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

Re: Proposed Changes to Hospital and Health Care Complex Cost Report (CMS 2552-10); OMB Control Number 0938-0050; Information Collection Notice (Vol. 87, No. 119), June 22, 2022

Dear Administrator Brooks-LaSure:

On behalf of the more than 145 voluntary and public hospitals that make up the acute care membership of the Greater New York Hospital Association (GNYHA), I appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Paperwork Reduction Act (PRA) package of changes to form CMS–2552–10, the Hospital and Hospital Health Care Complex Cost Report. Our comments pertain to new exhibits 3A, 3B, and 3C, and other changes to Worksheet S-10.

New Exhibits for Supporting Documentation

CMS requires providers to submit certain documentation for a successful cost report submission and proposes that they use standardized formats—i.e., the proposed exhibits 2A, 3A, 3B, and 3C—starting with cost reporting periods beginning on or after October 1, 2022. Below we recommend changes to reduce provider burden when completing these exhibits while preserving relevant information for audits.

Exhibit 2A—Listing of Medicare Bad Debts

In column 23 of Exhibit 2A, CMS instructs hospitals to enter the sources of payments received before the account was written off, as reported in column 22, but specifies that hospitals should not create separate lines to report multiple payment sources. GNYHA requests that CMS specify how hospitals should enter the requested information when an account has more than one payment source. For example, if a hospital receives a patient payment of $25 and a commercial insurance payment of $100, would it enter both payment sources on a single line?

Additionally, we ask CMS to clarify how hospitals should handle situations in which they have a recovery for an account listed with bad debt in a prior year, with no bad debt reimbursement to report in the current cost report year. In this situation, should the hospital report the recovery on Exhibit 2A or elsewhere?

Exhibit 3A—Listing of Medicaid Eligible Days for Disproportionate Share Hospital Eligible Hospitals

GNYHA submitted comments on the November 2020 proposed package requesting that CMS streamline its proposed requirement that hospitals complete a separate Exhibit 3A for each of six columns of data reported on Worksheet S-2, Part I, lines 24 (inpatient prospective payment system [IPPS]) and 25 (inpatient rehabilitation facility). GNYHA appreciates that CMS streamlined this requirement in the most recent version, which will allow providers to submit the same information in a less burdensome format.

Labor and Delivery Days

CMS requests that hospitals report labor and delivery days in column 11 separately from Medicaid eligible days reported in column 10. For some hospital stays, separating labor and delivery days from total days is challenging and the criteria will not be uniform across hospitals. CMS has not established criteria for which days hospitals should classify as labor and delivery days and has not stated why this information is necessary. Therefore, **CMS should delete column 11 and instead instruct hospitals to include labor and delivery days in column 10.**

Newborn Baby Days

CMS proposes that hospitals separate the newborn baby days that overlap and do not overlap with the mother's days. Specifically, hospitals would be required to enter in column 12 the number of newborn baby days occurring prior to the Medicaid eligible mother's date of discharge for a baby born to a Medicaid eligible mother in addition to the mother's days reported in column 10. Hospitals would also report in column 10 any newborn days that occurred after the mother's discharge date. Some of our member hospitals have expressed concern that isolating newborn days prior to and after the mother's discharge date would be cumbersome due to challenges matching the mother with the newborn. **GNYHA questions the value of isolating the days of overlap between the mother and the baby, particularly given the additional burden. If this information is not necessary, CMS should delete column 12 and request that hospitals report all newborn baby days in column 10.**

Should CMS decide to retain column 12, GNYHA asks CMS to clarify whether hospitals should report all newborn days in column 10 or only days for which a newborn remains in the hospital after the mother's discharge date (i.e., should newborn days reported in columns 10 and 12 sum to the total newborn days, or is column 12 a subset of column 10?).

Exhibit 3B—Charity Care Listing

Column 6 – Insurance Status

Some hospitals report they are not always able to determine the reason that certain services are not covered for an insured patient (e.g., whether it was due to an exhausted benefit for an otherwise covered service or that the service was not covered at all despite being medically necessary) because their systems are not populated with this type of information. Separating which patients are uninsured from those who are insured but not covered would require additional manual work, and CMS has not provided an explanation for why collecting this information is necessary. Therefore, we recommend that CMS only require hospitals to classify patients as insured or uninsured in column 6.

Column 21 – Write-Off Date

GNYHA requests that CMS clarify how hospitals should treat patient accounts with multiple write-off dates, particularly when they span more than one fiscal year. This is not an uncommon situation due to the process for determining charity care eligibility, and the account balance written off in a given year may not match the full write-off amount over the life of the account. Alternatively, CMS could require hospitals to only report the first write-off date.

Exhibit 3C—Bad Debts Listing

CMS instructs hospitals to calculate the patient bad debt write-off amount based on the total payments, allowances, and total charges entered in the preceding columns. However, charges often do not equal payments plus allowances. For example, if a hospital has a receivable for patient liabilities that has not been paid yet, this will result in a positive ending balance. Or a hospital may reverse an amount previously written off to charity care if a third-party payment comes in at a higher-than-expected amount, which would result in a negative ending balance that needs to be corrected. **CMS should allow hospitals to report the bad debt write-off amount straight from provider records rather than require them to calculate it from the other columns.**

CMS should also clarify how to handle multiple write-off dates, as described in the previous section.

Other Worksheet S-10 Issues

New Part II and Services Included in the Uncompensated Care Definition

CMS proposes to split Worksheet S-10 into two parts. Part I would continue to collect uncompensated and indigent care data for the entire hospital complex, including for any sub-providers associated with the hospital, and Part II would be a subset of Part I and would record uncompensated care costs for only the general short-term hospital inpatient and outpatient services billable under the hospital's provider number.

GNYHA questions the need for this additional information and is concerned about the additional time required to complete Worksheet S-10, Part II. In addition, while CMS implied in its "comment and response" document that it would continue to use uncompensated care costs reported for the entire hospital complex (Part I) to distribute uncompensated care payments in the near term, it left open the possibility of using Part II data in the future to distribute payments. **GNYHA strongly opposes using Part II to distribute uncompensated care payments because it excludes services that should be part of the definition of uncompensated care, such as inpatient psychiatric and substance abuse services provided in IPPS-exempt units.** Psychiatric and substance abuse emergency, observation, and clinic visits are reimbursed under the outpatient prospective payment system, and psychiatric and substance abuse admissions to hospitals without certified exempt units are reimbursed under the IPPS. Therefore, charity care and bad debt write-offs for those services are appropriately included in the definition of uncompensated care. Yet, charity care and bad debt write-offs associated with admissions to psychiatric exempt units—including admissions originating in the emergency room—would be excluded if CMS were to define uncompensated care using the Part II data. **We therefore urge CMS to delete the proposed Part II. It would be inappropriate to use these data to distribute uncompensated care payments, so collecting this information is unnecessary.**

Estimating the Cost of Non-Medicare Bad Debt

Worksheet S-10 currently estimates the cost of non-Medicare bad debt by multiplying the entire amount reported on line 28 by the cost-to-charge ratio (CCR) reported on line 1. This is incorrect because a portion of non-Medicare bad debt represents unpaid cost sharing, which should not be CCR-adjusted, *just as charity care for cost sharing is not CCR-adjusted on line 23*. The proposed PRA package does not correct this problem, so **we recommend that CMS separate the non-Medicare bad debt reported on line 28 into bad debt for charge-based services and bad debt for cost-sharing, with the former CCR-adjusted and the latter not CCR-adjusted.** CMS can do this either by adding two columns before the total on line 28 or by adding subscripted lines.

If you have any questions or would like further information, please contact Rebecca Ryan at (212) 506-5514 or rryan@gnyha.org.

Thank you for your consideration of our recommendations.

Sincerely,

Elisabeth R. Wynn
Executive Vice President, Health Economics and Finance