CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 31, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to share with you our concerns about the use of Worksheet S-10 in the Medicare uncompensated care (UCC) payment distribution methodology. We are particularly grateful to have this opportunity before the Centers for Medicare & Medicaid Services (CMS) releases its federal fiscal year (FFY) 2020 inpatient prospective payment system (IPPS) proposed rule. If CMS proceeds with expected plans, the potential exists for substantial redistributions (perhaps in the billions) of Medicare UCC payments from hospitals that have undergone Worksheet S-10 reviews to those that have not. Such an inappropriate redistribution will significantly impact many providers' financial viability and, therefore, threatens Medicare beneficiaries' ability to access care.

CHA respectfully requests that CMS:

- **Rescind guidance that has been issued to the Medicare administrative contractors (MACs) and their subcontractors related to current adjustments to Line 22 on FFY 2015 Worksheet S-10; this guidance reflects an inappropriate interpretation of expected versus actual payments received.**
- **Delay the current deadline — January 31 — by which MACs must submit the amended cost report data reflecting these and other adjustments. This delay would allow time for correction so that the file used for FFY 2020 rulemaking is not compromised.**
- **Fully address, through the notice and comment rulemaking the significant policy issues that these reviews have uncovered and their implications for FFY 2020 Medicare UCC payments so that stakeholders can provide substantive analysis and thoughtful comments to help guide the agency's next steps.**

As we have in the past, CHA convened providers and cost report experts, both inside and outside of California, to better inform our feedback on the opportunities and challenges these data present. CHA has a long history of working with the agency in identifying opportunities for improved data reliability and validity for purposes of Medicare payment. In February 2017, CHA shared its white paper detailing the confusion and reporting challenges related to Worksheet S-10 instructions that, we believed, contributed to the erroneous reporting present in the data. We have provided CMS with countless reports of our analysis, which consistently finds implausible and totally unexplainable data variation.

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In its efforts to date, CMS incorporated many recommendations from CHA's white paper; we applaud CMS for its commitment to improving the Worksheet S-10 instructions. However, we believe more can — and should — be done to improve shared understanding of these reporting instructions. We believe a greater understanding would, over time, improve the data's accuracy. CHA will share additional specific instruction recommendations under separate cover in the coming weeks.

In fall 2018, CMS staff suggested that all state hospital associations — including CHA — work directly with their MACs to identify and discuss reporting concerns so that issues could be raised through the appropriate provider audit review processes at CMS. Unfortunately, to our knowledge, only one contractor engaged in such efforts — Noridian, California's MAC. Noridian established a provider audit work group to identify and discuss these issues, share perspectives and engage in debate; it is not intended to be a policy working group. Unfortunately, due to competing MAC priorities in the last quarter of 2018, these conversations did not begin in earnest until November of last year and a number of topics remain unaddressed. Further, CMS' subcontractor, Figliozzi and Company, did not participate in these important conversations. Nonetheless, CHA very much appreciates this dialogue and applauds Noridian for dedicating limited staff resources to these important conversations. We have learned a great deal through this model and look forward to the continued dialogue through 2019. Further, we believe that CMS should replicate it at the national level in the very near future.

While the dialogue to date has been an important step, we invite CMS to — in light of the recent review findings and the number of questions still unaddressed — participate in a national conversation with stakeholders. We would be happy to convene such a discussion. Alternatively, establish a group — similar to a Medicare Technical Advisory Group — that is specific to provider audit issues and promotes dialogue and shared understanding of expectations. The group should be comprised of cost report experts, hospital finance and reimbursement staff and MACs to promote dialogue and shared understanding of expectations. We discuss these recommendations in more detail below.

Lastly, as a first step, when this process has concluded, we ask that CMS articulate the learnings of the Worksheet S-10 reviews in national provider calls and invest significant staff time and resources toward educational efforts to help auditors and the field better understand how together we can improve this data.

The following detailed comments and recommendations reflect learnings from our discussions to date with member hospitals and other stakeholders. We look forward to additional dialogue with CMS on each of these important issues and will share additional technical recommendations in the near future.

Worksheet S-10 Reviews: Challenges and Opportunities

Under Section 1886(r) of the Social Security Act, Medicare determines a national hospital UCC pool of payments. The pool equals 75 percent of aggregate payments for Medicare disproportionate share hospitals (DSH), adjusted for changes in the uninsured population since FY 2013. UCC payments are then distributed to each DSH-eligible hospital based on the hospital's share of national UCC costs. Prior to FFY 2018, CMS distributed the UCC pool using low-income patient days due to concerns with reporting of UCC care costs on Worksheet S-10 of the Medicare hospital cost report.

Ever since it began distributing UCC payments, CMS has expressed interest in using Worksheet S-10 data in place of low-income patient days. In fact, many policy makers have discussed the use of this data for other policy and payment determinations. This gives us great pause.

Under the current Medicare DSH methodology, California's hospitals experience the most significant financial losses. However, we have not opposed CMS' efforts to use Worksheet S-10 in the distribution. Instead — after conducting significant data analysis that contradicts the agency's findings — CHA strongly urged CMS to audit all hospital data, similar to an area wage index review, to ensure that each hospital's share of national UCC costs was based on sound data and evidence.

CMS began using Worksheet S-10 data in the UCC distribution beginning with FFY 2018. For FFY 2018, CMS used one year of Worksheet S-10 data, from FY 2014, and two years of low-income patient days. In that year, UCC costs were calculated differently than in later years, due a change in cost report instructions released in September 2017 (commonly referred to as "Transmittal 11[1]"). FFY 2014 UCC costs are calculated and used differently for FFY 2018 than for FFY 2019 UCC distribution.

As the basis for hospital UCC distributions in FY 2019, CMS is using two years of Worksheet S-10 data (FY 14 and FY 15 UC cost calculated using the Transmittal 11 update) and one year of low-income days. In the FFY 2019 IPPS final rule, CMS indicates "the use of low-income insured days would be phased out by FFY 2020 if the same methodology is proposed and finalized for that year." (83 FR 41417). This statement suggests that CMS plans to propose using FY 2014 through FY 2016 Worksheet S-10 data in the UCC distribution for FY 2020. That is three years of data, based on reporting over multiple years with various instructions, with only 600 hospitals having received any type of review.

CMS further indicated that "due to the overwhelming feedback from commenters emphasizing the importance of audits in ensuring the accuracy and consistency of data reported on the Worksheet S–10, we expect audits to begin in the Fall of 2018." (83 FR 41424). Those audits (referenced throughout this letter as "reviews") were recently completed and identified significant concerns for hospitals, such as:

- Inconsistent reporting due to confusion about Worksheet S-10 instructions. Examples identified to date include:
    - Offsetting charity care charges for expected versus actual payment
    - Financial assistance policy language and varying interpretations
- Inequity associated with any payment adjustment based on reviewing only a portion of hospitals eligible to receive a fixed pool of uncompensated care payments
- Variation in the application of audit protocols across Medicare auditors, which could be mitigated through increased oversight, as well as contractor and provider education and engagement.

CHA understands CMS' goal of using Worksheet S-10 data in the distribution of Medicare UCC payments. However, we believe these concerns — explained in detail below — must be addressed through engagement with the hospital community. Stakeholders must be afforded an opportunity to

[1] Key changes to in Transmittal 11 are: 1) the inclusion of uninsured discounts as charity care (if noted in hospital financial assistance policy); 2) charity care co-insurance and deductible amounts are not reduced by application of the cost to charge ratio); and 3) non-reimbursed Medicare bad debt co-insurance and deductible amounts are also not reduced by the cost to charge ratio for the remaining 35 percent of non-reimbursed Medicare bad debt.

fully respond to agency proposals, which we anticipate will, in the near future, fully incorporate Worksheet S-10 data.

Changes in Medicare Cost Report Instructions

The Medicare cost report instructions for Lines 20 and 22 of Worksheet S-10 are different, depending on whether a cost reporting period began prior to October 1, 2016. Line 20 is used to record charity care charges and uninsured discounts. Line 22 is used to record the amounts actually received from patients who received discounted charges under a charity care or financial assistance policy. For cost reporting periods beginning before October 1, 2016, hospitals were required to report full, undiscounted charges on Line 20 and amounts "received or expected to be received from patients who have been approved for charity care or uninsured discounts" on Line 22.For cost reporting periods beginning on or after October 1, 2016, hospitals are required to report only the charity care or financial assistance policy charges being waived on Line 20 as the "amounts written off with no expectation of payment." The instructions further articulate the only payments reported on these cost reports are from charity care reported on prior year cost reports, before October 1, 2016. The instructions for reporting payments on Line 22 of cost reports under the new instruction (on/after October 1, 2016) require hospitals to "Enter all payments received during this cost reporting period, regardless of when the services were provided, from patients for amounts previously written off on line 20 as charity care or uninsured discounts. This reporting instruction correlates to the reporting of actual payments as they are received from the hospital. As detailed below, the reporting of expected payments (as opposed to actual payments) on line 22 for cost reports beginning before October 1, 2016 creates signification variation, field confusion and is counter-intuitive to the updated cost report instruction to report actual payments as they are received by the hospital.

It has been CHA's experience that hospitals, both in California and throughout the country, find the instructions for cost reporting periods beginning before October 1, 2016 to be unclear. As such, they frequently report only those charges written off to a charity care or a financial assistance policy on Line 20. As the amount reported on Line 22 offsets the amount reported on Line 20 based on what the patient still owes or actually pays, the hospital will disadvantage itself in the UCC distribution if it reports less than full charges on Line 20.

This issue will affect all cost reports for FY 2016 and earlier years. However, it is of particular importance for FY 2015 as these cost reports have recently undergone reviews in which MACs apply an adjustment to line 22 that CHA, and many others in the hospital community, believe is incorrect. If not reversed, the adjustment will result in massive redistributions of UCC payments from hospitals that have undergone FY 2015 Worksheet S-10 reviews to hospitals that have not.

Further complicating the issue is the fact that revised instructions for FY 2016 cost reports were not released until **after** the cost reports were due. To date, CMS has not provided an opportunity to refile updated reports, despite doing so in similar past situations. For example, cost reports for the fiscal year ending December 31, 2015, were filed in May 2016. When it released Transmittal 11 in September 2017, CMS allowed hospitals to make revisions based on the updated instructions until January 2, 2018. However, it has not done so with FY 2016 cost reports that have been under review. In the FY 2019 IPPS final rule, CMS responds to this issue by stating:

> To the extent these commenters were requesting a further opportunity to revise their Worksheet S-10 data for use in future rulemaking for FY 2020 or later years, we are not addressing the issue of future resubmissions in this final rule. Therefore, the normal timelines and procedures apply for a hospital to request to amend a cost report. To the extent these commenters were requesting a further opportunity to revise their Worksheet S-10 data for use in future rulemaking for FY 2020 or later years, we are not addressing the issue of future resubmissions in this final rule. Therefore, the normal timelines and procedures apply for a hospital to request to amend a cost report. (83 FR 41420)

Given that revised instructions were released after cost reports were submitted, FY 2016 cost reports will most certainly reflect inconsistent and inaccurate reporting. Moreover, the complexities of the current FY 2015 reviews are causing uncertainty across the hospital field as to how FY 2016 could be amended and used in the future.

Line 22 Adjustment for Expected versus Actual Payments Received

As indicated above, the Line 22 cost report instructions require the hospital to report the amount "received or expected to be received from patients who have been approved for charity care or uninsured discounts." **However, it is our understanding that CMS has instructed the MACs to adjust Line 22 in its FY 2015 Worksheet S-10 reviews to include the amount actually due from the patient after a charge discount has been applied — regardless of whether that amount is ever paid.**

Given the time elapsed since FY 2015, hospitals will know the amounts paid on charges due — typically, a very small amount or nothing at all, as these discounts are furnished to uninsured or indigent patients. **As the amount actually received will be less than the amount due, the hospital will be offsetting an amount from its charity care charges that it did not — and will never — receive. The result, in many individual patient care cases, will be a negative charity care figure on Line 22, even though the hospital has discounted charges under its charity care and financial assistance policies.**

We understand that CMS has instructed the MACs to substitute $0 for a negative result on Line 22 — but it makes no sense that a hospital could have zero or negative charity care when it has discounted charges under a charity care or financial assistance policy. **Giving a hospital no allowance for charity care in this circumstance is patently unfair and will result in a significant redistribution of uncompensated care payments from hospitals subject to FY 2015 reviews to all other hospitals.**

We understand CMS' concern that, if the hospital does not report the amount due on Line 22, it could receive duplicate payment for charity care and bad debt if charges due are also reported as bad debt on Lines 28 and 29. While CMS' concern is understandable, its resolution effectively offsets full charity care charges for amounts owed but not paid. Even if those amounts are counted as bad debt, a hospital still receives no charity care credit — despite reducing its charges to patients eligible for its charity care and financial assistance policies.

The issue arises because of the distinction in the instructions between cost reporting periods beginning before October 1, 2016, and those beginning on or after October 1, 2016. The instructions for the earlier cost reporting periods mix both charity care costs and bad debt costs by requiring reporting of full charity charges on Line 20 (based on date of service within the hospital's cost report period), rather than

just the charges written off to charity care. Bad debt is reported based on the amount written off reflective of the respective bad debt transactions that occurred during the hospital's fiscal year. The problem is addressed in the instructions for the later cost reporting periods by clearly demarcating on the amounts written off to charity care on Line 20 and allowing charges due and not paid only to be counted as bad debt on Lines 28 and 29.

Reporting expected payments only addresses part of the crossing of the cost reporting instructions, and should not be used only on those hospitals selected for FY 2015 review. For instance, consider a patient who receives 100 percent charity care, discharged on December 31, 2016 – but written off as charity care on January 1, 2017. If the hospital has a December 31 fiscal year, this cost will be reported on both cost reports due the current cost report instructions for each respective year. There is no expected payment in this scenario, as the patient received 100 percent charity care. (Please see Appendix A for additional examples).

Indeed, applying the different instructions to the same circumstance produces different results — suggesting a clear problem with one set of CMS' instructions. It is evident that the problematic instructions are those for the pre-2016 cost reports, as they produce negative charity care figures; this is simply illogical.

In light of this significant discrepancy, which plagues both the FFY 2015 and the FFY 2016 cost reporting periods, CHA urges CMS to instruct the MACs and their subcontractors to reverse this adjustment. Not only is it inappropriate, but — in talking with cost report experts around the country, it also is not being applied consistently. While some variation is to be expected across MAC reviews, we have discovered that some auditors have implemented this adjustment whereas others in the same jurisdiction have not.

In addition to reversing this adjustment, CMS must provide additional time for the MACs and their subcontractors to make this change. The January 31 date for submission of the hospital cost report information system files does not allow sufficient time to make these adjustments, especially for hospitals that are settling cost reports. Settled cost reports will require the MACs to start the reopening process to make this adjustment. This is a significant and costly administrative and regulatory burden that can — and should — be avoided.

<u>Equitability of Reviewing Only Some Hospitals</u>

In August 2018, CMS instructed the MACs to review 600 hospitals, or approximately 25 percent of the hospitals eligible to receive UCC payments. These reviews are to be completed by January 31, 2019.

It is important to note that the pool of UCC payments is a fixed amount distributed to each hospital based on its own share of national UCC costs. Reducing a hospital's UCC costs does not result in any savings to Medicare — it only reduces that hospital's share of national UCC payments, thereby increasing the share for all other eligible hospitals.

We applaud the agency for taking this first step in the review process, as stakeholders requested. As anticipated, in even this short window, CMS, its subcontractors, MACs and providers have uncovered a number of issues that must be addressed.

Data that has never been reviewed will only improve with greater scrutiny. However, in this early stage, we believe it is absolutely unfair to distribute a limited and fixed pool of UCC payments based on one year of cost report data that has been reviewed for only 25 percent of hospitals eligible to receive those payments. CMS should strongly reconsider its use of Worksheet S-10 data until all hospitals' UCC payments are reviewed, under consistent review protocols, and share its thinking and policy rationale in future rulemaking.

Worksheet S-10 Reviews: Lessons Learned to Date

CHA continues to collect input from member hospitals, in addition to learning about Worksheet S-10 review experiences from hospitals nationwide. To improve this important effort going forward, we have attempted to synthesize some of the important learnings, examples of audit variation and opportunities for future education. CHA looks forward to working with CMS staff to identify areas where providers can also make changes to improve these processes.

Review Burden
The initial data request outlined by CMS and implemented by the MACs and their subcontractors was requested in an Excel spreadsheet. We believe the contractors quickly realized the volume of information being requested by the agency is not supported in Excel, especially for large hospitals. The data request requires hospitals to provide information by transaction type and revenue code.

The following was discovered at one hospital currently under audit, illustrating the magnitude of the requested data:

- The hospital had approximately 300,000 unique charity care claims during the course of the year. This is represented as 300,000 lines in the provider's existing uncompensated care support.
- To assign a revenue code to each of these 300,000 claims, it used approximately 6,000,000 lines of a database.
- If all the transaction codes are also included (contractual allowances, payments, refunds, etc.), the database would use more than 10,000,000 lines — nearly double the previous amount.

The data required by CMS to support uncompensated care reporting is far larger than most have the ability to review and or manage. Neither the field or the MACs were equipped with business intelligence solutions to efficiently report and review the data requested. In some instances, contractors circulated templates after initial data submission and asked hospitals to reformat and resubmit their data, further complicating these reviews. While we understood this template was optional, providers in some cases were led to believe it was mandatory and that they were required to resubmit data in this standardized format.

In reflecting on this first round of reviews, CHA urges CMS to carefully review its data request with hospitals and the MACs. Over the past 10 years, hospital technology — both on the revenue cycle and integration with electronic health record technology — has significantly evolved. We believe there are opportunities to identify best practices and create templates that could be used across the country for future reporting. However, this effort should begin as soon as possible so that hospitals and the MACs

have time to implement standardized data requests and cost report reporting templates to speed response times.

Provider and Auditor Education
CHA appreciates that CMS has begun these reviews. However, its process allowed very little time for auditor education, leaving many unable to explain to hospitals the policies that were being implemented. We understand as regulators, CMS does not provide its audit and review protocols. However, providers also want to fully understand the expectations for reporting and follow the rules. When there is lack of shared understanding and expectations, challenges arise. Unfortunately, due to the aggressive timelines and lack of education, particularly unfortunate audit practices have occurred — practices that, without additional oversight, may continue. The following are just two examples we have heard repeated around the country.

Example 1:

> Co-Insurance vs. Co-Payment Amounts – The cost report instructions state to report the co-insurance and deductibles related to charity care for patients qualifying for patient financial assistance. Some MACs are taking this language literally and disallowing "co-payments" that are charity care. This appears to be clearly an issue of shared understanding of the language, as co-insurance and co-payments essentially serve the same purpose (patient liability) and, in fact, are both used and allowed for the reporting of Medicare bad debts.

Example 2:

> Reporting of Total Hospital Charges – During the review of some FY 2015 hospitals, MACs identified uninsured accounts with both an uninsured discount under the hospital's financial assistance policy and a charity care discount (two separate transactions). In this hypothetical example, the patient has $10,000 in charges, 60 percent attributed to charity care ($6,000), and 40 percent to an uninsured discount ($4,000). If the MAC disagrees with the uninsured discount, the MAC will only allow the hospital to report $6,000 in charges. However, the cost report instructions clearly state to report "full hospital charges" ($10,000).

In reviewing these examples, we recommend that CMS consider:

- **Building infrastructure and looking to the field for technology solutions.** We learned very quickly this data is far too robust to produce meaningful information and Microsoft skills are not adequate to manage the amount of data necessary to report UCC. Together, we must identify meaningful technology solutions that will allow all parties to work effectively with these large datasets so that we can do this work efficiently and consistently.
- **Educating auditors.** Many auditors have a finance background, but not a patient financial services background. General education on how hospitals implement and record transactions based on their charity care and financial assistance policies would promote shared understanding. In addition, various state and federal law requirements influence how a facility may write and implement its policies, particularly with respect to section 501R of the tax code that imposes requirements related to financial assistance policies on not-profit hospitals. CMS acknowledges and allows for variation of

these policies as needed. However, there seems to be a "one size fits all" approach to review of language of these policies that may not be appropriate.

- **Engaging and educating providers.** So much has been learned through these reviews, and we anticipate that CMS and the MACs may identify best practices for reporting. CHA encourages the investment of significant staff resources to develop educational forums and opportunities for ongoing dialogue between CMS, the MACs and hospitals **prior** to the release of substantive revisions to or guidance on cost report instructions. CHA believes that CMS should release draft guidance or instructions prior to their adoption, to help bring about shared understanding of expectations and ensure more accurate reporting in the future.

The challenges we describe are not insurmountable, but they provide significant evidence that CMS should reconsider moving forward with three years of Worksheet S-10 data for the FY 2020 IPPS. As noted earlier, CHA remains supportive of and committed to use of Worksheet S-10 in the distribution of UCC payments, once those data are consistently reported and reviewed. We stand ready to work with the agency and continue this important dialogue, and we thank you for considering our concerns.

Sincerely,
/S/
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Vice President Federal Regulatory Affairs

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