National Alliance of Safety-Net Hospitals

January 11, 2021

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: Agency Information Collection Activities: Proposed Collection, Comment Request

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To Whom it May Concern:

I am writing on behalf of the National Alliance of Safety-Net Hospitals (NASH) to convey to the Centers for Medicare & Medicaid Services (CMS) our views in response to the agency information collection activities published in the *Federal Register* on November 10, 2020 (Vol. 85, No. 218, pp. 71653-71654).

NASH wishes to bring to your attention the following three areas addressed by the proposed changes in CMS's data collection activities.

**Proposed Changes in S-10 Data Reporting**

NASH would like to comment on four aspects of CMS's proposed changes in how hospitals report uncompensated care on their Medicare cost reports' S-10 form.

- NASH appreciates CMS's decision to clarify that the amounts hospitals are asked to report on lines 2 through 16 of the S-10 are mutually exclusive of the amounts reported on lines 17 and 18. Our analysis of hospital S-10 reports over the years and our conversations with hospital finance and accounting staff has consistently found that hospitals vary in how they interpreted these instructions and over the years we have asked CMS to clarify this matter. The proposed changes in reporting requirements should clarify the instructions and improve the accuracy of the data hospitals report and make it more useful in CMS's reimbursement and policy-making decisions.

- NASH also supports CMS's proposal to adjust cost reporting definitions in a way that acknowledges that hospital bad debt should encompass what is now described under the Healthcare Financial Management Association's revised guidelines for revenue recognition as implicit price concessions.

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- NASH supports CMS's proposal to limit the costs and charges hospitals report on their Form S-10 to costs and charges for services provided to patients within the acute-care portion of the hospital. Currently hospitals are required to report costs and charges for services provided throughout the entire facility, including excluded sub-providers and units, such as those providing inpatient psychiatric care, inpatient rehabilitation, and skilled nursing. These units are specifically excluded from reimbursement under Medicare's inpatient prospective payment system, and excluding their data from the calculation of uncompensated care is important because the uncompensated care value is used in the calculation of Medicare disproportionate share hospital payments (Medicare DSH). We believe that limiting the data to services provided within the acute-care hospital better reflects the purpose and the spirit of the Medicare DSH program and will result in more appropriate Medicare DSH payments for private safety-net hospitals and others that play leading roles in caring for low-income and uninsured Americans.

- NASH supports CMS's proposal to add an instruction for hospitals to report charges written off to charity care other than deductible, coinsurance, and co-payment amounts that represent insured patients' liability for medically necessary hospital services and the creation of line 25.01 of the S-10 to distinguish such charges from other charity care charges reported in line 20, column 2.

**Additional Documentation Required for Charity Care and Bad Debt Provided**

NASH is concerned about some of the additional documentation CMS proposes requiring hospitals to submit (Exhibit 3B – Charity Care Listing and Exhibit 3C Listing of Total Bad Debts). We believe some of the data fields requested are Protected Health Information (PHI) under HIPAA and that hospitals should not be required to electronically transmit it as part of the normal cost reporting process.

In addition, we believe that the timeline for submitting cost reports is not sufficient to establish a clear picture of what charity care and bad debt will look like at the time the worksheet is reviewed or audited. Cost reports must be submitted within five months of the end of the cost reporting period and final determinations of patient insurance status and charity care eligibility can take much longer. Any exhibits compiled at the time of cost report submission will require substantial revision before settlement.

A better approach, in our view, would be to advise hospitals to retain the kind of data that auditors ask to see and provide publicly the data collection requests that have been actually used by auditors. To facilitate this, NASH encourages CMS to create a uniform set of instructions specifying the information hospitals should retain for auditors.

**Additional Requirement to Report Negotiated Rates From Medicare Advantage Plans**

NASH opposes CMS's proposal to require acute-care hospitals to begin reporting the rates they negotiate with Medicare Advantage programs effective with cost reporting periods beginning on or after October 1, 2020. In so doing, NASH understands that it would be useful for CMS to have this information to inform its future rate-setting work and agrees that under ordinary circumstances it would not be a significant additional burden to include on the cost report information already collected and reported on the hospital's web site.

These are not ordinary times, however: hospitals are singularly focused on responding to the COVID-19 public health emergency in a way that they have never focused on an individual matter before, and adding this responsibility at this particular time would unquestionably distract us from what we believe everyone would agree are more important matters. We believe that not delaying implementation of the requirement

that hospitals publish this information on their web sites led to an implementation schedule that was extremely ill-timed and overly burdensome and that this additional requirement would only exacerbate an existing problem. For this reason, we respectfully request that CMS withdraw this proposed change in data collection requirements at this time and consider reissuing it after the current public health emergency ends.

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NASH appreciates the opportunity to share its views on CMS's proposed changes in data collection practices and welcomes any questions you may have about the views expressed in this letter.

Sincerely,

Ellen Kugler, Esq.
Executive Director

**About the National Alliance of Safety-Net Hospitals**

The National Alliance of Safety-Net Hospitals advocates for adequate recognition and financing of private safety-net hospitals that serve America's neediest communities. These private safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are older and poorer; they are more dependent on Medicare and Medicaid for revenue; they provide more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NASH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private safety-net hospitals. NASH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates. Until 2019 NASH was known as the National Association of Urban Hospitals, and its evolution into NASH reflects its members' recognition that private safety-net hospitals can be found serving communities not only urban but also rural and suburban across the country.