



healthcare financial management association

July 10, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1735-P
P.O. Box 8013
Baltimore, MD 21244-1850

File Code: CMS-1735-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals

Dear Administrator Verma:

The Healthcare Financial Management Association (HFMA) would like to thank CMS for the opportunity to comment on *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals* (hereafter referred to as the Proposed Rule) published in the Federal Register on May 29, 2020. HFMA is a professional organization of more than 58,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

HFMA would like to commend CMS for its thorough analysis and discussion of the many Medicare payment decisions addressed in the 2021 Proposed Rule. Our members would like to comment on the specific proposals related to:

- Post-Acute Care Transfer Policy and Special Payment MS-DRGs
- Disproportionate Share and Uncompensated Care
- Allogeneic Hematopoietic Stem Cell Acquisition Costs
- Market-Based MS-DRG Relative Weights
- Medicare Bad Debt Policy
- Final Rule Tables/File Review Timeframe

HFMA is providing detailed comments in a separate letter related to CMS's discussed and proposed policies related to market-based MS-DRG weights. This letter summarizes those comments. Below, please find specific comments on the items above.

Suspend Acute and Post-Acute Transfer Payment Policies for COVID-19 Discharges

Medicare reduces payment in some cases when a patient has a short length of stay (LOS) and is transferred to another acute care hospital, or in certain circumstances, to a post-acute care (PAC) setting. In response to the COVID-19 pandemic, HFMA members in areas that have experienced surges in COVID-19 admissions report frequently needing to transfer COVID-19 cases to other hospitals to balance the case load and ensure adequate inpatient capacity of medical-surgical and ICU beds.

HFMA's members report that the costs per case for COVID-19 admissions are considerably higher than non-COVID-19 discharges that result in the same MS-DRGs. While the CARES Act increased the weighting factor that would otherwise apply to the MS-DRG for COVID-19 cases by 20%, analysis suggests this payment increase is insufficient¹ as average hospital losses are projected to be \$2,800 per case on an all-payer basis. Further, we understand from hospitals in COVID-19 surge areas that they have needed to transfer patients to other hospitals or discharge them to appropriate PAC settings to rebalance patient loads and create capacity. Therefore, HFMA's members ask CMS to use its section 1135 waiver authority to suspend the CMS acute and post-acute transfer payment policies during the public health emergency (PHE) to reduce the loss hospitals are experiencing when providing medically necessary care to Medicare beneficiaries suffering from COVID-19.

Disproportionate Share (DSH) and Uncompensated Care (UC)

Factor 1: The 2021 IPPS proposed rule states that the CMS Office of the Actuary's (OACT) December 2019 Medicare estimates of DSH is \$15.359 billion. The proposed Factor 1 amount is 75% of this amount, or \$11.519 billion. **HFMA's members are deeply concerned the proposed Factor 1 for 2021 is about \$919 million less than the final Factor 1 for FY20.**

The "other" column in the table labeled, "Factors Applied for FY 2018 through FY 2021 to Estimate Medicare DSH Expenditures Using FY 2017 Baseline" on page 814² shows the increase in other factors affecting Medicare DSH estimates, including the difference between the total inpatient hospital discharges and the inpatient prospective payment system (IPPS) discharges and various adjustments to the payment rates that have been included over the years but are not reflected in other columns (such as the change in rates for the 2-midnight stay policy). The "other" column also includes a factor for Medicaid expansion due to the Affordable Care Act (ACA).

The rule states, "the factor for Medicaid expansion was developed using public information and statements for each State regarding its intent to implement the expansion. Based on this information, it is assumed that 55 percent of all individuals who were potentially newly eligible Medicaid enrollees in 2018 resided in States that had elected to expand Medicaid eligibility and, for 2020 and thereafter, that 58 percent of such individuals would reside in expansion States. In the future, these assumptions may change based on actual participation by States."

The shelter-in-place orders in response to COVID-19 have resulted in a significant economic downturn with an accompanying increase in unemployment, which the Congressional Budget Office (CBO) projects

¹ Strata Decision Technology. "[Report: Hospitals Face Massive Losses on COVID-19 Cases Even With Proposed Increase in Federal Reimbursement.](#)"

² Display copy

will be 9.5% at the end of 2021³ (up from 3.5% prior to the pandemic). The increase in unemployment will drive an increase in Medicaid enrollment that is not reflected in the OACT's estimate, given that the analysis was conducted prior to the pandemic. Manatt estimates that Medicaid enrollment could increase from 70 to 100 million Americans⁴ as a result of the downturn. Prior to publishing the 2021 IPPS Final Rule, HFMA's members believe the CMS OACT must recalculate the UC DSH Factor 1. **HFMA's members specifically ask that the CMS OACT recalculate the "other" factor to account for the significant increase in Medicaid enrollment that is resulting from the COVID-19-induced economic downturn. We also ask that CMS provide sufficient detail of its assumptions in determining the other factor in the Final Rule.**

Factor 2: For FY21, CMS estimates that the uninsured rate for the historical, baseline year of 2013 was 14% and for CYs 2020 and 2021 is 9.5%. As required, the Chief Actuary of CMS certified these estimates. As a result, Factor 2 for the FY21 Proposed Rule is 67.86% ($1 + (.095 - .14 / .14)$), and the uncompensated care amount for FY21 is calculated to be \$11.519 billion \times 0.6786 = \$7,816,726,243.

HFMA's members are deeply concerned that the rate of uninsured used to calculate Factor 2 is too low. Similar to Factor 1, the CMS OACT calculated Factor 2 prior to the economic downturn. The Kaiser Family Foundation estimates that, as a result of the pandemic, the number of uninsured will increase by at least 3.8 million.⁵ This number assumes that everyone who is eligible for either health insurance exchange or Medicaid coverage enrolls, which we know to be unrealistic. Even if 75% of those eligible for Medicaid or exchange coverage enrolled (again optimistic) the ranks of the uninsured would swell by 9.6 million (2.9 percentage points). This would increase the size of the UC DSH pool by \$2.3B or approximately 30.4%. **HFMA's members ask that CMS update its projections of the uninsured for 2020 and 2021, taking into account the significant economic changes that are driving rapid and prolonged increases in the rate of uninsured Americans.**

Calculation of Factor 3 for FY21: CMS proposes to use a single year of Worksheet S-10 data from FY17 cost reports to calculate Factor 3 in the FY21 methodology for all eligible hospitals except for Indian Health Service (IHS) and Tribal hospitals and Puerto Rico hospitals. For these hospitals, CMS will continue to use the low-income insured days proxy to calculate Factor 3 for one more year, as discussed below. CMS continues to believe that mixing audited and unaudited data for individual hospitals by averaging multiple years of data could potentially lead to a less accurate result. In addition, FY17 cost reports reflect the revisions to the instructions that were effective on October 1, 2017.

HFMA strongly supports the use of audited data. However, CMS notes in the proposed rule that it has only audited 65% of the proposed total uncompensated care payments for FY21. **HFMA's members strongly believe that CMS must provide the Medicare Administrative Contractors (MACs) with the resources necessary to audit 100% of uncompensated care payments to create a level playing field for**

³ Congressional Budget Office. "[CBO's Current Projections of Output, Employment, and Interest Rates and a Preliminary Look at Federal Deficits for 2020 and 2021](#)," April 24, 2020.

⁴ Ario, J., "[COVID-19: The Road Ahead for Commercial Health Insurance—Q&A](#)," Manatt Health, May 11, 2020.

⁵ Garfield, R., Claxton, G., Damico, A., et. al., "[Eligibility for ACA Health Coverage Following Job Loss](#)," Kaiser Family Foundation," May 13, 2020.

all providers. It is not uncommon for HFMA to hear of one health system having all of its hospitals in a market audited (and experiencing material disallowances that are arbitrary) while other hospitals in the market are not audited. Further, HFMA members continue to have concerns about the audit process. We continue to hear from our members that the various MACs are inconsistent—this includes not only different MACs but employees of the same MAC based in the same office—in their application of CMS’s audit criteria. HFMA provides suggestions later in this section to correct these policy failures which inappropriately (and randomly) benefit some providers at the expense of others.

HFMA members do not support the use of one year’s worth of audited data. Given the inadequacies of the audit process discussed above and the potential for random swings in uncompensated care volumes from year-to-year, HFMA members strongly recommend that CMS use multiple years of audited S-10 data to calculate Factor 3. While we believe that three years is optimal, we ask that for FY21, CMS use FY15 and FY17, given that both years have been subject to some degree of MAC audit.

Make CMS Audit Instructions for Worksheet S-10 Publicly Available: Although CMS stated in the FY18 Proposed Rule that it is working on audit instructions for MACs, it will not make these (or any other audit guidance) publicly available. In general, HFMA members have long considered this stance inappropriate and counterproductive. CMS has stated in the FY17 IPPS/long-term care hospital prospective payment system Final Rule (81 FR 56964), for program integrity reasons, CMS desk review and audit protocols are confidential and are for CMS and MAC use only. We respectfully disagree that providing hospitals details on how CMS will audit the S-10 would cause integrity issues. On the contrary, providing hospitals detailed specifics on how to report items on S-10 and how they will be reviewed would aid hospitals in providing more accurate data. This will reduce hospital and MAC costs related to the audit and appeals process (if one existed for Factor 3). While we believe there is no malicious intent, inconsistent reporting of the data could unknowingly damage another provider’s payments. This policy of opacity results in the various MACs (and sometimes different offices of the same MAC) taking different interpretations of CMS’s audit guidance. This could also lead hospitals to make their own interpretations, creating inconsistencies in reporting.

Specific to the S-10, guidance for completing the worksheet is limited to vague instructions (as discussed in further detail below). Further, unlike other worksheets that have an impact on payment and are audited by the MACs, the Provider Reimbursement Manual (PRM) is silent on the treatment of non-Medicare bad debt and charity care. This silence is appropriate, as each hospital’s financial assistance policy and broader community benefit strategy reflects the needs of its community. However, in this vacuum, our members who have undergone “meaningful use audits” or were subject to audits of their uncompensated care for FY15 and FY17, report that MACs have disallowed charity care, citing justifications ranging from arbitrary federal poverty limits, to inappropriately citing section 312 of the PRM, which pertains to determining indigence for purposes of identifying Medicare bad debt.

Further, in instances where a health system is subject to multiple MACs, our members have reported that each MAC made inconsistent audit adjustments to uncompensated care amounts claimed on worksheet S-10. HFMA staff is even aware of one egregious case where four hospitals in one market, owned by the same health system, had different criteria, applied to their FY17 uncompensated care audit. Despite the fact that the MAC auditors were all based out of the same office, categories of claimed uncompensated care that was allowed for one hospital was disallowed for the others. This

suggests that MACs are not interpreting and applying CMS's audit instructions in a standardized manner. **Given HFMA members' experience with these audits, we strongly encourage CMS to recognize the uniqueness of the circumstances surrounding worksheet S-10 and release the audit criteria for non-Medicare bad debt and charity care claimed on the worksheet.**

Clarify Providers May Use "Presumptive Eligibility" Tools to Document Eligibility for Charity Care: Many hospitals are using tools based on publicly available and proprietary data to determine if a patient qualifies to receive charity care. The use of these tools reduces the administrative burden on both the hospital and patient. It also increases the accuracy of charity care determinations as many patients who are eligible for charity care do not apply, or if they do apply, are unable to provide the required documentation, despite multiple attempts by providers to educate patients on both the availability of charity care and process for applying. One of the common issues experienced by hospitals during "meaningful use" and uncompensated care audits is the disallowance of charity care granted using a presumptive eligibility tool by some MACs.

In communications with HFMA, CMS has stated that its position on charity care is as follows:

Hospitals provide varying levels of charity care, which must be budgeted for and financed by the hospital depending on the hospital's mission, financial condition, geographic location and other factors. In advance of billing, hospitals typically use a process to identify who can and cannot afford to pay in order to anticipate whether the patient's care needs to be funded through an alternative source, such as a charity care fund.

Depending on a variety of factors, including whether a patient self-identifies as medically indigent or underinsured in a timely manner, care may be classified as either charity care or bad debt; however, a provider MAY NOT write off an account as charity care and also claim it as a Medicare bad debt. If the provider writes the account off as bad debt, Medicare has guidelines that they must follow including section 312 "Indigent or Medically Indigent Patients." If the provider writes the account off as charity care they must follow their charity care policy. Medicare does not dictate or have requirements for the hospital's charity care policies because charity care is not reimbursable by Medicare.

CMS has further clarified that it interprets the above to mean that if a presumptive methodology is part of a hospital's charity care policy, it may be used in identifying amounts reported on S-10. CMS indicates that it has provided this guidance to its contractors and is in the process of updating the PRM to reflect this position. **HFMA strongly supports CMS's position on the use of presumptive eligibility tools to identify charity care for reporting on the S-10 and encourages CMS to expedite its updating of the PRM.**

Improve Instructions/Form for Worksheet S-10: Line 26 of worksheet S-10 includes both patients for which the full balance was written off to bad debt expense and patients where only cost sharing was written off to bad debt expense. The cost sharing portion includes Medicare patients. Reimbursable Medicare bad debt expense (listed on line 27.01) is removed to arrive at non-Medicare bad debt expense on line 28 (includes balances-after-insured, uninsured patients, and Medicare allowable, non-

reimbursable bad debt). Line 29 calculates the cost of non-Medicare bad debt expense by multiplying line 28 by the hospital's cost-to-charge ratio (CCR).

Applying a hospital's CCR to the amount on line 28 will understate the cost of bad debt and is incorrect, as it mixes "apples and oranges." The CCR is the relationship between a hospital's cost and its charges in a given cost reporting period. It can be used to arrive at a proxy for a hospital's cost of services provided to a patient if it is multiplied by the hospital's charges from that same period. However, deductibles, coinsurances based on the negotiated payment rate, and the portion of allowable, nonreimbursable Medicare bad debt are not marked up to reflect the charged amount. Therefore, it is inappropriate to attempt to arrive at the cost of bad debt expense by multiplying uncollectible deductibles, coinsurance based on the negotiated rate, and the portion of allowable Medicare bad debt that is nonreimbursable times a hospital's CCR. Doing so understates the true cost of forgone revenue resulting from uncollectible accounts. Given the increased cost sharing many insured individuals currently face, a growing portion of a hospital's bad debt is related to deductibles, coinsurance and copayments. **Similar to how charity care is handled on worksheet S-10 (lines 20 – 23), CMS needs to create separate columns for insured and uninsured patients. The column for uninsured patients should be multiplied by a hospital's CCR to arrive at the cost of bad debt. The column for insured patients (which should include amounts related to Medicare allowable, nonreimbursable bad debt) should not.**

Clarify Instructions/Provide Examples for Worksheet S-10: CMS's refinements to worksheet S-10 in November 2016 (Transmittal 10) have greatly improved the instructions. However, our members provide specific examples of where the appropriate treatment of uncompensated care cost is not immediately clear, based on the revised instructions. This leaves the handling of these relatively common cases up to the discretion of both hospital reimbursement staff and the MACs' auditors, which will lead to inconsistent treatment across hospitals for similar cases. Included in Attachment 1 are examples submitted by HFMA members. **We ask that CMS provide guidance (either regulatory or sub-regulatory) on the treatment of these cases for purposes of Worksheet S-10.** We believe this guidance is necessary to improve the comparability of the uncompensated care data collected from hospitals and the equity of the allocation of UC DSH payments.

Create an Appeals Process for Disallowed UC: CMS must provide hospitals a mechanism to appeal adjustments to the S-10. Currently, hospitals are only allowed to appeal adjustments that have a material settlement impact on the cost report. While the data used to calculate the UC payment will have a material payment impact on hospitals, it does not "settle" on the cost report. We believe it is appropriate to create a process by which disallowed UC could be appealed to the Provider Reimbursement Review Board (PRRB), like other items on the Medicare cost report.

Allogeneic Hematopoietic Stem Cell Acquisition Costs

For cost reporting periods beginning on or after October 1, 2020, section 108 of the Further Consolidated Appropriations Act of 2020 requires allogeneic hematopoietic stem cell acquisition costs to be made on a reasonable cost basis instead of through the IPPS. In the 2021 IPPS rule, CMS is proposing to revise the regulations to implement this by:

- Requiring the hospital to formulate a standard acquisition charge for allogeneic hematopoietic stem cells based on costs expected to be reasonably and necessarily incurred in the acquisition of hematopoietic stem cells for all patients.

- Reducing the standard charge by the corresponding ancillary CCRs to determine the hospital's reasonable costs.
- Paying Medicare's share of the hospital's reasonable cost based on the ratio of Medicare to total patients receiving allogeneic hematopoietic stem cell transplants.
- Reconciling the hospital's interim payments with its Medicare reasonable costs at the end of each cost reporting period.
- Requiring the hospital to maintain an itemized statement that identifies the services furnished in collecting hematopoietic stem cells. The itemized statement would identify standard charges, the name of the donor and prospective recipient and the recipient's health insurance number.

The proposed rule states CMS is developing a worksheet similar to Worksheet D-4 for solid organs that will allow providers to report direct expenses, routine and ancillary costs for allogeneic hematopoietic stem cell acquisition costs. This form and its instructions will be available in a forthcoming Paperwork Reduction Act (PRA) package.

HFMA members appreciate CMS's efforts to implement cost-based reimbursement for allogeneic hematopoietic stem cell. Our members believe that if cost-based reimbursement is implemented properly, it will ensure access to this life-saving treatment for patients with life-threatening blood cancers like leukemia and lymphoma.

First, HFMA members agree with CMS's analysis of the shortcomings of accumulating stem cell acquisition costs in cost report line 77 (Allogeneic Stem Cell Acquisition). **Therefore, we strongly appreciate and support CMS's proposal to develop a worksheet similar to Worksheet D-4 for solid organs that will allow providers to capture costs from line 77 as well as to report charges by routine and ancillary cost center and compute the related costs.** HFMA members look forward to providing feedback on this worksheet and the related instructions when they are available.

Second, HFMA members are deeply concerned with CMS's proposed requirement that hospitals formulate a standard acquisition charge for allogeneic hematopoietic stem cells acquisition. There is wide variability in the resources required to match a patient with a compatible donor. For example, some patients may match with the first possible donor tested. However, other patients may require testing ten or more possible donors and still not find a match. This variability makes it impractical for hospitals to set a standard charge for services related to allogeneic hematopoietic stem cell acquisition. Below, HFMA's members offer both their proposed approach to reasonable cost-based payment for allogeneic hematopoietic stem cells acquisition costs—and an alternative that is conceptually closer to CMS's proposed policy. HFMA's members believe their proposed approach better supports hematopoietic stem cell transplant centers and their patients. It will be less administratively burdensome to implement given it is similar to the methodology used for solid organ acquisition costs.

Proposed Approach: Instead of paying for the reasonable costs of allogeneic hematopoietic stem cell acquisition on a claim by claim basis using an inaccurate standard charge based on an average of all cases and reconciling payments to actual reasonable costs when the cost report is filed, **HFMA's members ask that CMS finalize in the 2021 IPPS rule a methodology that allows actual donor charges to be reported on claims under revenue code 0815.**

Furthermore, HFMA's members ask that CMS use annual 0815 charges from the PS&R to base its estimate of bi-weekly periodic interim payments (PIP) for reasonable acquisition costs based on the prior year's cost report settlement. These PIP payments would be reconciled and settled to actual

reasonable acquisition costs when the cost report is filed. This is similar to the methodology used to pay for solid organ acquisition costs and is a mechanism with which both hospital reimbursement staff in transplant centers and the Medicare Administrative Contractors auditing them are familiar.

CMS currently does not have prior year data for allogeneic hematopoietic stem cell acquisition allowable costs on which to base partial interim payments. **HFMA’s members recommend that until CMS has allowable cost data from filed cost reports, it use accumulated charges from revenue code 815 from hospital’s prior fiscal year provider statistical & reimbursement (PS&R) report to calculate PIP payments during the transition period. The charges from the PS&R can be divided by 26 to arrive at an appropriate bi-weekly amount and multiplied by ancillary cost-to-charge ratios to determine the hospital’s interim reasonable cost-based payment.**

Alternative Approach: If CMS insists on requiring hospitals to develop a standard charge for allogeneic hematopoietic stem cells acquisition in the final rule HFMA’s members believe CMS should modify its current proposal to require hospitals to calculate two separate standard acquisition charges. One standard acquisition charge – the related donor acquisition charge – would represent the average acquisition costs for related donors. The second standard acquisition charge – the NMDP acquisition charge – would represent the higher average acquisition costs of matching the patient to a donor through the National Marrow Donor Program. While requiring hospitals to calculate two standard charges for hematopoietic stem cell acquisition costs is not HFMA’s members’ preferred approach, we believe it is an improvement on CMS’s proposal.

Finally, as with solid organs, CMS proposes to use the ratio of Medicare transplants to total transplants to determine Medicare’s share of acquisition costs. While this methodology is appropriate for solid organs, based on conversations with hematologists who provide allogeneic hematopoietic stem transplants, HFMA’s members are concerned using a simple ratio may not be sufficiently accurate. **HFMA’s members believe that prior to finalizing this methodology, CMS needs to convene a panel of hematologists and others with expertise in allogeneic hematopoietic stem transplantation to vet this allocation mechanism and develop a more accurate one if necessary.**

Market-Based MS-DRG Relative Weights

CMS is requesting comments on whether to use the data it is proposing that hospitals report – median MS-DRG Medicare Advantage (MA) and other third party payers’ “payer-specific negotiated charges” beginning with cost reporting ending in FY21. This data may be used to determining the MS-DRG relative weights, beginning in FY24 if CMS were to propose and finalize the weight-rebasing concept it requests feedback on in the Proposed Rule.

Unfortunately, HFMA members fail to see how transitioning to a system that uses median MA “payer-specific negotiated charges” achieves the stated policy goals or improves the accuracy of the Medicare IPPS. Therefore, we encourage CMS not to propose this policy change in a future IPPS rule.

As you are aware, HFMA members are strong supporters of efforts to increase price transparency. We appreciate the opportunities over the past 18 months to meet with you and your staff to discuss our proposal (discussed below and in detail in a separate comment letter) to remove regulatory barriers to creating the conditions for a functioning market for healthcare services by decoupling Medicare payments from charges. **We believe this proposal will address a number of longstanding problems that distort the accuracy of Medicare payments and fix Medicare payment policy issues that have**

increased payments for those patients and payers whose payment is calculated based on gross charges. Therefore, we strongly encourage the administration to work with HFMA, hospitals and health systems and other key stakeholders to test, refine and implement this proposal.

In support of its potential proposal to rebase MS-DRG weights in 2024 using the median negotiated MA rate, CMS proposes that hospitals would be required to report the median:

- payer-specific negotiated charge that the hospital has negotiated with all of its MA plans, by MS-DRG; and
- payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA plans, by MS-DRG.

Hospitals would be required to report this information on their Medicare cost report for cost reporting periods ending on or after January 1, 2021.

We do not see the utility of requiring hospitals to report their “payer-specific negotiated charges” and strongly encourage CMS not to finalize a proposal that increases provider administrative burden – contrary to the administration’s “Patients Over Paperwork Initiative” – and collects information that CMS is already requiring hospitals to publicly post.

HFMA is providing detailed comments and an alternative proposal for rebasing MS-DRG weights that will decouple Medicare payments from charges and address pricing failures – caused by CMS payment policy – in a separate letter.

Medicare Bad Debt Policy

HFMA appreciates CMS’s efforts to clarify certain Medicare bad debt policies that have been the subject of litigation, and generated interest and questions from stakeholders over the past several years in the proposed rule. Below please find HFMA members’ comments on these clarifications.

Reasonable Collection Efforts – Issuance of a Bill: CMS proposes to codify the following requirements in the PRM into §413.89(e)(2) of the CFR.

- The collection effort must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients.
- For cost reporting periods beginning before October 1, 2020, the effort must involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary’s personal financial obligations on or shortly after discharge or death of the beneficiary.
- For cost reporting periods beginning on or after October 1, 2020, the effort must involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary’s personal financial obligations on or before 120 days after the latter of one of the following:
 - The date of the Medicare remittance advice
 - The date of the remittance advice from the beneficiary’s secondary payer, if any
- The collection effort must also include other actions such as subsequent billings, collection letters and telephone calls or personal contacts with the party which constitute a genuine, rather than a token, collection effort.

CMS proposes to make all of the above requirements effective retroactively except for the provisions that have an effective date of cost reporting periods beginning on or after October 1, 2020. For the

regulations that have retroactive effect, the rule indicates the policies are longstanding from the PRM that are being codified in regulation.

HFMA generally supports these clarifications. However, HFMA members strongly encourage CMS to clarify that if a provider has documented extenuating circumstances, the hospital can issue a bill after 120 days from the latter of the date of the Medicare remittance advice or the remittance advice from the beneficiary's secondary payer and still meet the requirement that hospitals issue a bill "shortly after" the beneficiary's death or discharge. HFMA members also ask that CMS make the clarification regarding the timing of bill issuance retroactive.

120-day Collection Effort and Reporting Period for Writing Off Bad Debts: CMS makes two changes in this section of the rule. First, CMS is adding a requirement to §413.89(e)(2) that a bill cannot be considered uncollectible until at least 120 days have passed since the provider first attempted to receive payment. If the provider receives partial payment, the 120-day period restarts. This policy will be effective retroactively as CMS states that it merely codifies in regulation what was an established policy in the PRM.

Second, CMS is revising an existing provision of the regulations (§413.89(f)) to clarify that any payment on the account made by the beneficiary, or a responsible party, after the write-off date but before the end of the cost reporting period, must be used to reduce the final bad debt for the account claimed in that cost report. If the collection is made in a cost reporting period after the debt has been written off as uncollectible, the recovered amount must be used to reduce the provider's reimbursable costs in the period in which the amount is recovered.

HFMA generally supports these clarifications. However, our members ask that CMS makes two clarifications in the final rule. First, we ask that CMS in the final rule set a sliding scale threshold of amounts received from the patient during the 120-day timeframe that would trigger whether or not the 120-day period must restart. Collections activity is administratively burdensome and not without cost. If the patient is making de minimis payments relative to the account balance, we question the efficiency of this activity. For example, if a Medicare beneficiary has an outstanding balance of \$1,408 for a deductible related to an inpatient admission and makes one \$10 payment on day 119 of the collection period, the cost of collections activity on the account (statement dunning, phone calls to the beneficiary) likely exceeds the amount received. Additionally, assuming this rate of payment, it is unlikely the beneficiary's outstanding balance will be satisfied in a timely manner. In these situations, the administrative resources used to pursue de minus payments from Medicare beneficiaries would be better invested in patient care or used to address social determinants of health in the community.

Second, for accounts that have otherwise met CMS's criteria for allowable Medicare bad debt and been written off, if the hospital makes a partial recovery of the balance that was written off and claimed as allowable bad debt, the hospital must only offset the recovered amount against allowable bad debts claimed on the current cost report. **The recovery would not restart the 120-day clock and require the provider to offset the full amount written-off and attempt to collect the remaining unrecovered balance.**

Documentation of Reasonable Collection Efforts: CMS proposes to add §413.89(e)(2)(A)(i)(6) to codify longstanding provisions of the PRM related to documentation of reasonable collection efforts. The provider must maintain and, upon request, furnish to the Medicare contractor, documentation of the provider's collection effort, whether the provider performs the collection effort in house or uses a

collection agency to perform the required collection effort on the provider's behalf. The documentation of the collection effort must include: the provider's bad debt collection policy which describes the collection process for Medicare and non-Medicare patients; the patient account history documents which show the dates of various collection actions such as the issuance of bills, follow-up collection letters, reports of telephone calls and personal contact, etc. CMS proposes to make this policy effective retroactively.

HFMA generally supports these clarifications. However, we ask that CMS clarify that personal contact include communications efforts such as emails and text messages.

Determining Indigence: CMS is proposing to amend § 413.89(e)(2) by adding new paragraph (e)(2)(ii) to define an indigent non-dual eligible beneficiary as a Medicare beneficiary who is determined to be indigent by the provider and not eligible for Medicaid as categorically or medically needy. The amendment would also specify that to determine a beneficiary to be an indigent non-dual eligible beneficiary, the provider must apply its customary methods for determining whether the beneficiary is indigent under the following requirements:

- 1) The beneficiary's indigence must be determined by the provider, not by the beneficiary; that is, a beneficiary's signed declaration of their inability to pay their medical bills and/or deductibles and coinsurance amounts cannot be considered proof of indigence.
- 2) The provider must take into account a beneficiary's total resources which includes, but is not limited to, an analysis of assets (only those convertible to cash and unnecessary for the beneficiary's daily living), liabilities, and income and expenses. While a provider must take into account a beneficiary's total resources in determining indigence, any extenuating circumstances that would affect the determination of the beneficiary's indigence must also be considered.
- 3) The provider must determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill; for example, a legal guardian.

HFMA members do not support this clarification as it is currently written. First, HFMA members take issue with CMS stating this is a clarification of a longstanding policy and proposing to apply this new requirement retroactively. Section 312.B of the PRM states that:

*The provider **should take** (emphasis added) into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence...*

HFMA members note the PRM uses the word "should" to modify the action taken related to a "patient's total resources" (hereafter asset test) instead of "must," as is currently proposed. "Should" is used to denote recommendations, advice, or to refer to what is generally right or wrong within the permissible limits of society. By contrast, if an asset test were a compelled obligation, CMS should have used the term "must" in the PRM.⁶ As a result of the use of the word "should," which implies "may," the

⁶ Federal Aviation Administration. "[What's the only word that means mandatory? Here's what law and policy say about 'shall, will, may, and must.'](#)"

requirement for hospitals to conduct an asset test has been enforced inconsistently at best by the MACs. **Therefore, we do not support the agency's efforts to make new policy post hoc.**

Second, HFMA's members do not support the implementation of a prospective requirement to perform an asset test. We note there is no statutory language that requires hospitals to perform an asset test before making a determination of indigency for a Medicare beneficiary and claiming related bad debt as allowable. Further, if CMS were to suddenly invent a mandatory requirement as proposed, we are deeply concerned that this will result in an encroachment by CMS into hospital charity and indigent care policies. Appropriately, this is an area into which the agency has thus far refrained from treading.

If CMS compels the use of asset tests, we are concerned that MACs will attempt to overturn a hospital's determination of indigency because the MAC finds the hospital's indigency criteria too generous. For example, a Medicare beneficiary has no liabilities, their only income is their monthly social security check, and they have a \$10,000 certificate of deposit. They have no liabilities. Expenses related to food and utilities consume their income. Few, if any hospitals would pursue collections on this beneficiary and require them to cash the certificate of deposit. Instead, the Medicare beneficiary, by most financial assistance policies, would be determined indigent. However, HFMA members are concerned that a MAC auditor may believe otherwise and disallow any bad debt associated with a patient in this circumstance. This is not a hypothetical scenario as HFMA members' report having MACs attempt to disallow charity care claimed on the S-10 during the HI-TECH audits because the auditor believed the hospital's documented charity care policy – which extended partial charity care up to 400% of the federal poverty level (FPL) – was too generous.

While we appreciate CMS's policy goal in attempting to mandate this, we believe (as described below) there are more efficient ways to achieve the same end without compelling an administratively burdensome process for both the patient and the hospital.

Third, we strongly disagree with requiring hospitals to perform an asset test prior to determining that a patient is indigent as this is prohibited in some states. Washington state is one of several states that prohibits providers from performing asset tests as part of the indigency determination. If CMS persists in requiring hospitals to perform asset tests when determining indigency, this will disadvantage patients and providers in states that forbid them. Sick patients and their families will be compelled to provide documentation that may be difficult for them to collect under the circumstances. And if they are unable to produce it (or nonresponsive) they will be subjected to the hospital's accounts resolution process when they should have been granted financial assistance, or if they didn't qualify for financial assistance, written off to bad debt. For hospitals, it will needlessly increase administrative burden and drive up the cost to collect. Second, it will reduce the amount of allowable Medicare bad debt hospitals are allowed to claim due to indigence.

Fourth, we are concerned that requiring hospitals to perform asset tests as part of determining patient indigency will limit access to physicians in rural areas. The HRSA National Health Service Corps (NHSC) Loan Repayment Program requires physicians to practice at an NHSC-approved site.⁷ Critical

⁷ HRSA National Health Service Corps, "[NHSC Loan Repayment Program.](#)"

access hospitals are eligible sites if they meet other conditions of participation.⁸ One of these conditions of participation is to provide services at a discount based on family size and income for individuals and families with incomes above 100% and, at or below 200%, of the Federal Poverty Guidelines on a sliding scale. However, hospitals are not allowed to take assets into account (among other factors) when determining whether or not a patient qualifies for the discount.⁹ Hospitals participating in this program will be forced to pursue collections efforts on patients who would otherwise be determined indigent or forgo claiming indigent accounts as allowable Medicare bad debt in order to maintain eligibility as an NHSC-approved site which allows them to maintain adequate staffing due to the attractiveness of the loan forgiveness program for many providers.

Finally, HFMA members believe (as discussed above) that CMS should update the PRM to include the use of presumptive eligibility tools to document a patient's indigence. This would extend to determining if a Medicare patient is indigent. This would reduce administrative costs for hospitals and burden on Medicare beneficiaries who have been taxed by a recent illness.

Dual Eligible Beneficiaries: In the rule, CMS proposes to clarify that, "Any amount that the State is obligated to pay, either by statute or under the terms of its approved Medicaid State plan, will not be included as an allowable Medicare bad debt, regardless of whether the State actually pays its obligated amount to the provider." The rule further states that in instances where states will not process Medicaid crossover claims and provide a remittance advice that serves as a determination of liability, CMS will not accept the provider's calculation of the state's cost sharing liability. Instead, it encourages providers to work with an unwilling partner to determine the state's responsibility for the Medicare cost sharing.

HFMA members strongly disagree. Congress's intent in reimbursing hospitals for allowable bad debt related to Medicare beneficiary cost sharing is to prevent the costs of the program from being shifted to providers. And yet CMS is proposing just that. If a dual eligible beneficiary did not have Medicaid as a secondary payer, the full amount of the cost sharing would be allowable (assuming the hospital met the regulatory requirements). HFMA members struggle with the logic of why a joint state-federal program should be treated differently. **Therefore, HFMA members believe in instances where the state Medicaid program will not process the crossover claim, the Medicare beneficiary's cost sharing should be allowable if the provider can provide documentation that a crossover claim was submitted and the provider submits an estimate of the state's liability for cost sharing.**

Additionally, CMS proposes to amend § 413.89(e) to clarify and codify that, effective for cost reporting periods beginning on and before the effective date of this rule, to be considered a reasonable collection effort, a provider that has furnished services to a dual eligible beneficiary must determine whether the state's Title XIX Medicaid Program (or a local welfare agency, if applicable) is responsible to pay all or a portion of the beneficiary's Medicare deductible and/or coinsurance amounts. To make this determination, the provider must submit a bill to its Medicaid/Title XIX agency (or to its local welfare agency) to determine the state's cost sharing obligation to pay all or a portion of the applicable Medicare deductible and coinsurance. (This is effectuated by the provider submitting a bill to Medicare for payment and the MAC administering the payment process automatically 'crosses over' the bill to the applicable Medicaid/Title XIX agency for determination of the state's obligation, if any, toward the cost

⁸ HRSA National Health Service Corps, "[How to Meet NHSC Site Eligibility Requirements.](#)"

⁹ HRSA National Health Service Corps, "[National Health Service Corps Site Reference Guide,](#)" p. 10.

sharing.) The provider must then submit to its contractor a Medicaid remittance advice reflecting the state's payment decision.

HFMA members ask that the final rule clarify its amendment to § 413.89(e). We do not believe CMS intends for providers to submit all Medicaid remittance advices for all dual eligible beneficiaries for whom they are claiming Medicare allowable bad debt when the cost report is filed. This would create a significant and unnecessary administrative burden. And it is adding a similar, extra documentation requirement that is not included to justify claimed allowed amounts for other Medicare beneficiaries who have Medigap coverage. **Therefore, we ask CMS to clarify that hospitals are only required to submit Medicaid remittance advices to the MAC for those dual-eligible beneficiaries who are selected as part of the sample during the Medicare cost report audit.**

Topic 606: Although Accounting Standards Update (ASU) Topic 606 requires different reporting of providers and terminology for bad debts (implicit price concessions), there is no change in the required criteria a provider must meet to qualify a beneficiary's bad debt account for Medicare bad debt reimbursement under §413.89. Therefore, in this proposed rule, we are proposing to recognize the ASU Topic 606 terminology in §413.89. Specifically, we are proposing to recognize that bad debts, also known as "implicit price concessions," are amounts considered to be uncollectible from accounts that were created or acquired in providing services. "Implicit price concessions" are designations for uncollectible claims arising from the furnishing of services, may be collectible in money in the relatively near future and are recorded in the provider's accounting records as a component of net patient revenue. We are proposing to amend §413.89(b)(1) by adding new paragraph (b)(1)(i) to specify that for cost reporting periods beginning before October 1, 2020, bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future. Consistent with this proposal, we are also proposing to amend §413.89(b)(1) by adding new paragraph (b)(1)(ii) to specify that for cost reporting periods beginning on or after October 1, 2020, bad debts, also known as "implicit price concessions," are amounts considered to be uncollectible from accounts that were created or acquired in providing services. "Implicit price concessions" are designations for uncollectible claims arising from the furnishing of services, may be collectible in money in the relatively near future and are recorded in the provider's accounting records as a component of net patient revenue. We are also proposing to amend §413.89(c) by adding new paragraph (c)(1) to specify that effective for cost reporting periods beginning before October 1, 2020 bad debts, charity and courtesy allowances represent reductions in revenue. The failure to collect charges for services furnished does not add to the cost of providing the services. Such costs have already been incurred in the production of the services. We are also proposing to amend §413.89(c) by adding new paragraph (c)(2) to specify that, effective for cost reporting periods beginning on or after October 1, 2020, bad debts, also known as "implicit price concessions," charity and courtesy allowances represent reductions in revenue.

We appreciate and support the proposed update to create consistent terminology for both financial reporting and Medicare cost reporting. This will provide clarity for those who have implemented and have been unsure of any ramifications due to the revenue recognition accounting changes.

Medicare Bad Debt and Contractual Allowances: Based on recent questions received, it appears that many providers are not accurate in their accounting classification method of writing off a beneficiary's deductible and coinsurance amounts for Medicare-Medicaid crossover claims, by incorrectly writing off Medicare-Medicaid crossover bad debts to a contractual allowance account. Contractual allowances,

also known as contractual adjustments, are the difference between what a healthcare provider bills for the service rendered versus what it will contractually be paid (or should be paid) based on the terms of its contracts with third-party insurers and/or government programs. Some providers have been writing Medicare-Medicaid crossover bad debt amounts off to a contractual allowance account because they are unable to bill the beneficiary for the difference between the billed amount and the Medicaid claim payment amount. Other providers are writing these amounts off to a contractual allowance account because the Medicaid remittance advice referenced the unpaid amount as a “Medicaid contractual allowance.” These Medicare-Medicaid crossover claim amounts do not meet the classification requirements for a Medicare bad debt as set forth in PRM section 320 and are not compliant with §413.20 because these amounts were written off to a contractual adjustment or allowance account instead of a bad debt expense account. In this Proposed Rule, we are proposing to clarify that Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts (bad debt or implicit price concession). Consistent with this proposal, we are proposing to amend §413.89(c) by adding paragraph (c)(3) to specify that, effective for cost reporting periods beginning on or after October 1, 2020, Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts (bad debt or implicit price concession).

We appreciate the clarification on this issue and update to the language consistent with ASU 606, as there has been immense confusion among those in the industry because of inconsistent application of the existing language by MACs in various regions. However, on April 4, 2019, the Medicare Learning Network stated the following:

Providers claiming Medicare bad debt must meet 42 CFR413.89 and all requirements from Chapter 3 of the Provider Reimbursement Manual. Correctly classify unpaid deductible and coinsurance amounts for Medicare-Medicaid crossover claims in your accounting records. For bad debt amounts:

- *Do not write off to a contractual allowance account*
- *Charge to an expense account for uncollectible accounts (bad debt)*
- *Effective for cost reporting periods beginning on or after October 1, 2019, providers must comply with these longstanding Medicare bad debt requirements.*

We respectfully request additional clarification related to any Medicare bad debts written off or adjusted off through a contractual allowance account in periods prior to October 1, 2020 to ensure there is no penalty for the past accounting practices. As the language in the Proposed Rule states that *this is effective for cost reporting periods beginning on or after October 1, 2020, we ask for confirmation that this proposed rule supersedes the noted Medicare Learning Network guidance.*

Final Rule Tables/File Review Timeframe

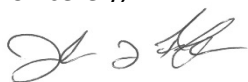
For FY21, CMS proposes that after the publication of the FY21 IPPS/LTCH PPS final rule, hospitals would have 15 business days from the date of public display to review and submit comments on the accuracy of the table and supplemental data file published in conjunction with the Final Rule. CMS acknowledges that this is less time than provided in previous years, but states that there is only a limited amount of time to review submitted information by hospitals and to implement the finalized policies before the beginning of the fiscal year. CMS believes that if there are any remaining merger updates and/or upload

discrepancies after the Final Rule, 15 days from the date of public display should be sufficient time to make any corrections to Factor 3 calculations. In addition, CMS states that it intends to revisit whether this additional comment period after the final rule is even necessary.

HFMA members believe that CMS needs to allow hospitals at least 30 days to review the files and tables underpinning payments in the 2021 final IPPS rule to ensure their accuracy. Given the uncertainties of the pandemic, many providers will likely still have staff who review these files either furloughed and/or redeployed to other administrative activities necessary to support the organization's COVID-19 response. While we can appreciate that these are extraordinary circumstances, we do not believe that hospitals should be penalized due to administrative delays that caused CMS to release the proposed 2021 IPPS rule later than customarily done.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the FY21 IPPS. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS and advisory groups. We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 58,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards.

Attachment 1: Examples of Cases Where Reporting on Worksheet S-10 Is Unclear

Scenario 1: A patient is insured under a third-party insurance company that does not have a contractual relationship with a hospital. The patient accumulated \$100,000 of inpatient charges and the third-party insurance company has negotiated with the hospital that they will pay 10% of charges after the patient meets their out-of-network deductible of \$10,000. The patient qualifies for 100% of charity care.

According to the instructions, Worksheet S-10 requires the hospital to "Enter in column 1, the full charges for uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider who meet the hospital's charity care policy or FAP."

In the above example, does "total charges" represent the \$100,000 original charge, or \$10,000 in charges the patient is responsible for (i.e., the deductible)? If it is the latter, please confirm that the \$10,000 should be entered into column 2.

Scenario 2: A patient is insured under a third-party insurance company that has a contractual relationship with the hospital. However, the patient has exhausted their benefits (i.e., reached maximum benefits), and the patient would be responsible to pay the contracted amount for the services. This amount would be reduced from full charges. If the patient is eligible for assistance under the financial assistance policy (FAP), how would this be reported (Column 1 vs. Column 2)? While the amount is not a deductible or coinsurance, the full charges were reduced based on the hospital's contracted amount (similar to how deductible and coinsurance responsibility amounts are calculated). For purposes of this example, please assume that based on the hospital's FAP the patient is eligible for a partial write-off of the amount due.

Scenario 3: A patient is insured under a third-party insurance company that has a contractual relationship with the hospital but has a patient responsibility related to noncovered charges. If the patient is eligible for financial assistance under the FAP, how would this be reported (Column 1 vs. Column 2)? The instructions only clearly state the handling of, "In addition, enter in column 1, charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria."

Scenario 4: A patient has a catastrophic coverage plan or a limited benefit plan in which the insurer covers the patient for \$1,000 per day. How would this be reported on Worksheet S-10 (Column 1 vs. Column 2) under the below example:

The insurance company has a contractual relationship with the hospital. The patient has accumulated \$85,000 of charges and the insurance company paid the hospital \$5,000 (\$1,000 per day). The hospital posts the contracted allowance for the services of \$20,000. The patient is responsible for the remaining balance of \$60,000. The patient is granted 100% charity care under the hospital's FAP and the \$60,000 is written off to charity care. Please advise how this should be reported on Worksheet S-10 (Column 1 vs. Column 2).