July 22, 2022

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB Control Number CMS-2552-20 (OMB 0938-0050)
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Submitted electronically at *http://www.reginfo.gov*

RE: Health Care and Hospital Complex Cost Report, Billing Code 4120-01-P

Dear Director William N. Parham, III:

On behalf of Allina Health, we are writing in response to proposed changes to the Hospital and Health Care Complex Cost Report. Specifically, we are focused on changes to the Medicare Provider Reimbursement Manual 15-2, Chapter 40 pertaining to the S-10 worksheet. We offer comments requesting changes, improved clarity, concerns of unintended consequences, and more as the agency seeks to revise certain components of the Hospital and Health Care Complex Cost Report.

Allina Health is dedicated to the prevention and treatment of illness and enhancing the greater health of individuals, families, and communities throughout Minnesota and western Wisconsin. We serve our communities by providing exceptional care, as we prevent illness, restore health, and provide comfort to all who entrust us with their care. As a not-for-profit health care system with 30,000 employees, Allina Health provides care to our patients from beginning to end-of-life through our 11 hospitals, 90+ clinics, 15 pharmacies, specialty care centers and specialty medical services providing home care, senior transitions, hospice care, and emergency medical transportation. We are focused on eliminating health disparities and unnecessary variations in care to improve the health of the communities we serve.

Background and Summary of Changes

The Centers for Medicare and Medicaid Services (CMS) is requesting review and approval by the Office of Management and Budget (OMB) for the revisions made to OMB. No. 0938-0050, Form CMS-2552-10, the Hospital and Hospital Health Care Complex Cost Report. Hospitals and health care complexes (hospitals) participating in the Medicare program submit cost reports annually to

supply cost and statistical data used by CMS to determine reasonable costs. In this Paperwork Reduction Act (PRA) package, the Form CMS-2552-10 is amended to revise, among other provisions, Worksheet S-10, Hospital Uncompensated and Indigent Care Data. In years past, CMS has made changes to the Cost Report Worksheet S-10 and the data used to calculate its various components. While we appreciate the agency's commitment to reducing administrative burden, we have concerns with many of the proposed changes. As such, please accept the following as our comments in relation to various elements proposed for the S-10 worksheet as part of the Hospital and Health Care Complex Cost Report.

Section 4012 – Worksheet S-10 Hospital Uncompensated Care and Indigent Care Data

Worksheet S-10 Part I and Worksheet S-10 Part II

The proposed instructions call for completion of two parts for worksheet S-10, with Part II being a subset of Part I. **We believe completion of an additional schedule that is a subset of the original schedule is an unnecessary exercise that duplicates work, particularly when the Hospital CCN and Component CCN are required fields on the proposed Exhibit 3B and Exhibit 3C.** Completing one form would reduce work and reduce the probability of errors being made on detailed work papers.

Medically Necessary Health Care Services

The proposed instructions call for inclusion of only "medically necessary" health care services in the charity numbers and exhibit for worksheet S-10, without a clear definition of "medically necessary" services. **We believe the agency should supply a definition of "medically necessary" health care services that can be translated to elective cosmetic procedures and excludes decision-making authority of insurance companies about whether or not a service provided was medically necessary**. The absence of a definition of "medically necessary" opens the door to subjectivity and argument between providers and payors. As physicians at hospitals do not typically provide care that is not medically necessary, we implore CMS to address this area to mitigate the possibility of medical necessity denials and appeals.

Inferred Contractual Relationship

We appreciate the change to allow charges for patients with an inferred contractual relationship to be included in S-10, Line 20, Column 2 instead of Column 1, and appreciate the definition of "inferred contractual relationship". **However, we would appreciate clarity as to how the threshold for meeting the definition of inferred contractual relationship is achieved.** For example, is showing a contractual adjustment posted on the patient account sufficient evidence of an inferred contractual relationship?

Exhibit 3B – Charity Care Listing

Auditable Data

The charity care listing in exhibit 3B sufficiently captures all charity care charges; however, it does not match the data we are required to submit for S-10 audits and is not considered to be a best practice. **We encourage CMS to engage current S-10 auditors to develop a listing that would be a best practice for audits**. This would reduce duplicative and burdensome work, such as requiring hospitals to submit additional listings in a different format at the time of audit. We believe that the audit listing developed by Figliozzi & Company is sufficient in capturing all data needed for audit.

Exhibit 3C – Bad Debt Listing

Auditable Data

The Medicare bad debt listing in exhibit 3C seems to be sufficient to capture all bad debt charges; however, it does not match the data we are required to submit for S-10 audits and does not appear to be a best practice. **We would appreciate if additional time and effort was taken to work with current S-10 auditors to develop a listing that would be a best practice for audits**. This would reduce duplicative and burdensome work, such as requiring hospitals to submit additional listings in a different format at the time of audit. We believe that the audit listing developed by Figliozzi & Company is sufficient in capturing all data needed for audit.

Medicare Bad Debt

Based on the proposal, hospitals are required to submit Medicare Bad Debt in two separate exhibits: Exhibit 2A for worksheet E, and Exhibit 3C for worksheet S-10. Both exhibits have fields that are exclusive to those exhibits, requiring separate completion of both exhibits. We suggest that CMS exclude Medicare Bad Debt from Exhibit 3C for worksheet S-10. Alternatively, CMS could include required fields for Exhibit 3C in Exhibit 2A, which may allow for easier completion.

Column 16 – Date Amounts were Written Off as Bad Debt in Financial Statements

We request column 16 be removed from Exhibit 3C. Worksheet S-10 is required to be completed utilizing cash basis accounting. Meaning, hospitals are to include bad debt at a detail level in the period in which it is written off. Conversely, financial accounting is completed utilizing accrual basis accounting, reporting bad debt and implicit price concessions in the period in which the revenue is recorded. **Requiring the date for which amounts were written off in the financial statements runs conversely to reporting requirements for worksheet S-10 and should not be a required field in Exhibit 3C.**

Exhibit 3A – Listing of Medicaid Eligible Days

CMS proposes revisions to the cost report instructions for Worksheet S-2, including revisions to Line 24 of that form, and instructions for the filing of new cost report Exhibit 3A. **We urge CMS**

to revise its instructions to clarify that patient days for newborns receiving inpatient hospital services while the Medicaid eligible mother remains in the hospital, are to be included on Worksheet S-2, Line 24, Columns 1 through 5. As written, the instructions are inconsistent and do not make clear whether such days can be included in Worksheet S-2 and therefore, potentially violate the Medicare DSH and Medicaid statutes and accompanying regulations. *See* 42 U.S.C. § 1396a(e)(4); 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II); 42 C.F.R. § 435.117; 42 C.F.R. § 412.106(b)(4).

The instructions for the new Exhibit 3A on which hospitals would be required to list their Medicaid eligible days are unclear about how, or whether, newborn days occurring prior to the Medicaid eligible mother's discharge are to be reported on Worksheet S-2, Line 24. Based on those instructions, hospitals would report in Column 9 of that exhibit the specific column on Worksheet S-2, Line 24 where their Medicaid eligible days would be recorded. The vast majority of those days would be reported in Column 10 of the new exhibit, including the number of days for newborns remaining in the hospital *after* the Medicaid eligible mothers are discharged. The hospitals' number of labor and delivery days would be reported in Column 11 of the new exhibit, and "the number of newborn baby days occurring prior to the Medicaid eligible mother's date of discharge" would be included in Column 12.

The conflict in instructions arises where CMS instructs providers on how to aggregate the days listed in those various columns of the new Exhibit 3A on Worksheet S-2, Line 24, Columns 1-6, which are totaled to calculate the numerator of the Medicaid fraction. The instructions for Column 9 indicate that newborn baby days reported in Column 12 should be included on Worksheet S-2, Line 24. Those instructions provide that "[f]or each entry in columns 10 *and 12*, or column 11, *enter the Worksheet S-2, Part I, column number where the days were reported*." (Emphases added). This language indicates that newborn days prior to the mother's discharge listed in Column 12 of the new exhibit should be included on Worksheet S-2, Line 24. But the instructions for Column 10 state that the number of days included on Worksheet S-2, Line 24, Columns 1-5 must equal the total number of days reported in Column 10, which appears to exclude the newborn days separately reported in Column 12. The instructions for Column 10 also state, however, that "the sum of the days summarized by each column reported in column 9 must equal the days reported in the respective column on Worksheet S-2," which would again seem to include the newborn days separately reported on Column 12. Thus, CMS's proposed instructions are inconsistent and do not elucidate how or whether newborn days occurring before the Medicaid eligible mother's discharge are to be reported on Worksheet S-2, Line 24.

To the extent that CMS seeks to exclude Medicaid eligible days for newborns while the mother is in the hospital from Worksheet S-2 and, in turn, the Medicaid fraction, its proposal is inconsistent with the Medicare DSH and Medicaid statutes and the implementing regulations. The Medicaid statute provides that "[a] child born to a woman eligible for and receiving medical assistance under

a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year." 42 U.S.C. § 1396a(e)(4). The implementing regulation similarly provides that "[t]he child is deemed to have applied and been determined eligible under the Medicaid State plan effective as of the date of birth, and remains eligible regardless of changes in circumstances until the child's first birthday..." 42 C.F.R. § 435.117(b)(3). Accordingly, the days associated with newborns while the Medicaid eligible mother is in the hospital must be considered Medicaid days. Those days must, in turn, be included in the DSH Medicaid fraction pursuant to the Medicare DSH statute and accompanying regulation. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (providing that the numerator of the Medicaid fraction consists of days for patients who were both eligible for medical assistance under the Medicaid statute and "not entitled to benefits under part A" of the Medicare statute); 42 C.F.R. § 412.106(b)(4) (same). To the extent that CMS's proposed instructions would potentially exclude such days from the Medicaid fraction, those instructions are not authorized by any statute or regulation and *ultra vires*. *See Fresno Cmty. Hosp. & Med. Ctr. v. Azar*, 370 F. Supp. 3d 139, 152 (D.D.C. 2019), *aff'd sub nom. Fresno Cmty. Hosp. & Med. Ctr. v. Cochran*, 987 F.3d 158 (D.C. Cir. 2021) (observing that an action is *ultra vires* where the agency "patently misconstrues a statute, disregards a specific and unambiguous statutory directive, or violates a specific command of a statute" (quoting *Hunter v. Fed. Energy Regul. Comm'n*, 569 F. Supp. 2d 12, 16 (D.D.C. 2008))); *Kaiser Found. Hosps. v. Sebelius*, 708 F.3d 226, 231-32 (D.C. Cir. 2013) (setting aside agency's payment decision because it conflicted with the agency's regulation); *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (setting aside agency action that is inconsistent with a "regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation").

In short, we urge CMS to revise its instructions to clarify that Medicaid days for newborn children before the Medicaid eligible mother is discharged from the hospital are to be included in Worksheet S-2, consistent with the plain language of both the Medicare DSH and Medicaid statutes as well as the accompanying regulations.

Column 8 – State Plan Eligibility Code

In Minnesota, there are two different state plan eligibility codes. The first being the matching code received from the state, and the second being the Medicaid program code for the recipient**. We ask CMS to provide clarity in the instructions as to what should be included in column 8 on exhibit 3A, as opposed to what should be included in the comments field in column 18.**

Exhibit 2A – Listing of Medicare Bad Debts

Column 14 – Date Amounts were Written Off as Bad Debt in Financial Statements

We ask that column 14 be removed from Exhibit 2A. The Medicare Bad Debt listing is required to be completed utilizing cash basis accounting. Meaning, we are to include bad debt at a detail level in the period in which it is written off. Conversely, financial accounting is completed utilizing accrual basis accounting, reporting bad debt and implicit price concessions in the period in which the revenue is recorded. **Requiring the date on which amounts were written off in the financial statements runs conversely to reporting requirements for Medicare Bad Debt and should not be a required field in Exhibit 2A.**

Column 23 – Payment Source

We ask CMS to provide clarity to the instructions for column 23 in terms of the level of detail required for the payments source. For example, would it be preferred to include "third party insurance" or the name of the insurance company? Providing detailed clarifications will minimize the possibility of unintentional errors when completing this section.

Conclusion

On behalf of Allina Health, we greatly appreciate the opportunity to submit comments on the proposed changes to the hospital and health care complex cost report. We ask that CMS consider our feedback to help provide clarity and support decreased administrative burden under the goals of the Paperwork Reduction Act in collecting, organizing, and submitting data for the Medicare cost report.

Please feel free to contact us with any questions.

Sincerely,

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