Federation of American Hospitals®

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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Subject: Proposed Changes to CMS 2552-10 Hospital and Health Care Complex Cost Report (OMB Control Number 0938– 0050)

Dear Administrator Verma:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care across settings in both urban and rural areas. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals. They provide a wide range of acute, post-acute, emergency, children's, cancer care, and ambulatory services. The FAH appreciates the opportunity to comment on proposed revisions to the Hospital and Health Care Complex Cost Report, Form CMS-2552-10 (OMB Control Number 0938– 0050), following CMS's Notice, published in the Federal Register on November 20, 2020 (85 Fed. Reg. 71,653).

As a preliminary matter, the FAH was dismayed to see that the proposed revisions to the cost report add numerous fields that have no apparent value to Medicare payment policies. Rather than promoting burden reduction and administrative simplification, it appears that the proposed revisions would significantly increase cost reporting burdens for hospitals. These changes to the cost report are particularly problematic in the midst of the COVID-19 public health emergency because they divert hospital resources from patient care at the worst possible time. The FAH urges CMS to reevaluate the proposed cost report form to ensure that the form focuses exclusively on high-value data fields that are necessary and appropriate to the efficient administration of the Medicare program and cull out the low-value fields that create unnecessary burdens for participating hospitals.

In addition, as explained further below, the FAH continues to strongly object to the collection of median payer-specific negotiated rate by MS-DRG for payers that are Medicare Advantage (MA) organizations (MAOs) and urges CMS to remove new Worksheet S-12 from the cost report. But, if CMS persists in adopting Worksheet S-12, the FAH is concerned that Worksheet S-12 would be applicable for cost reporting periods *ending* on or after January 1, 2021, which is far earlier than the other changes applicable for cost reporting periods *beginning* on or after October 1, 2020. This aggressive implementation date is particularly problematic when Worksheet S-12 necessitates significant clarification and refinements and hospitals' lack of familiarity with this new process. If CMS does not forego adoption of Worksheet S-12 altogether, it urges CMS to collect this data through an annual, standardized survey similar to the occupational mix survey so that the collected data would reflect rates over comparable time periods and to delay that survey until an appropriate data collection tool and instructions are developed and deployed. In the alternative, at a minimum, the FAH requests that CMS either delay the adoption of Worksheet S-12 or delay the filing date deadline for cost reports to allow no less than 90 days from finalization of the Worksheet and clarification of the instructions to submission of the cost report.

I. Worksheet S-2, Part I, Lines 24 and 25 and Exhibit 3A (DSH Eligible Medicaid Days)

CMS instructs hospitals to support the Medicaid days on Worksheet S-2, Part I, line 24 or line 25 by completing new Exhibit 3A. The FAH urges CMS to simplify the reporting of Medicaid days by consolidating the six columns in lines 24 and 25 into a single column for all Medicaid days and only require the completion of a single copy of Exhibit 3A for all Medicaid days reported. Although lines 24 and 25 have been included for some time, the FAH questions the necessity of separately reporting on specific categories of Medicaid days in six columns (Medicaid FFS In-State Paid Days, Medicaid FFS In-State eligible unpaid days, Medicaid Out of State days paid, Medicaid Out of State ineligible days unpaid, Medicaid HMO days, and Medicaid other). Refining the Medicaid days data into the six categories for reporting purposes does not further accurate payment and imposes a significant and unnecessary administrative burden on providers. This administrative burden would be compounded by new Exhibit 3A because many providers do not store claims data broken out by the six categories in columns 1 through 6 of lines 24 and 25.

The FAH, therefore, requests that CMS eliminate the separate columns for lines 24 and 25 to streamline reporting of Medicaid days and to instruct providers to only complete one version of new Exhibit 3A. If CMS maintains the separate columns in lines 24 and 25, the FAH requests that CMS permit providers to complete a single Exhibit 3A that crosswalks each entry to the six columns in lines 24 and 25. The FAH also asks that CMS clarify that column 5 (Medicaid HMO days) includes both in-state and out-of-state Medicaid HMO days and includes both paid and HMO-eligible but unpaid Medicaid HMO days.

Additionally, the FAH makes the following recommendations regarding new Exhibit 3A:

- **Patient Name (Columns 1-2).** Exhibit 3A requires hospitals to separately report the patient's last name in column 1 and first name in column 2. Some providers, however, maintain claims data showing the patient's full name in a single field.

The FAH asks CMS to clarify whether a provider can provide a listing of Medicaid eligible days that alters the presentation and order of data by combining the patient name into a single field.

- **Medicaid Recipient ID Number (Column 5).** The instructions for new Exhibit 3A ask for the Medicaid recipient identification number in column 5. However, hospitals may not have Medicaid identification numbers for Medicaid recipients. For example, Medicaid recipients covered by Medicaid managed care organizations (MCOs) may not have an identification number because MCOs frequently use their own HIC or insurance identification number. ***The FAH therefore asks CMS to clarify that a hospital may report any alternative identification number used by the Medicaid MCO in the absence of a Medicaid beneficiary identification number.*** In addition, the FAH is concerned that hospitals in some states may be unable to fully complete Exhibit 3A because some state Medicaid plans do not return recipients' Medicaid identification numbers to providers, and this data will not be available to providers in the event that a recipient does not provide their Medicaid identification number. Because eligibility matches can be (and, in past audits, have been) completed using social security numbers and birth dates—***the FAH requests that CMS permit the reporting of alternative data (including social security numbers or birth dates) in column 5 where the Medicaid recipient identification number is not available***. In the alternative, CMS requests that CMS require state Medicaid plans to provide Medicaid identification numbers to providers.

- **State Plan Eligibility Code (Column 10).** The instructions for column 10 require hospitals to enter the applicable state plan eligibility code number, but this information is burdensome to supply and provides no apparent value. In fact, because eligibility codes are variable between states, this data would not even be standardized across providers. ***Therefore, the FAH urges CMS to delete column 10 from Exhibit 3A as unnecessarily burdensome.*** If CMS nonetheless finalizes Exhibit 3A with column 10, the FAH is also concerned that the instructions do not address situations where a Medicaid recipient has multiple state plan eligibility codes over one inpatient admission during which Medicaid coverage was continuous. One patient may also have multiple codes from multiple states. ***The FAH therefore asks CMS to clarify in its instructions for reporting the plan eligibility code for inpatient stays when the patient has multiple eligibility codes for a single stay.*** For example, should hospitals enter multiple codes in column 10 in these cases? This clarification is especially critical in the case where the patient stay extends multiple months and has different eligibility codes from month to month.

- **Primary Payer (Column 13) and Secondary Payer (Column 14).** The instructions for columns 13 and 14 require hospitals to enter the name of the patient's primary and secondary insurer or other payer. This data is not necessary to confirm Medicaid eligible days, and the ***FAH recommends that CMS reduce the regulatory burden associated with Exhibit 3A by removing these unnecessary columns.*** If CMS does not remove these columns, the FAH seeks

clarification as to whether these columns include information for payers that failed to make payment for the stay.

- **Medicare Eligibility (Columns 15-17).** Lines 24 and 25 exclude days on which the patient was entitled to Medicare Part A. As such, it appears that columns 15 through 17 are unnecessary—any Medicare-eligible days are excluded from lines 24 and 25, and Exhibit 3A is focused only on supporting the listing of Medicaid eligible days. ***Including these columns adds unnecessary administrative burdens for hospitals, and the FAH requests that these columns be removed.*** In the event that these columns are retained, the FAH asks for clarification that the use of the Health Insurance Portability and Accountability (HIPAA) Eligibility Transaction System (HETS) is acceptable in situations where the state Medicaid verification system does not accurately return the Medicare indicator of Part A or Part B coverage. In addition, the FAH requests clarification of the difference between a patient's entitlement to Medicare Part A, as that term is used in the instructions for lines 24 and 25, and a patient's eligibility for Medicare Part A, as that term is used in the instruction for column 15 to Exhibit 3A.

- **Presumptive Eligibility.** Exhibit 3A does not provide instructions or a mechanism to link babies born to Medicaid eligible mothers to the mothers' eligibility. ***The FAH recommends that CMS add fields to indicate that a baby is covered under presumptive eligibility and report the account or control number for the baby's mother, or provide instructions for including information regarding the mother's accounts elsewhere (e.g., in the comment field, column 18).***

II. Worksheet S-2, Part I, Lines 88-89 (TEFRA Adjustment Date)

CMS proposes to add lines 88 and 89, including column 2 to line 89, which requests the effective date for the provider's permanent adjustment to the target amount per discharge under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). ***The FAH requests that CMS delete column 2 from new line 89*** because some hospitals may not know the specific date on which the permanent adjustment was granted and CMS already has this information. The proposed instructions for line 89 specifies that the requested date is for the cost reporting beginning date for which the permanent adjustment was effective. In many cases, the permanent adjustments to the TEFRA targets were granted more than a decade ago. Those individuals familiar with the circumstances of how and when the hospital received the adjustment have left the organization. Meanwhile, because CMS has this information, the inclusion of column 2, line 89 is unnecessary. ***In the alternative, CMS should require that the MAC provide the information requested in line 89 to any requesting provider.***

III. Worksheet S-2, Part I, Line 123 (Purchased Administrative Services)

The FAH urges CMS to remove proposed line 123 from Worksheet S-2, Part I because this addition to the cost report would impose a significant new administrative burden on providers without providing data necessary for determining the amount of payments due the provider. Section 123 would require providers to report the percentage of expenses that were

purchased from an unrelated organization located in a core-based statistical area (CBSA) outside of the main hospital CBSA. Hospitals widely use purchased legal, accounting, tax preparation, bookkeeping, payroll, and management consulting services and do not track the percentage of services that are purchased from unrelated organizations, let alone whether the unrelated organization is in the main hospital's CBSA. It is also unclear when an unrelated organization would be considered to be located in the main hospital CBSA for purposes of proposed line 123—in many instances, organizations providing these services may have a local office in the main hospital's CBSA but, in light of the complexity of the tax, accounting, and legal rules applicable to providers, will leverage staff resources outside the CBSA to provide the requisite level of expertise on individual projects.

Moreover, the instructions and supporting statement fail to provide any rationale for collecting this data. Rather, it appears that this burdensome data element is informational in nature, such that the costs imposed by this data element would be vastly disproportionate to the value of the data collected. In the alternative, if there is any rationale for collecting this data, it has not been presented to stakeholders for comment. As such, the FAH strongly opposes the addition of line 123 and urges CMS to remove it from Worksheet S-2.

IV. Worksheet S-2, Part II, Exhibit 2A (Listing of Medicare Bad Debts)

A. Flexibility, Beneficiary Name (Columns 1 & 2) and Medicaid number (Column 7)

The FAH requests the CMS permit providers flexibility to alter the presentation and order of data reported in Exhibit 2A and to include additional information and data elements where appropriate. Updating provider templates to present these data elements in the exact order and with identical wording would be administratively burdensome and impose unnecessary costs on providers. For example, some providers normally have recoveries listed in a separate tab, and if they are required to conform to the format of Exhibit 2A, columns 18 and 19 on the new template may have missing information if years have passed since the provider claimed the initial bad debt. In addition, updating current templates that are not separated by inpatient and outpatient would be burdensome, and the FAH requests confirmation as to whether providers have the ability to report Medicare bad debts without separate listings for inpatient and outpatient services.

Along these lines, the FAH notes that Exhibit 2A does not include columns for reporting non-allowable portions, which need to be taken into consideration in order to compute the amount of the patient responsibility. The Exhibit does not include columns for non-covered items and services, such as self-administered drugs and professional fees. Additional patient payments may be proportionally applied to these items, but without this information, and this data would aid in substantiating the allowable bad debt amount in these situations. The flexibility to modify the form and fields of Exhibit 2A, as described above, would enable providers to report this information where appropriate.

Likewise, for the same reasons explained above with respect to Exhibit 3A, ***the FAH requests CMS clarification that a provider may combine the patient name into a single field and furnish the alternative identification number used by the Medicaid MCO in the absence of***

a Medicaid beneficiary identification number. Likewise, the FAH requests that CMS make a corresponding change to the instructions to Exhibit 2, column 4 so that alternative identifiers may be used where no Medicaid identification number is available.

B. Beneficiary Responsibility Amount (Column 12)

The FAH requests that CMS remove column 12 from Exhibit 2A as unnecessary and burdensome. It is unclear how this data would be used, but it does not appear that column 12 furthers accurate program payments in a way that would warrant the associated burden on hospitals. In the alternative, the FAH asks that CMS explain the utility and value of this data so that stakeholders can comment on potential burden reduction options. In addition, if this field is retained, the FAH request that CMS clarify whether the patient responsibility reported should be from Medicare, a secondary payer, or both and confirm whether the amount reported is confined to deductible and coinsurance amounts or also includes non-covered charges that are the patient's responsibility.

C. Collection Effort Ceased Date (Column 16)

Column 16 on new Exhibit 2A requires reporting of the "date all collection efforts ceased, both internal and external, including efforts to collect from Medicaid and/or from a state for its cost sharing liability." ***The FAH urges CMS to remove this column as unnecessary.*** In many instances, this date is the same date that will be reported in column 15 (return date from collection agency) and/or column 17 (Medicare write off date), making column 16 largely redundant. In addition, because providers do not currently report on the Medicaid denial date, reporting in column 16 will necessitate another burdensome process change to gather and provide this information. If columns 15 through 17 are retained, the FAH requests that CMS clarify in the instructions that the date in column 16 may be the same as the dates in columns 15 and 17.

D. Medicare Bad Debt Write-Off Date (Column 17)

It is the FAH's understanding that the write-off date cannot be earlier than the latest date reported in columns 14, 15, or 16, but the FAH requests that CMS clarify that a provider is not otherwise limited in the write-off date (*i.e.*, the Medicare bad debt write-off date may be later than the dates reporting in columns 14, 15, and 16). ***In addition, the FAH requests that CMS address differences in the write-off date and write-off effective date for correct MAC misunderstandings of hospital operations and accounting.*** In some cases, a provider might have a Medicare year end of December 31 with a post-close period through January 4. Bad debts written off in this post-close period would still have an expense effective date of December 31, which is the actual write off date recorded on the general ledger for the provider cost reporting period in question, and the bad debt in these situations should still be allowed in the period that the expense is realized.

E. Recoveries—Fiscal Year End Date (Column 19)

Exhibit 2A includes new fields concerning recoveries, and providers are instructed to enter the fiscal year end of the cost reporting period in which the Medicare bad debt (to which the recovery applies) was claimed and reimbursed in column 19. ***The FAH urges CMS to make***

column 19 optional such that only providers that seek to limit recovery to the original bad debt claim would complete this field. At present, many providers currently do not limit recoveries in this manner because of the associated administrative burden of crosswalking to the original bad debt claim. Requiring providers to complete column 19 in all cases would impose this unnecessary administrative burden across the board, essentially eliminating a burden-reduction option that is currently available and widely used by providers.

F. Current Year Payments Received (Columns 22 & 23)

Exhibit 2A includes new data fields on the amount and source of any deductible or coinsurance payments received from or on behalf of the Medicare beneficiary during the cost reporting period, before the account was written off. ***The FAH requests the elimination of these columns because payments related to the Medicare beneficiary deductible and coinsurance balance will often occur in prior year(s) and the separate reporting of prior and current year payments adds complexity and administrative burden without providing commensurate value.***[1] Instead, the FAH recommends replacing this column with a field to report the unpaid deductible and coinsurance amounts at the time of the Medicare write-off date reported in column 24. During an audit, the MAC would still be able to properly validate the unpaid deductible and coinsurance balance against the detailed payment history as part of the normal audit review process for bad debt amounts.

V. Worksheet S-10

A. Introduction

The FAH supports CMS's addition to the first paragraph of the instructions for Worksheet S-10 of a sentence clarifying that "CMS does not mandate the eligibility criteria that a hospital uses under its financial assistance policy." The FAH, however, requests that CMS further confirm that the eligibility criteria can involve the use of a presumptive eligibility tool under the hospital's charity care or financial assistance policy. The use of presumptive eligibility tools that draw from publicly available as well as proprietary data to determine eligibility reduces the administrative burden on both the hospital and the patient and increases the accuracy of financial assistance determinations.

B. Medical Necessity (definition of charity care and uninsured discounts, line 20, line 25, and Exhibit 3B columns 6 and 16)

The revised definition of "Charity Care and Uninsured Discounts" includes a reference to medical necessity that invites confusion and potential arbitrary disallowances, and similar references are included in the instructions for lines 20 and 25 as well as columns 6 and 16 of Exhibit B. ***The FAH requests that CMS strike the addition of "medically necessary" from the definition and other instructions***. Under the revised definition, charity care and uninsured discounts must result from a hospital's policy to provide all or a portion of "medically necessary health care services" free of charge to patients who meet the hospitals charity care policy or

[1] In addition, the FAH requests a corresponding change to strike "less any payments in columns 18 and 22" from the instructions for Allowable Bad Debts reported in column 24.

financial assistance policy, and the notion of medical necessity is incorporated in other instructions. As a general matter, Medicare cost report auditors are not clinicians and will not know the underlying clinical details of a case, and the FAH is concerned that these new references to medical necessity may give rise to inappropriate reviews of medical necessity, diverting both hospital and auditor resources without improving the accuracy of the data reported in Worksheet S-10.

C. Inferred Contractual Relationships (lines 20, 22, and 23, and Exhibit 3B)

The FAH requests that CMS further clarify the meaning of "inferred contractual relationship" as that term is used in lines 20, 22, and 23 and Exhibit 3B and provide illustrative examples of such relationships. In the instructions for cost reporting periods beginning on or after October 1, 2020, the instructions specify that column 2 of line 20 includes deductible, coinsurance, and copayment amounts for hospital services required by the payer for insured patients covered by a private insurer with which the provider has a contractual or "inferred contractual relationship" and specify that a contractual relationship will be inferred "where a provider accepts an amount from an insurer as payment, or partial payment, on behalf of an insured patient." It appears that this term is intended to capture payers such as workman's compensation funds, automobile insurance coverage for medical costs, transitional or non-compliant ACA plans that offer a limited hospitalization benefit, and out-of-network services provided to HMO members. However, without a clear definition of this new term and illustrative examples, the FAH is concerned that hospitals will apply varying interpretations, which will introduce inaccuracy and unreliability into the S-10 data.

D. "If Such Inclusion is Specified" (lines 20 & 24, and Exhibit 3B)

The revisions to the instructions for Worksheet S-10 also includes the qualification that charges can only be included in particular fields "if such inclusion is specified in the hospital's charity care policy or FAP." ***The FAH requests that CMS remove this ambiguous language from the instructions for line 20, line 24, and Exhibit 3B to reduce the risk of arbitrary disallowances and unnecessary administrative burdens.*** As written, this language could prompt some auditors to erroneously interpret and extend this language to require unreasonably specific and granular provisions in charity care and financial assistance policies. An overly stringent interpretation of this term could result in the particularized description of a wide variety of clinical and coverage scenarios in hospital policies to ensure that each patient who meets the financial criteria to receive charity care or financial assistance can be included in the charity care charges and uninsured discounts reported in Worksheet S-10. The resulting costs and administrative burdens would not further the accuracy or reliability of Worksheet S-10 data, and the FAH therefore urges CMS to remove this language. The propriety of including amounts in line 20 should turn on whether the patient has an outstanding balance related to services rendered and meets the financial criteria set forth in the hospital's charity care or financial assistance policy.

E. Reporting simplification through the use of insured and uninsured Columns (lines 20 to 23)

At present, column 1 of line 20 is used to report uninsured individuals and column 2 of line 20 covers (1) deductible, coinsurance, and copayment amounts for insured patients, (2) non-covered charges for days exceeding a length of stay (LOS) limit under Medicaid or another indigent care program, and (3) charges other than deductibles, copayment, and coinsurance amounts that represent the insured patient's liability. ***The FAH believes that reporting in line 20 could be simplified by moving the second and third categories of charges to column 1 and making corresponding changes to lines 21 through 23, which would simplify the preparation of the cost report and reduce the likelihood of error.*** Under this approach, column 2 would be limited to deductible, copayment, and coinsurance amounts for insured patients that are written off to charity care. Meanwhile, column 1 would cover gross charges written off to charity care for uninsured individuals, insured individuals with charges for non-covered services or days that exceed a LOS limit, and gross charges other than deductible, copayment, or coinsurance amounts. This change would be consistent with the instructions to new Exhibit 3B, which requires separate listings of charity care amounts for uninsured and insured patients.

F. Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 29)

The FAH is concerned about continued flaws in the calculation of the cost of non-Medicare and non-reimbursable Medicare bad debt expense. Despite the proposed changes to the instruction text for lines 26 through 27.01, line 29 understates the true expense of foregone revenue resulting from uncollectible accounts. Line 29 is calculated in part by multiplying line 28 (non-Medicare bad debt expense) by the hospital's cost-to-charge ratio (CCR). Because line 28 reflects the difference between line 26 (bad debt expense) and line 27.01 (Medicare allowable bad debts) and line 26 itself includes charges for both patients for which the full balance was written off to bad debt expense and patients where only the patient's cost-sharing obligation was written off to bad debt expense, line 28 also includes deductible, coinsurance, and copayment amounts. Although the hospital's CCR can be appropriately used to reduce a hospital's charges to costs, multiplying patient cost-sharing amounts (deductible, coinsurance, and copayment amounts) by the CCR does not similarly convert these amounts to costs. This is because deductibles, coinsurance, and copayment amounts are not charge-based values and are not marked up as hospital charges. Thus, multiplying these cost-sharing amounts by the CCR understates the true expense of forgone revenue resulting form uncollectible accounts. This problem is significant and growing as payers impose increasing cost-sharing obligations on patients and a growing portion of a hospital's bad debt shifts to uncollectible cost-sharing amounts.

In order to address this issue and accurately capture the cost of bad debt associated with patient cost-sharing amounts, the FAH urges CMS to create separate columns for insured and uninsured patients on lines 26 through 29 and instruct hospitals to only apply the CCR to the charges reported in the column for uninsured patients. Under this approach, the column reporting bad debt expenses for uncollectable deductibles, copayments, and coinsurance amounts would not be multiplied by the CCR or otherwise reduced. This approach is similar to

the methodology applied in lines 20 through 23 of Worksheet S-10 for charity care and financial assistance.

In addition, if CMS accepts the proposed redefinitions for columns 1 and 2 of lines 20 through 23, discussed above, the FAH recommends that CMS make an analogous change to the newly created bad debt columns in lines 26 through 29. This would result in column 1 including amounts written off to bad debt at gross charges and column 2 including cost-sharing amounts for insured patient.

G. Exhibit 3B (Charity Care Listing)

1. Simplification and Consistency with Audit Schedules

As a threshold matter, the FAH is concerned that Exhibit 3B differs from the audit schedules that have been used in audits of charity care amounts to date. ***In order to achieve administrative simplification and reduce unnecessary costs associated with cost reporting and charity care audits, the FAH urges CMS to mandate that auditors use the final version of Exhibits 3B and 3C as the audit document for reported charity care and bad debt.*** Imposing this requirement on auditors would facilitate consistent auditing practices while economizing both CMS and provider audit resources. In addition, to facilitate smooth audits, the FAH also requests that the instructions for Exhibit 3B be modified to offer providers the ability to update this schedule to reflect subsequent changes in a patient's insurance status prior to an audit. Any charity care listing will reflect the patient account's status at the time the cost report is prepared, and as this information may change prior to audit, providers should be permitted to update Exhibit 3B at audit.

In addition, the FAH urges CMS to revisit the structure of Exhibit 3B to remove unnecessary complexity and extraneous information. The proposed, new Exhibit 3B will significantly increase hospitals' administrative burdens because it is overly complex and captures a significant amount of immaterial or unnecessary information. CMS should instead simplify Exhibit 3B, limiting it to the following columns:

- Columns 1 & 2 (patient name)
- Column 3 (date of admission)
- Column 4 (date of discharge)
- Column 5 (patient account number)
- Column 7 (payer name or type)
- Column 8 (Medicare beneficiary identifier (MBI))
- Column 9 (Medicaid number or equivalent)
- Column 24 (total charity care amount)
- Column 25 (write-off date)
- Column 27 (payments received)

2. Flexibility, Beneficiary Name (Columns 1 & 2), and Medicaid number (Column 9)

Presenting charity care data using the form and structure of new Exhibit 3B would impose significant and unnecessary administrative burdens on providers unless providers have

flexibility to alter the presentation and order of data reported in Exhibit 3B. As is true with respect to Exhibit 3A to Part I of Worksheet S-2 and Exhibit 2A to Part II of Worksheet S-2, ***the FAH therefore requests that CMS clarify that providers have the flexibility to modify or alter the presentation and order of data in this exhibit.***

By way of example, Exhibit 3B requires separate charity care listings for uninsured and insured patients. Having the option to report data for both types of patients in a single listing while still including a data element to identify uninsured and insured patients would enable providers to reduce some of the administrative burden associated with Exhibit 3B while still providing the full scope of requested data. The FAH thus requests that providers be granted the flexibility to provide a single charity care listing.

Likewise, for the same reasons explained above with respect to Exhibit 3A to Worksheet S-2, Part I and Exhibit 2A to Worksheet S-2, Part II, ***the FAH requests that CMS clarify that a provider may combine the patient name into a single field (columns 1 & 2).*** In addition, because some Medicaid MCOs do not use Medicaid numbers, ***the FAH requests that CMS permit the use of alternative Medicaid MCO identification numbers in column 9.***

3. UI/INC (Column 6)

Exhibit 3B requires reporting uninsured (UI) for a patient that did not have any insurance coverage, and insured but not covered (INC) if the patient had insurance through an insurance company with which the provider does not have a contractual relationship, had insurance coverage and the services provided were medically necessary but not covered, or had insurance coverage and the patient had exhausted their benefits. ***The FAH requests that CMS delete column 6 as unnecessary, ambiguous, and burdensome.*** Entering data in column 6 may be a labor intensive, manual data entry process for many providers because this is not a field in hospital patient accounting system that is universally populated. This data does not appear to improve the accuracy and consistency of charity care reporting. The values reported will not crosswalk to line 25.01 of Worksheet S-10, and the FAH understands that this data has not been collected in the course of S-10 audits to date. Moreover, the instructions can give rise to differing interpretations, which further diminish any value this data might have. For example, providers are instructed to enter "INC" if the patient "had insurance coverage through an insurance company with which [the provider] do[es] not have a contractual relationship." In some situations, an insurer will contract with a provider for specified lines, excluding other product lines (*e.g.*, narrow network products) such that the insurer and provider have no contract governing services provided to certain insured patients, and it is unclear whether the provider would enter "INC" in this field in this situation.

4. Name of Insurer (Column 7)

The FAH requests that CMS delete column 7 (name of insurer) because this field is unnecessary and provides no apparent value, particularly when providers systems do not use standardized nomenclatures for the insurer's name. In the alternative, if CMS retains this field, the FAH recommends that CMS change column 7 to report the category or type of payor

rather than the actual name of the primary payor.[2] Many providers regularly classify payers in categories such as commercial, Medicare FFS, Medicare Advantage, Medicaid, FFS, Medicaid MCO, Self-Pay, and Other. Reporting the actual payor name rather than the payor classification would be unnecessarily burdensome for providers, particularly when the payor name data does not have any apparent use.

5. Charity Care Determination (Columns 10 & 11)

Columns 10 and 11 require reporting of the approval of the patient for charity care and identification of the policy under which the charity care was approved. The first piece of data appears to be redundant—Exhibit 3B is limited to charity care supporting the charity care amounts claimed on Worksheet S-10, line 20 and thus, every entry would include a "Y" in column 10 of Exhibit 3B. ***The FAH, therefore, requests that CMS delete Column 10 as unnecessary and redundant.*** If CMS views this field as reporting useful information, the FAH requests that CMS include an example of a situation where an "N" would be entered in column 10 for a patient that is nonetheless properly be included in Exhibit 3B.

CMS also proposes to require providers to identify the relevant policy ("Charity" or "FAP") under which the charity care was approved in Column 11. ***The FAH also requests that CMS delete Column 11 because it creates an unnecessary administrative burden and does not improve the quality of data reported to CMS.*** The hospital industry generally uses the terms "charity care policy" and "financial assistance policy" interchangeably, with both terms referring to policies detailing how a hospital will forgive or reduce charges for care provided to an individual that meets financial eligibility criteria. Certainly, some hospitals may adopt separate charity care and financial assistance policies, but most do not. Moreover, CMS policy does not distinguish between charity care and uninsured discounts under a charity care policy as compared to a financial assistance policy, making the reporting of this information unnecessary.

6. Uninsured Patients (Columns 12, 15, 16, 17, 18, 19, 20, and 21)

Providers report gross charges net of reductions in column 20, which they are instructed to calculate by subtracting any professional charges (column 15), non-covered charges (column 16), uninsured discount (column 17), contractual allowance (column 18), and courtesy discount (column 19) from the gross charges reported in column 12. Because the instructions for column 12 expressly confine the gross charges data to uninsured patients, it appears that the intent is for column 20 to capture gross charges net of reductions for uninsured patients only. However, the values that are subtracted from column 12 for purposes of column 20 include values associated with insured patients. In particular, column 12 is reduced by column 18, which expressly *excludes* data for uninsured patients and reports the "amount of the contractual allowance for the insured patient, i.e., the difference between the hospital's billed charges and the amount contractually paid by an insurer for an insured patient, if applicable." ***Because column 12 is limited to uninsured patients and column 18 is limited to insured patients, it appears that the instruction for column 20 errs in calling for column 12 to be reduced by the contractual allowance reported in column 18, and the FAH requests that CMS remove the reference to***

[2] Data concerning any secondary payers is not included in Exhibit 3B.

column 18 in column 20. In the alternative, the FAH requests that CMS explain why column 18 should properly be included in the formula for column 20.

The FAH is also concerned that the instructions for columns 15 and 20 would result in professional fees being removed twice from gross charges for uninsured charity care cases. Column 15 specifies that professional charges are to be excluded from the gross charges reported in column 12. But, column 20 instructs providers to subtract the value of column 15 from column 12 in calculating the gross charges net of reductions, which would result in professional charges being subtracted from a value that already excludes these charges. ***The FAH therefore requests that Exhibit 3B be revised to avoid this double reduction by either excluding this amount from column 12 and eliminating column 15 or including this amount in column 12 and column 15.***

Column 20 also reduces column 12 by the value in column 17, which is "the amount of the uninsured discount given to the uninsured patient pursuant to the hospital's written charity care policy or FAP." The uninsured discount reported in column 17 is then reported again in column 23, which is added to the allowable charity care charges in column 21 (*i.e.*, the portion of column 20 written off as charity care) to provide the total allowable charity care amount in column 24. ***The FAH reads these instructions as indicating an intent to distinguish between uninsured "discounts" provided pursuant to the charity care or financial assistance policy (column 17) and amounts "written off" as charity care under the charity care or financial assistance policy (column 21).*** If this is correct, the FAH requests that CMS clarify this distinction by adding the following sentences to the instructions for column 17: "Do not report amounts written off as charity care pursuant to the provider's written charity care policy or FAP in column 17. Amounts written off as charity care pursuant to the provider's written charity care policy or FAP are reported in column 21." The FAH also requests a corresponding instruction in column 21 ("Do not report uninsured discounts given pursuant to the provider's written charity care policy or FAP in column 21. Uninsured discounts provided pursuant to the provider's written charity care policy or FAP are reported in column 17."). If, however, this interpretation is incorrect, the FAH requests further clarification as to the definition of the uninsured discount (column 17) and the rational for excluding this amount from the gross charges net of reductions (column 20) and the allowable charity charges (column 21). In this case, the FAH also asks that CMS provide guidance on how providers should handle cases where a patient received an uninsured discount and eventually had the remaining balance of account written off as charity.

7. Insured Patients (Column 13)

The FAH has been unable to identify the data field(s) in Exhibit 3B that support the charity care amounts reported for insured patients in Worksheet S-10. First, there is no column for reporting gross charges for insured patients (column 12 expressly excludes insured patients), and there are no instructions for calculating gross charges net of reductions (column 20), allowable charity care charges (column 21), or the total allowable charity care amount (column 24) using data for insured patients. ***It would appear that the contractual allowance data reported in column 18 is intended to aid in the calculation of the total allowable charity care amount for insured patients, but the instructions do not indicate where or how this data is to be used and the FAH therefore cannot comment on whether column 18 is properly used in the charity care listings for insured patients.***

Although providers report the deductible, coinsurance, and copayment amount for insured charity care patients in column 13 of Exhibit 3B, there is no column reporting on the amount by which this cost-sharing amount is reduced by any uninsured discount or charity care write off pursuant to the provider's charity care or financial assistance policy. In addition, in Worksheet S-10, line 20, column 2, the data for insured patients also includes the non-covered days exceeding a LOS stay limit for patients covered by Medicaid or other indigent care programs and charges other than deductibles, copayment, and coinsurance amounts that represent the insured patient's liability, but this data is not separately reported in Exhibit 3B. Rather, the charges for non-covered days exceeding a LOS stay limit for patients covered by Medicaid or other indigent care programs are combined with the charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs (which is reflected in the uninsured patient data in column 1 to lines 20 through 23 of Worksheet S-10). And it does not appear that charges other than deductibles, copayment, and coinsurance amounts that represent the insured patient's liability are included in Exhibit 3B.

In providing instructions for the reporting of charity care data for insured patients, the FAH asks that CMS consider the necessity of reporting deductible, coinsurance, and copayment information in column 13. Some hospital accounting systems do not report the amount owed by the patient for deductibles, coinsurance, and copayment amounts in a separate field and reporting this data is not a standard practice for hospitals. As such, the FAH is concerned that column 13 would be subject to interpretation and would create operational difficulties and burdens where providers need to resort to manual data input processes. At present, column 13 does not calculate into any other field in Exhibit 3B, and it is unclear how, if at all, this data would be used to support charity care amounts claimed on Worksheet S-10.

8. Charity Care Approved Ratio (Column 22)

The FAH urges CMS to delete column 22 as unnecessary. The ratio reported in column 22 is not used for any calculation in Exhibit 3B or to support any data reported in Worksheet S-10, and it does not appear that this field provides value that warrants the administrative burden created by its inclusion. If this field is retained, the FAH would ask that CMS clarify whether this column is limited to uninsured patients (as appears to be the intent given its reliance on the uninsured-only gross charge data in column 12) or provide specific instructions for completing this field for insured patients.

9. Write Off Date (Column 25)

The FAH requests that CMS provide instructions as to how hospitals should report accounts that have multiple write-off dates. An individual account may have multiple write-off dates where, for example, a patient first receives an uninsured discount and then a subsequent write-off of the remaining balance. In other cases, a patient might receive a series of partial write-offs under the hospitals charity care or financial assistance policy over multiple fiscal years as the patient's clinical or financial circumstances change.

10. Patient Responsibility Charges (Column 26)

As explained above, because the gross charges reported in column 12 are limited to uninsured patients, the gross charges net of reductions (column 20) and allowable charity care charges (column 21) are likewise limited to uninsured patients. As such, the FAH requests that the instructions for the patient responsibility charges reported in column 26 (column 20 minus column 21) explicitly note that column 26 only contains patient responsibility chares for uninsured patients only. In the alternative, specific instructions for calculating columns 20, 21, and 26 for insured patients should be included.

11. Payments Received (Column 27)

The FAH requests that CMS remove column 27 (payment received) as unnecessary to support the charity care amounts claimed on Worksheet S-10 or provide further clarification around the inclusion of this column. Column 27 appears to be targeted to payments received during the cost reporting year for amounts that may have been written off in prior cost reporting periods, but Exhibit 3B only pertains to charity care amounts claimed for the cost reporting period in Worksheet S-10, line 20. In addition, it is questionable whether column 27 would yield material amounts as providers may be legally obligated to return any non-patient portion cash payment made after a charity care award is extended to a patient.

H. Exhibit 3C (Listing of Total Bad Debts)

As a threshold matter, ***it is the FAH's understanding that reporting in Exhibit 3C is optional and the failure to submit Exhibit 3C with the annual cost report will not cause the cost report to be rejected.*** As such, the comments set forth below assume that this submission is optional. If CMS disagrees with this understanding, the FAH requests that CMS make clear its intent to require submission of Exhibit 3C and identify the rulemaking that supports this requirement. In addition, if Exhibit 3C is required, the FAH would urge CMS to revise the instructions for columns 7 and 8 (primary and secondary payer) to clarify that these columns are optional to report because this data may be unavailable for older accounts that are written off and claimed on Worksheet S-10, line 26 as bad debt years later.

The FAH also requests instructions for reporting recoveries in new Exhibit 3C. Patient information for recovery accounts (negative bad debt) may be difficult for many providers to extract given the way that these post-close transactions are posted. Although auditors have accepted the recovery amount data without patient detail, it appears that Exhibit 3C would not permit listing of recovery amounts without this patient-level detail.

Total Patient Payments (Column 12). The FAH requests that CMS include specific instructions that would apply where a patient has multiple accounts (dates of service) with outstanding balances and submits payment without indicating the account to which the payment should be applied. The FAH further recommends that CMS clarify that the provider may apply any such funds received to the oldest date(s) of service first, consistent with the recommendations in the Health Care Financial Management Association's *Best Practices for Resolution of Medical Accounts Receivable.*

Patient Charity Care Amount (Column 14). The FAH requests additional instructions for this data element, confirming that this field includes both charity care and uninsured discounts as reported in Worksheet S-10, line 20.

Patient Bad Debt Write Off Amount (Column 17). The FAH is concerned that the formula set forth in column 17 will not consistently calculate an accurate bad debt amount, particularly in the case of Medicare cross-over bad debt for dual eligible beneficiaries. The FAH therefore asks that CMS revise the instructions to column 17 to direct hospitals to report the patient bad debt write off amount rather than calculating an amount using the specified formula. This approach would accommodate bad debt reversals and discrepancies in data collected in columns 12 through 15, improving the accuracy of the amounts reported in column 17.

VI. New Worksheet S-12 (Median Payer-Specific Negotiated Charge Data)

The FAH continues to strongly object to the collection of median payer-specific negotiated rate by MS-DRG for payers that are Medicare Advantage (MA) organizations (MAOs) and urges CMS to remove new Worksheet S-12 from the cost report. As set forth in the FAH's comments on the FY 2020 inpatient prospective payment system (IPPS) proposed rule (85 Fed. Reg. 32,460 (May 29, 2020)), CMS's use of this data to shift from a resource-based MS-DRG weighting system to one based on market rates is impermissible. CMS lacks any authority to adopt a "market-based" MS-DRG weighting methodology because Congress has explicitly instructed CMS to weight MS-DRGs based on "relative hospital resources used with respect to discharges" for each MS-DRG in 42 U.S.C. § 1395ww(d)(4)(B). Moreover, although CMS has authority to collect certain information through annual cost reports, this authority only reaches that data that is necessary to determine appropriate payment amounts and does not permit the collection of market data that is wholly irrelevant to Medicare payment. This data collection is also inappropriate in light of the significant administrative burdens and costs it imposes on providers. Therefore, the FAH continues to strongly urge CMS to abandon its unlawful and inappropriate collection of market-based rate data for use in its relative MS-DRG weighting methodology.

The FAH's objections to the collection of median payer-specific negotiated weights is compounded by proposed Worksheet S-12, which is unclear and fails to provide hospitals with sufficient guidance to enable consistent and accurate reporting of median payer-specific negotiated rates. If CMS persists in adopting Worksheet S-12, the ***FAH urges CMS to clarify the worksheet instructions to address the issues set forth below and to either delay the adoption of Worksheet S-12 and the collection of median payer-specific negotiated rates for MAOs or delay the filing date deadline*** for cost reports to allow no less than 90 days from finalization of the Worksheet and clarification of the instructions to submission of the cost report. In addition, if CMS finalizes the collection of median payer-specific negotiated rate data for MAOs, the FAH requests that CMS address the following issues that preclude consistent reporting in Worksheet S-12:

- ***Clarify that Worksheet S-12 only collects data for discharges occurring during the cost reporting year (rather than for payments during the cost report year).*** The instructions state that median rate data is to be determined from "each MAO-paid discharge in the cost reporting period," which suggests that CMS is

requesting that the median amount be determined for discharges that occurred during the cost reporting period (regardless of the date of payment) rather than for discharges that were *paid* during the cost reporting period (regardless of the date of discharge). The FAH requests that CMS clarify the instructions to confirm that reporting is based on the data for discharges occurring during the cost reporting period. Reporting based on date of payment would increase the complexity of completing Worksheet S-12 because data is more frequently stored by discharge date rather than date of payment.

- ***Define "basis of payment" to include beneficiary cost-sharing amounts.*** It is our understanding that median payer-specific negotiated rates include MAO members' cost-sharing amounts (*e.g.*, copayments and deductible amounts), but we ask that CMS clarify the instructions to confirm that the "basis of payment" includes MAO member cost-sharing amounts. This will ensure that the median payer-specific negotiated rate reported on Worksheet S-12 includes the full negotiated MAO rate.

- ***Define "basis of payment" to permit the use of expected payments.*** The instructions rely on the undefined term "basis of payment" to explain how the provider is to determine the median payer-specific negotiated rate for each MS-DRG in Part I. It is unclear what the "basis of payment" is and how it should be reasonably determined. The FAH maintains that providers should be permitted to determine the "basis of payment" by reference to the expected payment amount for each MAO discharge. Many providers have data concerning the expected payment amount available at the time of billing, and the use of this data will, in some cases, be somewhat less burdensome than using another amount as the "basis of payment." It is the FAH's understanding that, in the FY 2021 IPPS final rule,[3] CMS specifically declined to require reporting on median actual reimbursement amounts or other alternative measures, and that therefore, the actual payment amount should not be used or reported in Worksheet S-12.

- ***Exclude MAO discharges not paid on an inpatient basis.*** The proposed instructions indicate that data should only be provided for "each MAO-paid discharge." The FAH interprets this to mean that only discharges of beneficiaries covered by an in-network MAO where the MAO actually made payment on an inpatient basis for the discharge are included. Thus, MAO discharges that were not fully paid (*e.g.*, not paid at the inpatient rate) or for which the MAO denied payment should be excluded.

- ***Exclusion of psychiatric and rehabilitation discharges from distinct part units.*** Medicare does not pay for inpatient care provided in a distinct part psychiatric or rehabilitation unit under the IPPS, and thus, the FAH believes that discharges from these distinct part units should thus be excluded from the calculation of the median payer-specific negotiated MAO rate. It is our understanding that the

[3] 85 Fed. Reg. 58,432, 58,884 (Sep. 18, 2020).

reference to the subsection (d) hospital in the instructions to Worksheet S-12 is intended to exclude a psychiatric or rehabilitation unit of the hospital in accordance with 42 U.S.C. § 1395ww(d)(1)(B), but the broad definition of "items and services" in the instructions creates potential ambiguity on this issue.

- ***Revise and clarify Worksheet S-12, Part II, Line 1 to address exclusion of capitated, out-of-network (non-negotiated) rates.*** The instructions for Worksheet S-10, Part II, Line 1 require an attestation that "the provider had zero MAO discharges (for any MAO payer) for each MS-DRG without a MPS negotiated charge amount in Part I." It is unclear whether the broad reference to "any MAO payer" encompasses MAOs that pay on a fully or partially capitated basis and out-of-network MAOs with which the hospital does not have a negotiated rate. Both capitated and out-of-network MAO rates appear to be excluded from Part I of Worksheet S-12 (the former are expressly excluded in the instructions, and the latter are excluded by the use of the term "negotiated" rates), so a provider might have a mix of MS-DRGs without a median payer specific negotiated rate amount in Part I where some MS-DRGs. How should a provider that had zero MAO discharges for one MS-DRG and only excluded MAO discharges for another MS-DRG complete Part II?

- ***Instructions for particular types of payer-specific negotiated rates.*** The instructions assume that each MAO contract uses an MS-DRG payment methodology for each and every inpatient discharge and does not provide any guidance for the range of alternative payment methodologies that may be applied by MAOs. For example, some MAOs may negotiate payment based on a percentage of charges methodology or a per diem methodology. It is unclear how a hospital should crosswalk from this rate information to any payer-specific negotiated charge for an MS-DRG or whether data for such discharges should be excluded (and, if so, how the hospital should complete Part II of Worksheet S-12). Without guidance on this issue, hospitals will be unable to consistently calculate a median payer-specific negotiated rate for each MS-DRG.

- ***Clarify inclusion or exclusion of outlier payments.*** The instructions to Worksheet S-12 do not address whether the basis of payment includes or excludes outlier or stoploss payments negotiated with MAOs and should be revised to expressly address this issue.

- ***Clarify reporting or exclusion of transfer-adjusted cases.*** The instructions to Worksheet S-12 do not address whether or how MAO negotiated rates for transfer-adjusted cases should be handled, and the instructions should be revised to expressly address these cases.

- ***Clarify inclusion or exclusion of quality adjustments and add-on payments.*** Many MAOs negotiate payment methodologies that adjust the base payment rate based on various quality metrics. In some cases, these operate in a similar manner to Medicare's Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital Acquired Condition penalty. MAOs may also

include add-on payments that might be comparable to disproportionate share hospital and indirect medical education payment adjustments. The instructions for Worksheet S-12 should be revised to expressly address the inclusion or exclusion of these adjustments and add-on payments.

- ***Clarify inclusion or exclusion of shared-risk contracts.*** The instructions to Worksheet S-12 indicate that the median payer-specific negotiated rates should exclude rates negotiated on a capitated basis, but the instructions do not define "capitated basis" or address shared risk contracts more broadly. Shared risk contracts are different from traditional capitated contracts. For example, an MAO may pay the hospital a percentage of the IPPS-based payment amount upon patient discharge. Then, on an annual basis, the MAO and provider will undertake a reconciliation process, which evaluates the MA plan savings against a target for the entire population of patients that received services from the hospital or were attributed to an accountable care organization (ACO) in which the hospital participated. If additional savings were achieved beyond the target, the payer would make a lump sum shared savings payment to the provider or ACO. In two-sided risk arrangements, if target savings were not achieved, the provider or ACO would provide a lump sum payment to share in the loss. In these cases, it is unclear whether the basis of payment would be the negotiated MS-DRG rate before any withholds or reductions that are part of the shared risk arrangement or some other value.

The FAH is also concerned that collecting median rate information through the cost report will result in non-standard data reflecting median rates for differing hospital cost reporting periods. Therefore, if CMS persists in its policy to collect median, payer-specific negotiated rate data, the FAH also recommends that CMS collect this data through an annual, standardized survey similar to the occupational mix survey. This approach would at a minimum ensure that hospitals report rate data for a standardized time period on an annual schedule. In addition, this would enable CMS to address the significant issues with proposed Worksheet S-12 in a new median rate survey and provide adequate time for submitting the data without delaying the submission of cost reports.

In sum, Worksheet S-12 does not provide an avenue for collecting reliable data on median, payer-specific negotiated rates that can be standardized across providers, and the instructions leave areas of significant ambiguity that compound these issues. Additionally, the diversity of payment methodologies among MAOs likely precludes the reporting of reliable and standardized data on median, payer-specific negotiated rates. Therefore, Worksheet S-12 should be eliminated along with the requirement to report median, payer-specific negotiated MAO rates. In the alternative, CMS should either delay the submission date of cost reports or the Worksheet S-12 requirement until at least 90 days after the clarification and revision of Worksheet S-12 so that providers have an opportunity to apply CMS guidance when completing Worksheet S-12.

VII. Worksheet D-4 (Computation of Organ Acquisition Costs)

The FAH requests that CMS provide clarification as to the new organ acquisition cost fields for kidney transplants in lines 53.01 and 75.02 of Worksheet D-4. While the instructions for line 63.01 state that it is "[e]ffective for dates of service on or after January 1, 2021," the instructions to line 75.02 reference "kidney transplants occurring on or after January 1, 2021." The FAH believes that the temporal language in these two lines should be consistent in order to ensure consistent application. In particular, the FAH requests that the dates of service (rather than the date of discharge) be used for purposes of both lines in order to ensure that pre-acquisition costs are appropriately paid for MA beneficiaries.

VIII. Worksheet D-6 (Computation of Acquisition Costs)

A. Allogenic hematopoietic stem cells

The FAH requests clarification to the instructions for Worksheet D-6, lines 1-6, column 3, which defines a "cellular therapy acquisition services day as an inpatient day of care before admission for the actual transplant or infusion." It is unclear what would constitute an "inpatient day of care" before the inpatient admission, and the FAH requests that CMS provide explanation and illustrative examples of a pre-admission, inpatient day of care.

B. T-cells for FDA-approved CAR T-cell immunotherapy infusions

The instructions to Worksheet D-6 indicate that it is to be completed for informational purposes to determine the Medicare reasonable cost of acquiring T-cells for CAR T-cell immunotherapy infusion. This informational data collection was not addressed in the proposed or final IPPS rules regarding reimbursement for CAR T-cell therapies, and the FAH urges CMS to propose and finalize the collection through notice-and-comment rulemaking.

IX. Worksheet E-5 (Outlier Reconciliation at Tentative Settlement)

New Worksheet E-5 will be used by contractors to report outlier reconciliation amounts during the cost report tentative settlement. ***The FAH supports the addition of Worksheet E-5 and requests that CMS urge all MACs to apply the outlier reconciliation adjustment at the time of cost report tentative settlement and to notify CMS of interim reconciliation.*** This process will enable a prompt outlier reconciliation adjustment, which should operate to eliminate interest accruals on outlier reconciliations. At present, providers have confronted interest accumulations even when payment of provider-estimated outlier reconciliation amounts was made with submission of the cost report, and the FAH strongly supports establishing a process for permitting prompt outlier reconciliation adjustments in a manner that eliminates unnecessary interest accruals.

The FAH appreciates the opportunity to comment on the proposed changes to CMS-2552-10, Hospital and Health Care Complex Cost Report. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,