January 11, 2021

William Parham III
Director
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Ref: CMS-2552-10/OMB No. 0938-0050: Hospital and Hospital Health Care Complex Report; Agency Information Collection Activities: Proposed Collection; Comment Request

Dear Director Parham:

America’s Essential Hospitals appreciates the opportunity to submit comments in response to the Centers for Medicare & Medicaid Services’ (CMS’) notice of proposed information collection. We agree with the need for accurate reporting of hospital cost and statistical data on Medicare cost reports, which has implications for reimbursement by Medicare and other payers. We urge the agency to ensure that changes to the cost report worksheets and instructions are minimally burdensome and do not disproportionately disadvantage certain types of hospitals. The need to minimize unnecessary burden is especially true as hospitals respond to the continued threat of the COVID-19 pandemic in the midst of record-breaking numbers of hospitalizations and cases.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including the vulnerable. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation’s uncompensated care (UC), and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. The average essential hospital provides $80 million in UC annually, about 10 times more than other hospitals. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins one-third that of other hospitals—2.5 percent on average compared with 7.6 percent for all hospitals nationwide.¹ These narrow operating margins result in minimal reserves and low cash on hand—circumstances exacerbated by financial pressures related to COVID-19.

We are concerned CMS has not adequately accounted for the administrative burden of the proposed cost reports or the consequences these changes could have on reimbursement for

hospitals. The proposed changes are substantive in nature and would affect data used by both federal and state policymakers in determining reimbursements for hospitals, such as reimbursement based on reported UC data. As they provide a disproportionate share of UC, essential hospitals realize the importance of accurately capturing UC data on the worksheet S-10. However, some proposed changes could disfavor essential hospitals and are not supported by any policy justification. In our detailed comments below, we urge CMS to reconsider some of the proposed cost report changes and to make additional revisions that will allow for accurate data reporting.

1. CMS’ proposed collection of median third-party payer charges would be burdensome for hospitals.

In the fiscal year (FY) 2021 Inpatient Prospective Payment System (IPPS) final rule, CMS finalized a requirement that hospitals report median negotiated charge data for Medicare Advantage (MA) organizations by Medicare Severity-Diagnosis Related Group (MS-DRG). CMS intends to begin using these data to recalibrate Medicare inpatient payment rates in FY 2024. To implement the reporting requirement, CMS adds a new worksheet (S-12) to the cost report, which will require hospitals to list their median charge for every MS-DRG. We urge CMS to withdraw this burdensome requirement, because presenting the data by MS-DRG is a difficult process that is challenging for hospital staff responsible for extracting this information.

There are many scenarios in which a hospital would not have a median payment rate at the MS-DRG level. First, not all payers use the MS-DRG classification system to set inpatient payment rates. Third-party payers, including MA plans, often use variants of CMS’ MS-DRG system, distinct DRG systems such as All Patients Refined Diagnosis Related Groups (APR-DRGs), or per diem payment arrangements. This means that absent a crosswalk, hospitals cannot convert these different payment rates to MS-DRGs.

Second, APR-DRGs and MS-DRGs adjust for severity of an inpatient admission, based on the presence of comorbidities or complications. The method of adjusting payment for patient comorbidities and complications differs based on classification system. There will be subjectivity involved in determining how to crosswalk these systems to MS-DRGs, which will result in non-uniform and unreliable data for public use.

Third, there is not a standard “negotiated charge” the provider receives from the payer that is consistent across all patients with the same diagnosis. Certain high-cost cases, for example, receive outlier payment amounts that differ on the costs of a given case and are not equivalent to a flat negotiated rate. In the case of per diem payment arrangements, the actual amount paid will vary based on the number of days associated with the inpatient admission. The payment amounts in per diem arrangements also can vary, as many contracts carve out high-cost items and services, such as surgical implants and costly drugs, from the per diem amount. Other payment arrangements, whether in per diem or APR-DRG systems, can include percentage of charges or stop-loss arrangements, while others include value-based or shared savings arrangements that vary payment based on outcomes. Due to the variance in payments that can be made for a given diagnosis, it would be impractical and extremely cumbersome to produce a median negotiated charge for each MS-DRG across MA organizations for publication on hospital cost reports. Therefore, CMS should withdraw its policy to require reporting of median MA organization negotiated charges by MS-DRG.
2. CMS should ensure it accurately and consistently captures UC data on the worksheet S-10.

CMS makes numerous revisions to the worksheet S-10 on hospital uncompensated and indigent care data. Data reported on the S-10 serve many purposes; CMS uses the S-10 to determine Medicare disproportionate share hospital (DSH) payment amounts, state Medicaid agencies use it to determine supplemental Medicaid payments, and stakeholders use these data for analysis. Due to these many uses, it is imperative the information is accurately and consistently reported across all hospitals, and not disfavor or favor any particular group of hospitals. Some of the proposed revisions would be burdensome for hospitals, while other changes could result in the underreporting of UC. As outlined below, CMS should withdraw certain changes, while making other changes it has yet to propose, to ensure the accuracy of UC data on the S-10.

a. CMS should continue to allow hospitals to incorporate UC costs from all sub-units of the hospital facility.

For costs reports beginning on or after October 1, 2020, CMS proposes to limit the reporting of UC costs to the short-term acute care hospital and exclude charity care charges and costs from other units within the hospital, including skilled nursing facilities and inpatient psychiatric units. This change is a reversal of CMS’ longstanding policy and would result in the understatement of charity care and bad debt costs for large, integrated hospitals and health systems that provide a variety of services within the walls of the hospital. For many hospitals, providing coordinated care requires the ability to provide holistic care to patients, including the need for long-term or psychiatric care. In addition to the resulting undercounting of charity care and UC costs, the language change also would be impracticable for hospitals to implement, especially in cases when a patient moves across different units of the hospital during one visit or admission. Breaking out UC costs for a patient for a given admission by the unit of the hospital where the patient receives care is not feasible. For these reasons, CMS should remove this language and continue to allow hospitals to report UC costs for the entire hospital facility.

b. CMS should remove the references to medically necessary health care in the worksheet S-10 instructions.

CMS revises the definition of charity care and uninsured discounts to read, “medically necessary health care services free of charge to patients who meet the hospital’s charity care policy or [financial assistance policy].” We agree that UC costs reported on the S-10 should only be for medically necessary care, but this language is redundant and, without further explanation of what constitutes “medically necessary care,” could result in inconsistent reporting. The addition of this language also might lead to retrospective adjustments to hospital UC amounts based on Medicare contractors’ assessments of what is medically necessary, potentially resulting in reversals that contradict clinical judgment made by practitioners at individual hospitals.

Hospitals provide charity care based on documented financial need, and their financial assistance policies (FAPs) incorporate language limiting coverage to emergency care and medically necessary services. Therefore, the inclusion of the language “medically necessary” in the cost report instructions is unnecessary. Medicare contractors tasked with reviewing hospital cost reports and auditing worksheet S-10 would be placed in the untenable situation of evaluating every charity care line item for medical necessity. Consider a situation in which a hospital approved a patient presenting at a burn unit for charity care for the cost of reconstructive surgery. Without being aware of the clinical need for the surgery, a Medicare
contractor could make a determination that the procedure was for cosmetic surgery not considered medically necessary. This is just one of the many scenarios that could materialize due to the addition of the words “medically necessary.” We therefore urge CMS to remove this added language.

c. CMS should include all patient care costs when converting UC charges to costs on the S-10.

The S-10 does not account for all patient care costs when converting charges to costs. Most important, the current worksheet ignores substantial costs hospitals incur in training medical residents, supporting physician and professional services, and paying provider taxes associated with Medicaid revenue. As CMS continues using the S-10 as the data source for measuring UC costs, the agency should refine the worksheet to incorporate all patient care costs—including those for teaching—into the cost-to-charge ratio (CCR). In particular, CMS should:

- use the total of worksheet A, column 3, lines 1 through 117, reduced by the amount on worksheet A-8, line 10, as the cost component; and
- use worksheet C, column 8, line 200, as the charge component.

The line items above are not limited to Medicare-allowable costs and include additional patient care costs, such as the cost of graduate medical education (GME). Because of this, the result would more accurately reflect the true cost of hospital services, compared with the CCR currently in the S-10.

CMS also should include the cost of providing physician and other professional services when calculating UC. In addition to employing physicians and paying community specialists directly for patient care, many essential hospitals subsidize the cost of physician services to ensure vulnerable patients have access to necessary care. Because hospitals regularly incur these costs when providing charity care and other UC, CMS should recognize them when determining UC. By refining the S-10 to reflect these issues, CMS will accurately measure the UC costs hospitals incur to serve low-income and uninsured patients.

d. CMS should not apply the CCR to non-Medicare bad debt.

CMS also should clarify the instructions on line 29 regarding non-Medicare bad debt for insured patients to ensure consistency in its treatment of coinsurance and deductibles. The agency should allow hospitals to include coinsurance and deductibles on the S-10 without multiplying these amounts by the CCR. CMS’ revised cost report instructions dictate hospitals do not have to multiply nonreimbursed Medicare bad debt by the CCR, because coinsurance and deductibles are actual amounts expected from the patient (as opposed to charges, which are not the actual amounts a patient is expected to pay). However, the revised instructions still state hospitals should multiply their non-Medicare bad debt by the CCR. The different treatment of nonreimbursed Medicare bad debt and non-Medicare bad debt is inconsistent, and the agency provides no justification for the inconsistency. Coinsurance and deductible amounts for patients other than Medicare fee-for-service patients, such as those with Medicare Advantage, are actual amounts the hospital expects the patients to pay. Therefore, hospitals should list unpaid coinsurance and deductible amounts as bad debt in their entirety and CMS should not reduce those amounts by the CCR. Making this change would be consistent with the way CMS treats charity care amounts for insured patients. CMS has clarified that charity care amounts for insured patients—that is, coinsurance and deductible amounts that
patients do not have the ability to pay—do not have to be reduced by the CCR. **CMS should clarify the instructions for bad debt expenses to treat all coinsurance and deductibles for non-Medicare bad debt the same—not multiplying them by the hospital CCR.**

e. CMS should revise the worksheet S-10 instructions on the reporting of Medicaid revenue to ensure the accuracy of these data.

CMS must revise the S-10 so data on Medicaid shortfalls better resemble actual shortfalls incurred by hospitals. Current data underestimate the amount of Medicaid shortfalls. First, GME-related costs are excluded, while GME-related reimbursements are included. Without the necessary revision to the CCR mentioned above, counting payments but not costs is an inaccurate way to measure shortfall. Second, the S-10 should consistently allow hospitals to reduce their Medicaid revenues by the amount of any contributions to funding the nonfederal share of the Medicaid program, whether through provider taxes, intergovernmental transfers (IGTs), or certified public expenditures (CPEs). Like provider taxes and assessments, provider-funded IGTs and CPEs are used to finance the nonfederal share of Medicaid and are critical to a state’s ability to fund the program at adequate levels.

Allowing offsets for one such type of contribution—for example, provider taxes and assessments—and not others distorts shortfall amounts and might create inequities among hospitals. Because of this discrepancy in the instructions and the different types of permissible financing arrangements used by states, the S-10 in its current form provides an incomplete picture of Medicaid shortfalls and should be revised to allow hospitals to deduct IGTs, CPEs, and provider taxes from their Medicaid revenues.

3. **CMS should provide additional instructions for reporting opioid treatment program costs on Worksheet A.**

CMS proposes to add a new line 102 to worksheet A of the cost report for reporting opioid treatment program costs. **Because this is a new data point for hospitals to report, we request CMS provide additional instructions on the costs to be included in this line to ensure consistency in reported data and to minimize confusion for hospitals.** As proposed, the instructions simply state: “Effective for cost reporting periods ending on or after January 1, 2021, enter the cost of providing services associated with opioid treatment programs.”

Opioid treatment programs are complex in nature, and the patients treated for opioid addiction receive services attributable to multiple cost centers, including inpatient and outpatient routine cost centers, as well as ancillary cost centers. A patient treated for opioid addiction could have costs associated with an inpatient detoxification program, as well as outpatient addiction treatment. Additionally, there would be costs associated with cost centers such as laboratory, pharmacy, and behavioral health care. It is unclear from the instructions whether the costs reported should include patients for whom Medicare reimbursement was received, or if those patients are excluded. **As hospitals begin to report information on this new field of the cost report, we ask for additional clarity and instructions to allow consistent and accurate data reporting.**

4. **CMS’ cost report changes would be burdensome for hospitals and involve time and resources far exceeding CMS’ estimates.**

CMS’ revisions to the cost report would be administratively burdensome for hospitals. This administration has emphasized the importance of reducing provider burden and focusing on
patient care, as exemplified in its Patients Over Paperwork initiative. America’s Essential Hospitals commends the administration for its attempts to reduce regulatory and administrative burden through such initiatives. CMS’ proposed revisions, however, would be a setback to the agency’s efforts to reduce provider burden. The additions to the cost report are operationally complex, bound to increase regulatory burden, and will strain hospital systems and staff resources. We urge CMS to consider the administrative burden its proposed information collection would impose on essential hospitals.

As part of Paperwork Reduction Act requirements, CMS estimates that completion of the cost report would take 694 hours for the average hospital to complete. CMS estimates an increase of only 21 hours attributable to the cost report changes. This is a gross underestimate of the actual resources required to prepare the additional information necessitated by the cost report changes. As explained above, the requirement to report median Medicare Advantage charges by MS-DRG on new worksheet S-12 will be extremely resource intensive if not infeasible because of the need to match MS-DRGs and rates not based on MS-DRGs. This will require the creation of crosswalks and manual review of charges to determine the appropriate MS-DRG equivalent negotiated charge amount.

In addition to the addition of worksheet S-12, CMS adds four new exhibits for the listing of Medicaid eligible days, Medicare bad debts, charity care, and total bad debts. These exhibits require the reporting of multiple data elements at the patient level. While CMS began requiring this information in previous IPPS rulemaking, it did not prescribe a specific template. The use of these standardized templates will require hospitals to query and extract data from multiple different systems and databases, remove any sensitive patient data, and present the data in the format requested by CMS. The standardized data elements CMS requires in the templates for charity care listing, for example, might not all readily be available in a hospital’s charity care accounts. Extracting and presenting the information in these four exhibits will require significant investments of time far beyond what CMS estimated. **For these reasons, CMS should reconsider the burden estimates in the information collection request and, where appropriate, remove proposed additions we have highlighted above that will add burden.**

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America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

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President and CEO

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