The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

July 10, 2020

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

SUBJECT: CMS-1735-P. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Rule, May 29, 2020

Dear Administrator Verma:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents approximately 240 member institutions, we appreciate the opportunity to comment about the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system proposed rule for federal fiscal year (FFY) 2021.

This year's proposed rule comes during a time in a state of uncertainty unlike we have seen before. While we are pleased to see CMS continue its efforts to reduce the administrative burdens often associated with its quality programs, HAP remains very disappointed that CMS continues down the unlawful path of requiring hospitals to disclose privately negotiated contract terms.

The following comments provide areas of emphasis. HAP otherwise incorporates by reference all comprehensive comments by the American Hospital Association.

Thank you for your consideration of HAP's following comments regarding this proposed rule. If you have any questions, contact Kate Slatt, vice president, innovative payment and care delivery, at (717) 561-5317.

Sincerely,

Jeffrey Bechtel
Senior Vice President, Health Economics and Policy
Attachment

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HAP Comments—Inpatient Prospective Payment System
Proposed Rule for Calendar Year 2021

REQUIREMENT FOR HOSPITALS TO REPORT MEDIAN PAYER-SPECIFIC NEGOTIATED CHARGES BY MS-DRG AND INCORPORATE THAT INFORMATION IN RELATIVE WEIGHTS

In its fiscal year (FY) 2021 Inpatient Prospective Payment System (IPPS) proposed rule, the Centers for Medicare & Medicaid Services' (CMS) proposes to require hospitals to include on the annual Medicare cost report what the agency calls "market-based payment rate information."[1] Specifically, every hospital would be required to report "(1) The median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage (MA) organizations ... by Medicare Severity Diagnosis Related Groups (MS–DRG); and (2) the median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA organizations, by MS–DRG."[2] The agency also requests comment about incorporating this information in the IPPS MS-DRG relative weights beginning in FY 2024. ***HAP strongly agrees with the American Hospital Association (AHA) and believes that both proposals are unlawful and urges CMS not to finalize them.***

CMS cites no authority to require hospitals to furnish median payer-specific negotiated charge information by MS-DRG. Instead, CMS relies exclusively on a rule the agency promulgated in 2019, denominated by CMS as the "Hospital Price Transparency Final Rule,"[3] to require disclosure of negotiated charge information by MS-DRG. CMS explains that "[t]he payer-specific negotiated charges used by hospitals to calculate these medians would be the payer-specific negotiated charges for service packages that hospitals are required to make public under the requirements we finalized in the Hospital Price Transparency Final Rule (84 FR 65524) that can be cross walked to an MS–DRG. We believe that because hospitals are already required to publically report payer-specific negotiated charges, in accordance with the Hospital Price Transparency Final Rule, that the additional calculation and reporting of the median payer-specific negotiated charge will be less burdensome for hospitals."[4]

The Hospital Price Transparency Final Rule is scheduled to go into effect on January 1, 2021, but it has been challenged by the AHA and other hospitals on statutory, procedural, and constitutional grounds. Although the district court denied hospitals' motion for summary judgment,[5] the hospitals have appealed that decision to the United States Court of Appeals for

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[1] 85 Fed. Reg. 32,460, 32,464 (May 29, 2020).
[2] 85 Fed. Reg. at 32,791.
[3] 84 Fed. Reg. 65,524 (Nov. 27, 2019).
[4] 85 Fed. Reg. 32,460, 32,465 (May 29, 2020). We note that, because there is no comparator in the statement, it is not clear what CMS means when it says that reporting median payer-specific negotiated charges is "less burdensome for hospitals."
[5] *American Hospital Assn, et al. v. Azar,* No. 19-CV-3619 (D.D.C. June 23, 2020).

the District of Columbia Circuit. The appeal will be fully briefed by the end of August, and the parties are requesting oral argument as soon after that as possible. Because the information to be furnished under the proposed rule would be derived from information collected under the Hospital Price Transparency Final Rule, the new information collection requirement suffers from the same legal infirmities: It is not authorized by statute and violates both the Constitution and Administrative Procedure Act. Moreover, if the Hospital Price Transparency Final Rule were found unlawful, then CMS's requirement for disclosure of median payer-specific charge information by MS-DRG would be similarly unlawful.

The same is true as to the potential approach to change the method of calculation for MS-DRG relative weights beginning in FY 2024. CMS says that it is considering adopting in the FY 2021 IPPS final rule a "change to the methodology for calculating the IPPS MS–DRG relative weights to incorporate this market-based rate information, beginning in FY 2024. . . ."[6] But if it is unlawful to require disclosure of median payer-specific negotiated charge information by MS-DRG, then CMS could not use that information to change relative weights.

In addition, HAP agrees that it would be arbitrary and capricious to use median payer-specific negotiated charge information by MS-DRG to change relative weights. As set forth in section 1886(d)(4)(A) of the Act, relative weights are intended to reflect "the relative hospital resources used with respect to discharges classified within that group" and not the relative price paid. CMS currently uses "a cost-based methodology to estimate an appropriate weight for each MS–DRG."[7] In proposing to use median payer-specific negotiated charges to set MS-DRG relative weights, CMS has not adequately explained why it thinks market price rather than costs is a better measure of hospital resources used. Instead, the agency appears to *conflate market price with cost*.

The rationales CMS uses for basing MS-DRG relative weights on price (e.g., promoting transparency, bringing down the cost of health care, wanting to move beyond the chargemaster, etc.) have nothing to do with whether median payer-specific negotiated charges are a measure of "hospital resources used" as the Medicare statute requires. Rather, CMS proposes to use this information to "advanc[e] the critical goals of [Executive Orders] 13813 and 13890, and to support the development of a market-based approach to payment under the Medicare fee-for-service (FFS) system."[8] But that is not the statutory test. Simply put, we believe CMS has not adequately explained why basing IPPS MS-DRG relative weights on market price would result in relative weights being based on hospital resources used. As such, it would

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[6] 85 Fed. Reg. 32,460, 32,465 (May 29, 2020).
[7] *Id.* at 32,791.
[8] *Id.*

be arbitrary and capricious to adopt this proposal. *See Motor Veh. Mfrs. Ass'n v. State Farm Ins.*, 463 U.S. 29 (1983).

HAP and the AHA are hopeful that the appeals court will rule on the challenge to the Hospital Price Transparency Final Rule before the end of this year. Should it be found unlawful, CMS would have no legal basis for requiring hospitals to disclose their median payer-specific negotiated charges by MS-DRG. ***If, despite hospital concerns about CMS's proposals to collect data and base IPPS MS-DRG relative weights on median payer-specific negotiated charges, the agency nevertheless elects to finalize them, HAP believes it should not do so unless and until (1) the court upholds the Hospital Price Transparency Final Rule, (2) the agency has adequately explained the basis for concluding that payer-specific negotiated charges by MS-DRG reflect resources used, and (3) stakeholders have had another opportunity to comment on the proposal.***

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT CHANGES

Under the DSH program, hospitals receive 25 percent of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH payments). The remaining 75 percent flows into a separate funding pool for DSH hospitals. This pool is reduced as the percentage of uninsured declines and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

For FY 2021, CMS estimates that the total amount of Medicare DSH payments that would have been made under the former statutory formula is $15.359 billion. Accordingly, CMS proposes that hospitals would receive 25 percent of these funds, or $3.840 billion, as empirically justified DSH payments.

The remaining $11.519 billion would flow into the 75-percent pool, which is then adjusted to reflect changes in the percentage of uninsured. CMS determined that the percentage of uninsured for FY 2021 would be 9.5 percent; thus, after inputting that rate into the statutory formula, it proposed to retain 67.86 percent—or $7.817 billion—of the 75-percent pool in FY 2021. This would result in a decrease of about $534 million in uncompensated care payments in FY 2021 compared to FY 2020.

As in previous years, to distribute the 75-percent pool, the agency would continue to use the share of uncompensated care provided by each DSH hospital. For example, if Hospital A accounts for 1 percent of the total uncompensated care provided by all DSH hospitals, it would receive 1 percent of what remains of the 75-percent pool.

CMS Should Account for Impact of COVID-19 Public Health Emergency (PHE) in the Uncompensated Care Payment Methodology

CMS calculates Factor 1 of its uncompensated care payment methodology to estimate 75 percent of the estimated DSH payments that would otherwise be made in the absence of Section 1886(r) of the Social Security Act. CMS' estimate for DSH payments in a given FY is partially based on CMS' Office of the Actuary's (OACT) Part A benefits projection model. The OACT's most recent available projections of Medicare DSH payments for the FY are used as a baseline and are updated through a projection model to ensure the estimate accounts for several update factors. CMS typically updates these projections one time and they are not revised again.

Among the factors used to update the Factor 1 estimates, OACT makes projection update changes based on changes in Medicare rates, discharges, case mix and a residual "other" factors that will include Medicaid enrollment. OACT's estimate uses the same projections and assumptions that were used for the President's budget that precedes the COVID-19 PHE. OACT's estimates do not indicate an increase in Medicaid enrollment. However, other sources indicate Medicaid enrollment is estimated to increase substantially during the PHE because of the increase in unemployment and the loss of employer sponsored insurance (ESI). Between 12 and 21 million people are expected to gain Medicaid coverage as a result of losing ESI due to the COVID-19 PHE. Some estimates show that of the 27 million people losing ESI as of May 2, 2020, nearly half (12.7 million) are eligible for Medicaid. The economic dislocation resulting from the COVID-19 PHE is expected to continue into FY 2021.

For CMS through OACT to most accurately represent Factor 1, it will be necessary to account for the large increase in Medicaid enrollment in FY 2020 and FY 2021 that is resulting from large-scale unemployment. ***To ensure the FY 2021 Factor 1 amount accurately reflects the impact of the COVID-19 PHE on DSH payments, HAP strongly urges OACT to recalculate its update projection again with a model that accurately accounts for the increased number of Medicaid beneficiaries.***

CMS calculates Factor 2 of the methodology to determine the total available uncompensated care payment pool, which is then distributed to individual hospitals based on Factor 3 of the methodology. Factor 2 is an annually determined percentage amount that represents the percent change in the rate of uninsured in FY 2013 and the estimated percent of uninsured in the most recent year where data is available. OACT determines Factor 2 using National Health Expenditure Accounts (NHEA) data estimates of the rate of uninsured based on data from the census bureau, and then applies a weighted average of the projections in order to ensure that the rate of un-insurance reflects both calendar years (CY) represented within a given fiscal year. CMS relies on NHEA estimates because of their availability and timeliness—features the agency cites as critical because the estimates must be updated annually. OACT determines its

own estimates by "using the projected growth in the sum of enrollment across all public and private insurance categories together with a projection of the overall population of the U.S." For FY 2021, CMS proposes to use a weighted average of the CY 2020 and CY 2021 OACT projections to determine the proposed Factor 2.

OACT's Factor 2 estimates also do not incorporate the impact of the COVID-19 PHE will have upon the number of uninsured treated by hospitals. On the CMS website in a document dated March 24, 2020, OACT indicates that, "the models used to project trends in health care spending are estimated based on historical relationships within the health sector, and between the health sector and macroeconomic variables. Accordingly, the spending projections assume that these relationships will remain consistent with history, except in those cases in which adjustments are explicitly specified." Clearly, circumstances have changed since this was written and economic trends in FY 2020 and FY 2021 will *not* be consistent with the sustained economic growth experienced in recent years. ***HAP urges CMS to account for the impact of the COVID-19 public health emergency in its CY 2020 uninsured estimate used for Factor 2.***

For CY 2020, the spike in uninsured rates caused by the PHE alone will result in the provision of uncompensated care at significantly higher levels than anticipated in the NHEA's current projected rates of uninsured for CY 2020. If Factor 2 fails to reflect the uncompensated care provided at hospitals across the country, then the uncompensated care payment pool will understate the actual level of uncompensated care provided. Since CMS' proposed uncompensated care payment pool for FY 2021 of $7.816 billion already represents a significant $534 million reduction from the final FY 2020 pool of $8.351 billion, CMS must ensure the FY 2021 Factor 2 calculation and resulting uncompensated care payment pool reflects the unanticipated rate of uninsured in CY 2020.

Implicit Price Concessions Must be Included in the Calculation of Factor 3 and the Definition of Uncompensated Care

The bad debt proposals included in this proposed rule could result in the elimination of implicit price concessions from bad debt reporting on Worksheet S-10. Whether labeled as bad debt or implicit price concessions, the result is that both terms mean uncompensated costs.

HAP is concerned that without clear reporting instructions from CMS, implicit price concessions may no longer be reported on Worksheet S-10, which will reduce a hospital's reported bad debt. Not including implicit price concessions as bad debt on Worksheet S-10 would mean that some of our members would report no bad debt, which would not accurately reflect the uncompensated care and bad debt they incur. Moreover, this would negatively affect a hospital's uncompensated care payment. Worksheet S-10 data is used to determine a hospital's uncompensated care payment. ***CMS must make clear that implicit price concessions are***

to be included as bad debt on Worksheet S-10 in order to accurately calculate Factor 3 and hospitals' uncompensated care payments.

CMS also is proposing for FFY 2022, and all subsequent fiscal years, to use the most recent single year of cost report data that has been audited for a significant number of hospitals receiving substantial Medicare uncompensated care payments to calculate Factor 3 for all eligible hospitals. ***HAP is supportive of CMS' proposal to use the 2017 audited data for 2021 DSH calculations; however, we also believe that from a process standpoint, CMS should continue to propose the specific data year to be used in these calculations each year. That process ensures that public comment and stakeholder input is considered for final rules.***

CHIMERIC ANTIGEN T-CELL (CAR-T) THERAPY

CMS proposes to create a new MS-DRG for CAR-T, with a proposed relative weight of 37.1412. CMS developed this relative weight using only non-clinical-trial CAR-T cases since such cases do not account for the cost of therapy itself. As a result, CMS proposes to adjust the relative weight for clinical trial CAR-T cases when determining reimbursement associated with those discharges. Specifically, CMS proposes to apply an adjustor of 0.15 when calculating payment for clinical trial cases assigned to the proposed MS-DRG 018 in FY 2021. This adjustor was determined by the ratio of the average cost for CAR-T cases identified as clinical trial cases to the average cost for non-clinical trial CAR-T cases, using claims data from the December 2019 Medicare Provider Analysis and Review (MedPAR) update. The 0.15 adjustor also would be used to adjust the case count for CAR-T clinical trial cases for purposes of determining national average standardized cost per case, budget neutrality, and outlier simulations. CMS would re-calculate the adjustor for the final rule based on the most updated data available. CMS does not propose other payment adjustments for CAR-T cases in the rule.

CMS Must Ensure Future Payments for CAR-T-Cell Therapies are Adequate

HAP appreciates CMS' proposal to create MS-DRG 018 for CAR-T-cell therapies and to exclude cases that are part of a clinical trial from the relative weight determination and also to pay these cases exclusive of the cost of the CAR-T-cell product. We agree with CMS' clinical advisors that CAR-T-cell therapy is sufficiently different clinically from other treatments to warrant its own MS-DRG. However, we continue to be concerned that the reimbursement for CAR-T-cell therapies is inadequate and could place significant financial stress upon teaching hospitals to ensure patients have access to this important treatment. Insufficient inpatient reimbursement may lead some programs to begin outpatient CAR-T-cell therapy too soon.

CMS payment policies should not influence the safety of new therapies prior to appropriate experience with the treatment protocol. Additionally, given the low volume of CAR-T-cell claims to date, CMS must continue to accurately identify claims to be included in the calculation of the

relative weight. In addition, CMS should consider requiring the National Drug Code (NDC) be included on the claim to accurately identify CAR-T-cell claims and also specify the immunotherapy used for that claim.

Due to the extremely high cost of the CAR-T-cell therapy and its concomitant inpatient care, including increase utilization of intensive care unit stays, the Medicare reimbursement that hospitals receive barely covers the costs of the therapy, leaving little for the myriad medical services that the hospital provides when it administers this therapy. ***CMS must ensure that the reimbursement for CAR-T-cell treatment is adequate to reflect the costs of an efficient hospital providing this care.***

AREA WAGE INDEX MODIFICATIONS

The area wage index adjusts payments to reflect differences in labor costs across geographic areas. For FY 2021, CMS proposes to use data from FY 2017 cost reports to determine the area wage index.

Modifications to Wage Index Values for Low-wage and High-wage Hospitals

CMS again proposes to increase wage index values for low-wage hospitals. Specifically, for hospitals with a wage index value below the 25th percentile, the agency proposes to increase the hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals. The agency also would decrease the wage index for hospitals with values above the 75th percentile to make this policy budget neutral. Specifically, for hospitals with a wage index value above the 75th percentile, the agency proposes to reduce the hospital's wage index by a set percentage of the difference between the otherwise applicable wage index value for that hospital and the 75th percentile wage index value for all hospitals. CMS proposed that this policy be effective for at least four years, beginning in FY 2020.

Because the methodology is based on quartiles, approximately 25 percent of hospitals will experience an increase in their wage index, 25 percent will experience a decrease, and 50 percent will experience no change due to this policy.

Cap on Decrease in Wage Index from FY 2020 to FY 2021

CMS again proposes to cap any decrease in a hospital's final wage index in FY 2021 compared to its final wage index in FY 2020 at 5 percent. This provision is not specific to changes in wage index due to particular policy proposals. Instead, it would ensure that a hospital's FY 2021 final wage index value would be no less than 95 percent of its final wage index for FY 2020. CMS again proposes to make this provision budget neutral through an adjustment to the standardized amount.

The area wage index is intended to recognize differences in resource use across types and location of hospitals. Hospitals, Congress, and Medicare officials have repeatedly expressed concern that the wage index is flawed in many respects. ***HAP applauds CMS for recognizing the need to address low wage index values. However, improving wage index values for some hospitals—while much needed—by cutting payments to other hospitals, is unacceptable, particularly when Medicare already pays far less than the cost of care. CMS has the ability to provide needed relief to low-wage areas and should do so by allocating additional funds for this purpose.***

MEDICARE BAD DEBT

The Medicare program reimburses providers for a percentage of their allowable bad debts, which result from unpaid, uncollectible deductibles and coinsurance amounts. Currently, Medicare reimburses 65 percent of the allowable bad debt for prospective payment hospitals and critical access hospitals. The Medicare Provider Reimbursement Manual (PRM) outlines actions that providers are recommended or required to take in order for an unpaid amount to be considered a bad debt for Medicare purposes. CMS is proposing to clarify, modify, and codify into regulation the activities related to bad debt, in addition to proposing new requirements.

HAP is very concerned that CMS proposes to retroactively apply a number of bad debt policy proposals. The agency offers insufficient, unclear and, in some cases, contradictory justification for retroactive application, as described below. We do not agree that retroactive implementation is warranted, and we strongly urge CMS to withdraw retroactive implementation in its rulemaking. In addition to retroactivity, we also have concerns with the substance of several of the proposals, which are outlined further below.

The standard set forth in section 1871(e)(1)(A)(ii) of the Social Security Act on which CMS is relying to make the changes retroactive requires that "failure to apply the change retroactively would be contrary to the public interest." While the agency states that applying the policies before the upcoming fiscal year would serve the public interest, it provides neither clear nor adequate support for this conclusion. **Indeed, we strongly disagree with CMS and believe that it actually would be *contrary* to the public interest to apply the proposals retroactively.**

CMS claims that, unless the policies are applied retroactively, providers could have confusion regarding the cost reporting periods to which the regulations apply. The agency states that such confusion among providers would cause many of them to resubmit cost reports, leading to an increased and inappropriate use of provider and government resources. CMS asserts that applying the proposals retroactively would prevent this from occurring. However, this is incorrect. Retroactive implementation would actually have the opposite effect—providers would

likely request re-opening and re-submitting cost reports out of an abundance of caution to ensure compliance with retroactive rules. Indeed, providers would feel compelled to re-assess all previous cost reports if policies were made retroactive. This is especially the case for any clarified, modified, or new requirement.

As a specific example of this, CMS is proposing to retroactively require hospitals to retain a Medicaid remittance advice for services provided to dually eligible beneficiaries in order to claim allowable bad debt for those services. If this were to be finalized, providers would have to possess Medicaid remittance advices for all previous Medicare-Medicaid crossover bad debts in order to prevent any reductions to prior bad debt amounts—even if the provider had indeed billed the state, but the state had not been able or willing to issue a timely remittance advice. Expecting providers to retroactively obtain remittance advice is unreasonable. Not only would this be extremely burdensome for both the providers and state agencies to carry out, but providers would wish to re-submit cost reports in order to supplement previously filed reports with Medicaid remittance advices.

In addition, in its discussion of retroactive rulemaking, CMS does not acknowledge that several of the bad debt proposals would transform *recommended* activities into *mandated* actions, such that new requirements would be applied to past behavior. This fact alone would make retroactive application inappropriate since a retroactive effective date could put providers out of compliance by default, despite them having followed applicable conventions of an earlier time-period. It is unreasonable and illogical to expect hospitals to have historically met new requirements that were not compulsory at the time. Retroactively changing hospital bad debt practices from recommended to required would affect the standard to which prior actions are held, ultimately calling into question the validity of previously submitted cost reports; imposing additional burdens on providers, government, and in some cases, beneficiaries; and adversely affecting prior bad debt reimbursements.

For example, CMS proposes to alter the guideline that "the provider *should* [emphasis added] take into account a patient's total resources" (Provider Reimbursement Manual (PRM) Chapter 3, Section 312) when determining whether the beneficiary is considered indigent, to a regulation that states that a provider "*must* [emphasis added] do the following:...(2) take into account a beneficiary's total resources." Retroactive application would therefore hold providers to a standard that had not been in place for past indigence determinations, and could ultimately disallow previously reimbursable bad debt because the requirements for deeming bad debt for unpaid amounts differs for indigent and non-indigent beneficiaries. This retroactive change likely would trigger cost report re-submissions to prevent bad debt losses. **In addition, it could cause significant burden on beneficiaries who could be called upon to submit financial documentation to providers for an ex post facto examination of total resources.** Again, it would not be reasonable to consider such onerous activities—especially for beneficiaries—to be in the public interest.

HAP opposes retroactive application of the bad debt policies described in the proposed rule. A retroactive effective date would induce additional burden and usage of provider and government resources, and as a result, would be contrary to the public interest, failing the 1871(e)(1)(A)(ii) test for imposing retroactivity. **We strongly urge CMS to withdraw its proposals to retroactively apply proposed policies related to Medicare bad debt. Instead, the agency should only apply any finalized bad debt proposals to cost reporting periods ending on or after Oct. 1, 2020.**

Our concerns on the individual proposals are discussed below.

Policy for Determining Indigence
According to Chapter 3, Section 312 of the PRM, "once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible." Determining indigence is therefore a crucial component of bad debt activity because providers do not have to engage in "reasonable collection efforts" for debts associated with indigent beneficiaries.

The PRM guidance discusses two methods by which a provider can identify a Medicare beneficiary as indigent: by determining that the beneficiary also is eligible for Medicaid, or by applying "its customary methods for determining the indigence of patients" under a number of guidelines. One such guideline is that the provider "should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses." CMS proposes to make this component of the indigence determination required by regulation. As indicated above, this proposal would change aspects of indigence determination from a recommendation or guideline to a regulatory requirement.

We have several concerns related to changing this policy from a guideline providers should consider to a requirement providers must carry out; we urge CMS not to finalize its proposal.

According to the regulations governing Medicare bad debt (42 CFR § 413.89(e)), providers must utilize "sound business judgment" to determine that there is no likelihood in recovering an unpaid amount. The guideline in the PRM in its current form affords providers the opportunity use "sound business judgment" in this manner because it gives providers flexibility to make adjustments in their consideration of indigence for each patient. As the Provider Reimbursement Review Board (PRRB) has previously attested, "each determination of indigence must take into consideration each patient's circumstances. In some instances, that will require an asset test

while other circumstances may obviate the need for that test."[9] However, this flexibility disappears when guidelines are put into regulation. These regulations have the force of law and, as such, no longer allow providers to take into consideration each patient's circumstances per the PRRB. We describe our specific concerns below.

First, the agency does not provide a clear threshold or endpoint for the analysis of the beneficiary's total resources. Thus, it is unclear when a provider would acquire sufficient information such that it would meet the regulatory requirement and could rightfully deem the patient indigent for Medicare bad debt purposes. Similarly, it is unclear whether any one particular data point would be sufficient to prohibit a beneficiary from being considered indigent. In addition, we have heard from several AHA members that Medicare Administrative Contractors (MAC) may differ in their assessment of providers' conclusions on indigence, with some MACs denying bad debt amounts due to considering the hospital's customary methods to be too generous. **Without further clarification of what would be considered to be an adequate amount or a variety of information for identifying indigent beneficiaries, there is a considerable likelihood that bad debt could inappropriately be denied, with variation across regions.**

Second, if the proposal were finalized, the level of information required to identify a beneficiary as indigent for Medicare bad debt purposes would be more restrictive than many hospitals' charity care or financial assistance policies. This would not only cause confusion and burden for providers, since debts associated with charity care services would possibly not qualify for Medicare bad debt, but it would expose financially vulnerable beneficiaries to a potentially lengthy and challenging collections process. **Clearly, the Medicare program does not intend for providers to engage in collections for patients with few resources, in light of Chapter 3, Section 312 quoted above. However, requiring the total resource analysis would undermine this position by increasing restriction on who could be deemed as indigent.** Many providers utilize presumptive eligibility tools to appropriately and efficiently identify indigent patients, in accordance with their charity care or financial assistance policies. CMS should consider presumptive eligibility as a sufficient indication of indigence for the purpose of Medicare bad debt.

Third, a Medicare requirement to evaluate assets, liabilities, and other elements of total resources directly conflicts with some state-level policies and requirements related to national programs. For example, some states prohibit or greatly restrict health care providers from performing asset tests as part of indigence determination. Given this constraint, the proposal would result in substantial reductions in the amount of allowable bad debt that could be written

[9] PRRB Dec. No 2008-D12. (June 20, 2007). https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/downloads/2008D12.pdf

off by hospitals in these states. In addition, other hospitals could be restricted by participation requirements for national programs. Specifically, in order for critical access hospitals (CAH) to participate in the National Health Service Corps (NHSC) program—which addresses clinical workforce shortages in underserved communities—they must not consider patient assets when offering certain discounted care. **Thus, CMS's proposal conflicts with certain state laws and also could threaten CAHs' participation in the NHSC program by compelling them to conduct asset evaluations in order to claim bad debt. In light of the concerning trend of rural hospital closures and ongoing workforce challenges, CMS should not take any steps that could jeopardize opportunities for rural or other hospitals to recruit and retain clinicians in their communities.**

Fourth, requiring an analysis of total beneficiary resources puts extraordinary burden on both beneficiaries and providers
In order for the provider to fully examine total resources, beneficiaries could be called upon to furnish personal documents (e.g., tax returns, bank statements) for providers to assess. Requesting potentially intrusive information at a time when a beneficiary is medically and potentially financially vulnerable is inappropriate and counter to the spirit of many charity care/financial assistance policies. Furthermore, the amount of documentation that providers would have to collect and maintain to meet the proposed requirement would be extremely burdensome and clearly contradicts CMS's Patients Over Paperwork initiative.

Implicit Price Concession as Bad Debt
In 2014, the Financial Accounting Standards Board (FASB) issued its Accounting Standards Codification Topic 606 ("Revenue from Contracts with Customers"), which directs hospitals and other organizations to report their revenue in external financial statements in accordance with Generally Accepted Accounting Principles (GAAP). Specifically, Topic 606 characterizes most bad debts and uncollectible amounts as "implicit price concessions" rather than bad debt. While the FASB differentiation of implicit price concession and bad debt does not change the economic value of bad debts for Medicare purposes, implicit price concessions must be reported as reductions of net patient revenue, rather than operating expenses, in external financial statements. CMS proposes to "recognize that bad debts, also known as 'implicit price concessions,' are amounts considered to be uncollectible from accounts that were created or acquired in providing services."

We appreciate CMS' efforts to better align its documentation requirements with existing accounting standards. However, it is crucial that CMS issue guidance to both providers and MACs to clarify that implicit price concessions are a component of bad debt for Medicare purposes. We also recommend that CMS develop a line in Worksheet S10 to properly document and account for implicit price concessions for calculating uncompensated care. CMS should make the proposed policy effective only after appropriate guidance and documentation have been made available to providers.

"Crossover" Bad Debt Reporting
Medicare-Medicaid "crossover" bad debt includes the unpaid deductible and coinsurance amounts associated with dually eligible beneficiaries. State Medicaid programs may reimburse providers for none, some, or all of these amounts, in accordance with the state's Medicaid policy. As discussed in Chapter 3, Section 322 of the PRM, "any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of Section 312 [indigence determination] or, if applicable, Section 310 [reasonable collection efforts] are met."

Providers have generally written off this crossover bad debt to a contractual allowance account. A contractual allowance is a GAAP concept that refers to the difference between a provider's charge and the contractual discounted payment. Historically, crossover bad debt has been considered to be a contractual allowance because providers are bound by their Medicaid provider agreements to accept the amounts paid by the state plan as payment in full. **According to discussions with our members, MACs have historically found this contractual allowance classification to be acceptable, and considered these crossover balances as part of reimbursable bad debt for Medicare purposes.** On external financial statements, crossover bad debts—and all other uncollectible amounts—are applied as reductions to net patient revenue, in accordance with GAAP.

CMS proposes to require providers to write off Medicare-Medicaid crossover bad debts to an expense account for uncollectible amounts (bad debt) and not to a contractual allowance amount. Although this policy change would not affect the value or treatment of the crossover bad debt, as had been previously noted, it would require providers to create a unique methodology for recording "crossover" bad debt—a methodology that would only be utilized for and necessary because of CMS. **We continue to believe that this would result in substantial, unnecessary administrative burden for providers without any benefit to the accuracy or efficiency of bad debt reporting.** Moreover, the proposal conflicts with the implicit price concession policy described above. Specifically, it would create inconsistency between the FASB standard that would be adopted by CMS per above—i.e., crossover bad debt as implicit price concession—and a new CMS requirement—i.e., crossover bad debt as bad debt expense. **Thus, we urge CMS to clarify its bad debt reporting policies, including those for crossover bad debt, such that they would be aligned with FASB standards in a sensible manner.**

Bad Debt Related to Dual-eligible Beneficiaries
State policies may require Medicaid programs to pay part or all of the enrollee's deductible and coinsurance for certain services. According to Section 322 of the PRM, "where the State is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under

Medicare." The proposed rule outlines actions that providers must take in order to satisfy the "reasonable collection effort" requirement for dual-eligible beneficiaries. Specifically, CMS proposes to require providers to bill the state and submit the Medicaid remittance advice to Medicare as evidence of the state's Medicare cost sharing liability (the "must bill" provision), so that any state Medicare cost sharing liability can be deducted from the Medicare bad debt reimbursement.

In some cases, the Medicaid program will not process crossover claims, leaving the provider without a remittance advice. CMS states that in this circumstance, the provider would have to acquire alternative documentation from the state that demonstrates the Medicaid program's Medicare cost sharing liability (or lack thereof). Under this construct, the burden remains on the provider to work with the state to determine the state's cost sharing amounts, and CMS would not accept the provider's estimate of the state's cost sharing responsibility. **HAP is concerned by the burden that this policy would put on providers that serve dually eligible beneficiaries, including those in rural and underserved areas.** We recommend that CMS accept a provider's estimate of the state's cost sharing when the provider submits documentation that it has billed the state, but the state does not provide a remittance advice. In addition, our recommendation should be extended to crossover bad debts related to care that may not be covered by the state's Medicaid program, including certain psychiatric services. We have heard from our members that such crossover bad debts are often disallowed because, when the service is not covered by the state's program, it is not possible to enroll a provider into Medicaid and therefore not possible to receive a remittance advice.

Issuance of a Bill

In order to deem an unpaid amount to be bad debt, providers must first demonstrate that they have made a "reasonable effort" to collect the amount. According to Section 310 of the PRM, reasonable effort must involve the issuance of a bill "on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations." CMS proposes to clarify and modify this provision such that a provider must issue the bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or before 120 days after the date of the remittance advice from Medicare or from the beneficiary's secondary payer, whichever is latest. **We appreciate CMS's efforts to clarify this requirement and support the proposed modifications.** We also request that CMS make two clarifications if the agency finalizes the provision. First, we request clarification that the provision requires the provider's attempt to issue the bill, and not the receipt of the bill. Second, because the secondary payer may not send a remittance advice, we also recommend that the agency clarify that a notice of non payment (or other similar documentation) would substitute for a secondary payer's remittance advice if applicable.

120-day Time Period for Collection
Currently, Section 310.2 of the PRM stipulates that a bill cannot be considered uncollectible until at least 120 days have passed since the provider first attempted to receive payment. In the rule, CMS proposes that the 120-day clock restart when the provider receives a partial payment. We understand and support the intent of this policy, which is to allow an appropriate timeframe for patients to make progress toward payment before a provider deems an unpaid amount to be uncollectible. Moreover, many of our members establish extended payment schedules for patients that require more flexibility in light of personal financial circumstances. However, we have heard from our members that nominal partial payments can unintentionally stretch the period for collection efforts for an unreasonable amount of time—even years in some cases. This scenario exposes the beneficiary to a drawn out collections process that can cause ongoing financial strain. It also worsens stability in hospital finances and drains administrative resources because conclusion of the collection efforts remains unknown. **Thus, we recommend that CMS consider setting a minimum threshold for the level of partial payment that is sufficient to restart the 120-day clock. Having a threshold of some kind would allow patients to continue to make good faith payments toward an unpaid amount, while also providing more predictability for providers.**

Graduate Medical Education (GME)
When a teaching hospital closes a residency program or the hospital closes entirely, Medicare regulations permit the hospital to temporarily transfer a portion of its hospital-specific direct GME and indirect medical education (IME) full-time equivalent (FTE) resident caps to other hospitals that are willing to accept and train the displaced resident(s). The proposed rule states that CMS has previously defined "displaced resident" as one that is physically present at the hospital training on the day prior to or the day of hospital or program closure. CMS proposes to modify this definition to be based upon the day that the closure was publicly announced. In addition, CMS proposes to consider as "displaced" those residents that were not physically present at the closing program/hospital, but had intended to train at—or return to training at—the closing program/hospital.

To apply for the temporary increase in the Medicare resident cap, the receiving hospital must submit a letter to its MAC within 60 days of beginning the training of the displaced residents. The number of Medicare resident slots available to be transferred is capped at the number belonging to the closed hospital (or the hospital's closed program).

HAP Strongly Supports CMS' Proposal to Change the Definition of "Displaced" Resident and Asks that It Be Made Retroactive
HAP thanks CMS for acknowledging that both residents and teaching hospitals face challenges when a hospital or residency program closes and for proposing to change the definition of a "displaced" resident. As we describe below, HAP strongly supports the proposal that CMS will

consider a resident displaced at the time the hospital or program closure is publicly announced. This change will give residents added flexibility to identify another program to continue their training and will provide assurance to teaching hospitals that agree to train displaced residents that they will receive the temporary cap adjustment to which they are entitled.

Training the next generation of our nation's physicians is a key mission of teaching hospitals. In part, because of the Medicare resident "caps," teaching hospitals are constrained in the number of residents they can train. When a teaching hospital or a program closes, even more stress is placed upon the graduate medical education system to ensure that the displaced residents can find programs to continue their training and the slots are preserved.

Under current policy, Medicare provides for a temporary cap adjustment for hospitals that are above their cap and accept residents (the "receiving hospital") from a hospital or program that is closing. This allows the receiving hospital to receive Medicare direct graduate medical education (DGME) and IME funding for the displaced residents for the duration of their training. However, Medicare policy defines a displaced resident as "one that is physically present at the hospital training on the day prior to or the day of hospital or program closure." (p. 32785).

We have heard from members that took in displaced residents in the past that they have been denied the temporary cap increase because a resident was not on-site the day before or the last day of the hospital or program closed. This was particularly evident during the Hahnemann University Hospital closure when so many residents were displaced. And, with few patients in the hospital for weeks prior to the official closing, the training was of little to no value. These receiving hospitals accepted displaced residents in good faith with the promise that they would receive DGME and IME payments for the duration of the residents' training. These hospitals should not be penalized because they did what was best for the residents—gave them an opportunity to continue their training. We appreciate that you are proposing a permanent rule change.

CMS acknowledges in the proposed rule that it has heard the concerns that "limiting the 'displaced residents' to only those physically present at the time of closure" is burdensome for all residents who are attempting to find alternative programs to complete their training and may impose barriers to the "originating and receiving hospitals with regard to seamless Medicare IME and direct GME funding." (p. 32785). Therefore, CMS is proposing to change the definition of a "displaced resident." Under the proposal, a resident would be considered "displaced" if the resident was training in the hospital on "the day the closure was publicly announced." (p. 32786). Displaced residents also would include residents who have matched into a residency program but not yet begun to train and residents that are on rotation at another hospital on the date the hospital program closure is announced but intend to return to training to the closing hospital/closing program. HAP was a strong advocate for this change. **We agree with CMS that it would "provide greater flexibility for the residents to transfer while the**

hospital operations or residency programs were winding down." (p. 32786). **HAP fully supports the proposal. We also ask that it be made retroactive.**

HOSPITAL QUALITY REPORTING AND VALUE PROGRAMS

Data Collection to Address and Eliminate Inequities

This country has struggled with inequities in health care on the basis of racial/ethnic and sociodemographic differences for a very long time. However, the COVID-19 pandemic has even further magnified the significant issues patients in this country face. While CMS has recently used the IPPS rulemaking process to expand the role of quality measurement to identify inequities, HAP believes there is still significant work to do.

CMS recently began confidential hospital-specific reporting of stratified data using two disparity methods for readmission measures. This is a positive first step, but falls short of accurate methodology to assess social risk as it is based on dual eligibility and does not account for patient-level health related social needs and community—level determinants of health.

HAP urges CMS to begin a data collection standardization process that will ensure the collection of accurate patient-level and community-level social determinants of health (SDOH) data to help hospitals and health systems begin to address the impacts of SDOH factors and end inequities in care and outcomes.

Hospital Quality Star Ratings

Because of the current COVID-19 pandemic, CMS has announced that it had not included planned proposals to update the Overall Quality Star Rating methodology. There are several issues at play related to the Star Ratings, flaws in the current methodology that have been present for some time as well as the unknown impacts of COVID-19.

Because of the unknown impacts of COVID-19 on quality, HAP urges CMS to refrain from any updates to ratings and remove publication of current ratings until it is able to address significant methodology concerns through future rulemaking.

Hospital IQR Inpatient Quality Reporting (IQR) Program and Electronic Clinical Quality Measure (eCQM) Reporting

The IQR Program is a pay-for-reporting program. Failure of hospitals to meet the required program requirements reduces payment to hospitals equal to one quarter of the annual market-basket update. The program also requires hospitals to report on certain eCQMs that are reported from electronic health records (EHR) using CMS-mandated reporting standards.

Pertaining to eCQM reporting, CMS proposes retaining its current requirement that hospitals report data on four self-selected eCQMs. Beginning with CY 2022 reporting period, hospitals must report the Safe Use of Opioids eCQM as one of the four measures.

CMS also proposes two key changes to the program:

- Increasing the number of quarters for which hospital are required to report from one quarter to two self-selected quarters for CY 2021 reporting period, three self-selected quarters for CY 2022 reporting period, and four quarters for CY 2023 reporting. These changes would impact payments in FY 2023, FY 2024, and FY 2025 respectively
- Beginning to report eCQM measures publicly in late 2022

While the shift toward collecting more data (i.e., increased number of quarters) is understandable, the current pandemic has created unprecedented strains on the health care system, severely limiting hospitals' ability to perform necessary system upgrades needed to accomplish this work. HAP supports delaying the implementation of this phased-in approach by at least one year and re-evaluating the environment before moving forward with this proposal.

The proposal to begin reporting performance on eCQMs also is concerning. While we support CMS' commitment to creating transparency for patients, this information still is fraught with challenges. HAP strongly recommends that public reporting of the eCQMs be postponed until a time where accuracy can be assured.

Measure Validation Process

Hospitals are required to meet CMS' measure validation process requirements to avoid the IQR's payment reduction penalty of one quarter of the annual market-basket update. CMS is proposing to combine the process for chart-abstracted measure validation with eCQM validation. CMS also proposes to decrease the maximum number of hospitals selected for validation from 800 to 400.

Included in this proposal is calculating a single validation score for chart-abstracted measures and eCQMs starting with FY 2024 payment determination. Currently, eCQMS validation does not score hospitals on the accuracy of their measure results. CMS is proposing to weigh the chart-abstracted validation at 100 percent of the validation score, but notes that the agency will increase the weight of the eCQMs in future rulemaking.

While we agree with the concept of combining and simplifying the validation process, there is significant work required to ensure accurate eCQM validation before considering increasing the weight of this measure. For this reason, HAP supports delaying this process by at least one year to ensure the accuracy of the eCQM validation process.

Hybrid Measures
After finalizing the required reporting of a hybrid hospital-wide 30-day readmission measure which included 13 core clinical data elements and six "linking" variables last year, CMS is proposing that future hybrid measures use the same reporting requirements as the readmission measure.

While providers have long argued that claims data only is an insufficient way to measure outcomes, the introduction of additional required hybrid measures may be premature. Hospitals are at varying levels of sophistication related to connectivity. The proposed measure also requires the reporting of a significant number of data elements.

HAP encourages CMS to withhold from implementing any additional required hybrid measures until the accuracy and validity of the measure specification can be verified and the EHR vendors necessary to support the reporting of the measure are ready. We urge CMS to allow the experience of the field to inform any requirement to report the measure in the future.