured discounts reported in Worksheet S-10. The resulting costs and administrative burdens would not further the accuracy or reliability of Worksheet S-10 data, and the FAH therefore urges CMS to remove this language. The propriety of including amounts in line 20 should turn on whether the patient has an outstanding balance related to services rendered and meets the financial criteria set forth in the hospital's charity care or financial assistance policy.

D. Reporting simplification through the use of insured and uninsured Columns (lines 20 to 23)

At present, column 1 of line 20 is used to report uninsured individuals and column 2 of line 20 covers (1) deductible, coinsurance, and copayment amounts for insured patients, (2) non-covered charges for days exceeding a length of stay (LOS) limit under Medicaid or another indigent care program, and (3) charges other than deductibles, copayment, and coinsurance amounts that represent the insured patient's liability. ***The FAH believes that reporting in line 20 could be simplified by moving the second and third categories of charges to column 1 and making corresponding changes to lines 21 through 23, which would simplify the preparation of the cost report and reduce the likelihood of error. This would also eliminate the need for line 25.01.*** Under this approach, column 2 would be limited to deductible, copayment, and coinsurance amounts for insured patients that are written off to charity care. Meanwhile, column 1 would cover 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 deductible, copayment, or coinsurance amounts. This change would be consistent with the instructions to new Exhibit 3B, which requires separate listings of charity care amounts for uninsured and insured patients.

E. Exhibit 3B (Charity Care Listing)

1. Simplification and Consistency with Audit Schedules

As a threshold matter, the FAH is concerned that Exhibit 3B differs from the audit schedules that have been used in audits of charity care amounts to date. ***In order to achieve administrative simplification and reduce unnecessary costs associated with cost reporting and charity care audits, the FAH urges CMS to mandate that auditors use the final version of Exhibits 3B and 3C as the audit document for reported charity care and bad debt.*** Imposing this requirement on auditors would facilitate consistent auditing practices while economizing both CMS and provider audit resources. In addition, to facilitate smooth audits, the FAH also requests that the instructions for Exhibit 3B be modified to offer providers the ability to update this schedule to reflect subsequent changes in a patient's insurance status prior to an audit. Any charity care listing will reflect the patient account's status at the time the cost report is prepared, and as this information may change prior to audit, providers should be permitted to update Exhibit 3B at audit.

2. Multiple CCNs

The proposed instructions for Exhibit 3B (as well as those for Exhibit 3C) would require a separate listing for each CCN in the hospital healthcare complex, while Worksheet S-10 would require reporting data for all CCNs in the hospital health care complex in Part I and limiting the data to inpatient and outpatient services billable under the hospital CCN in Part II. In order to promote consistency and enable the direct crosswalking of data from these exhibits and Worksheet S-10, the FAH urges CMS to instead instruct providers to provide two listings of the exhibits that mirror Parts I and II of Worksheet S-10. In other words, the FAH urges that CMS instruct hospitals to submit two listings of patients for Exhibit 3B: the first listing would include data for all CCNs in the hospital health care complex (corresponding to Part I of Worksheet S-10) and the

second listing would be limited to data for inpatient and outpatient services billable under the hospital CCN (corresponding to Part II of Worksheet S-10).

3. Flexibility, Beneficiary Name (Columns 1 & 2)

Presenting charity care data using the form and structure of new Exhibit 3B would impose significant and unnecessary administrative burdens on providers unless providers have flexibility to alter the presentation and order of data reported in Exhibit 3B. ***The FAH therefore requests that CMS clarify that providers have the flexibility to modify or alter the presentation and order of data in this exhibit (as well as Exhibits 3A to Part I of Worksheet S-2 and Exhibit 2A to Part II of Worksheet S-2).***

Likewise, for the same reasons explained above with respect to Exhibit 3A to Worksheet S-2, Part I and Exhibit 2A to Worksheet S-2, Part II, ***the FAH requests that CMS clarify that a provider may combine the patient name into a single field (columns 1 & 2).***

4. Insurance Status (Column 6)

The form requires the provider to indicate the insurance status in one of three categories. Insured patients are broken out into two categories ("insured" and "insured but not covered"), but on Worksheet S-10, line 20, there is only a single column for entering data for insured patients (with no differentiation based on coverage). The FAH requests that CMS instead limit the categories of insurance status in column 6 to uninsured and insured patients, mirroring the columns in line 20 of Worksheet S-10 and reducing unnecessary provider reporting burdens. Otherwise, it is unclear how a hospital would report data for an insured patient that had both deductible and coinsurance and non-covered charges.

5. Write Off Date (Column 21)

In proposed Exhibit 3B, a provider would report "the date the charity care amount or uninsured discount was written off" in column 21. Because a patient may have multiple write off dates, the FAH requests that CMS clarify in the instructions that, in the event of multiple write off dates, the latest date in the cost reporting period should be reported in column 21.

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

Multiple CCNs. The proposed instructions for Exhibit 3C (as well as those for Exhibit 3B) would require completing a separate listing for the hospital and each component of the hospital complex (*i.e.*, each CCN), while Worksheet S-10 would require reporting data for all CCNs in the hospital health care complex in Part I and limiting the data to inpatient and outpatient services billable under the hospital CCN in Part II. In order to promote consistency and enable the direct crosswalking of data from these exhibits and Worksheet S-10, the FAH urges CMS to instead instruct providers to provide two listings of the exhibits that mirror Parts I and II of Worksheet S-10. In other words, the FAH urges that CMS instruct hospitals to submit two listings of patients for Exhibit 3C: the first listing would include data for all CCNs in the hospital health care complex (corresponding to Part I of Worksheet S-10) and the second listing would be limited

to data for inpatient and outpatient services billable under the hospital CCN (corresponding to Part II of Worksheet S-10).

Primary and Secondary Payor (Columns 7 & 8). The FAH urges CMS to revise the instructions for columns 7 and 8 (primary and secondary payer) to clarify that these columns are optional to report because this data may be unavailable for older accounts that are written off and claimed on Worksheet S-10, line 26 as bad debt years later.

Reporting Recoveries. The FAH also requests instructions for reporting recoveries in new Exhibit 3C. Patient information for recovery accounts (negative bad debt) may be difficult for many providers to extract given the way that these post-close transactions are posted. Although auditors have accepted the recovery amount data without patient detail, it appears that Exhibit 3C would not permit listing of recovery amounts without this patient-level detail.

Total Patient Payments (Column 12). The FAH requests that CMS include specific instructions that would apply where a patient has multiple accounts (dates of service) with outstanding balances and submits payment without indicating the account to which the payment should be applied. The FAH further recommends that CMS clarify that the provider may apply any such funds received to the oldest date(s) of service first, consistent with the recommendations in the Health Care Financial Management Association's *Best Practices for Resolution of Medical Accounts Receivable.*

Patient Charity Care Amount (Column 14). The FAH requests additional instructions for this data element, confirming that this field includes both charity care and uninsured discounts as reported in Worksheet S-10, line 20.

Write-Off Date (Column 16). The FAH appreciates CMS' confirmation in response to comments that the accounts receivable write-off date for the proposed Exhibit 3C is "the date that the provider writes off the account in the hospital's financial accounting system (and financial statements)." The FAH further requests, however, that CMS address MAC misunderstandings of hospital operations and accounting with respect to the write-off date and write-off effective date. In some cases, a provider might have a Medicare year end of December 31 with a post-close period through January 4. Bad debts written off in this post-close period would still have an expense effective date of December 31, which is the actual write off date recorded on the general ledger for the provider cost reporting period in question and reported in column 16, and the bad debt in these situations should still be allowed in the period that the expense is realized.

Patient Bad Debt Write Off Amount (Column 17). The FAH is concerned that the formula set forth in column 17 will not consistently calculate an accurate bad debt amount, particularly in the case of Medicare cross-over bad debt for dual eligible beneficiaries. The FAH therefore asks that CMS revise the instructions to column 17 to direct hospitals to report the patient bad debt write off amount rather than calculating an amount using the specified formula. This approach would accommodate bad debt reversals and discrepancies in data collected in columns 12 through 15, improving the accuracy of the amounts reported in column 17.

III. Worksheet E-5 (Outlier Reconciliation at Tentative Settlement)

New Worksheet E-5 will be used by contractors to report outlier reconciliation amounts during the cost report tentative settlement. ***The FAH supports the addition of Worksheet E-5 and requests that CMS urge all MACs to apply the outlier reconciliation adjustment at the time of cost report tentative settlement and to notify CMS of interim reconciliation.*** This process will enable a prompt outlier reconciliation adjustment, which should operate to eliminate interest accruals on outlier reconciliations. At present, providers have confronted interest accumulations even when payment of provider-estimated outlier reconciliation amounts was made with submission of the cost report, and the FAH strongly supports establishing a process for permitting prompt outlier reconciliation adjustments in a manner that eliminates unnecessary interest accruals.

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The FAH appreciates the opportunity to comment on the proposed changes to CMS-2552-10, Hospital and Health Care Complex Cost Report. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,