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healthcare financial management association

June 22, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: 1678-P
P.O. Box 8013
Baltimore, MD 21244-1850

File Code: CMS–1694-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 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

Dear Administrator Verma:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the *2018 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 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs)Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims* (hereafter referred to as the Proposed Rule) published in the *Federal Register* on May 7, 2018.

HFMA is a professional organization of more than 38,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

HFMA would like to commend CMS for its thorough analysis and discussion of the many Medicare payment decisions addressed in the 2019 Proposed Rule. Our members would like to comment on the specific proposals related to:

- Requirements for Hospitals to Make Public a List of Their Standard Charges via the Internet
- Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Supplier
- Proposed Revision of Hospital Inpatient Admission Orders Documentation
- Disproportionate Share (DSH) Payment Adjustment and Additional Payment for Uncompensated Care

Below please find specific comments on the items listed above.

Requirements for Hospitals to Make Public a List of Their Standard Charges via the Internet

CMS has requested that hospitals publish a list of their standard charges via the internet in order:

> "to help patients understand what their potential financial liability might be for services they obtain at the hospital, and to enable patients to compare charges for similar services across hospitals."

HFMA's members believe that publishing a list of their standard charges via the internet would not meet CMS's intent or desire as described in the 2019 IPPS proposed rule as outlined below.

CMS posed the following questions to which we have responded below:

What types of information would be most beneficial to patients, how can hospitals best enable patients to use charge and cost information in their decision-making, and how can CMS and providers help third parties create patient-friendly interfaces with these data?

> The price information that is most beneficial and useful to consumers is an estimate of their individualized out-of-pocket responsibility for the specific service(s) they seek. For insured patients, this amount is contingent on their health plan benefit design, including coinsurance and copayments, and the amount of deductible remaining to be met. Uninsured patients may seek information about the cash price when (a) they are uninsured (b) they are covered by high-deductible health plans (HDHPs), or (c) they are seeking care with an out-of-network provider.
>
> Price transparency for the uninsured is subject to a substantial and growing number of laws at both the federal and state levels. It is the first responsibility of providers to ensure that policies and practices adhere to these legal requirements.

Insured patients may obtain an individualized price estimate from their health plan. Estimates are based on CPT codes, which must be obtained from a patient's physician or other care provider. Resources on the estimate-request process are available to consumers, including HFMA's *Understanding Healthcare Prices: A Consumer Guide*, which is available at no charge to any healthcare organization for posting online in the patient financial services section of their websites.

In addition, many hospitals and health systems post price information for common procedures online, and/or make this information available by phone.

Beyond that, HFMA's Patient Financial Communications Best Practices stipulate that providers should inform uninsured patients that they will review insurance eligibility with them to identify payment solutions or financial assistance options that may help them with their financial obligations for the care received. If appropriate, the patient should be referred to a financial counselor and/or offered information about the provider's financial counseling and assistance policies and programs. Financial assistance may take the form of free or discounted care, depending on an individual patient's circumstances, along with organizational policies.

For those patients who are not eligible or choose not to apply for financial assistance, and who are able to pay cash at the time of service, some organizations offer a discount. The cash discount may be posted on the organization's website or communicated by telephone or in person, upon request. In recent years, some hospitals offer uninsured patients or patients with high-deductible health plans (HDHPs) an option to pay for common tests and procedures in full at the time of service in exchange for sharply discounted prices.

If a patient seeks care from an out-of-network provider (based, for example, on that provider's reputation) and contacts the health plan for assistance, the health plan should clearly explain what percentage (if any) of out-of-network provider charges the plan will cover, and describe any other significant out-of-network benefit plan issues (e.g., a "reasonable and customary rate of reimbursement" limit on what the health plan will pay). The health plan should also inform the patient that—if the patient intentionally seeks care from an out-of-network provider—it is the patient's responsibility to independently obtain price information from that provider. Provider policies vary on whether to offer a self-pay or cash discount to these patients.

Should "standard charges" be defined and reported for both some measure of the average contracted rate and the chargemaster? Or is the best measure of a hospital's standard charges its chargemaster?

Information on charges or on average or "standard charges" is of limited value to consumers, as it will likely be significantly different from the amount they will be expected to pay. Chargemaster prices serve only as a starting point; adjustments to these prices are routinely made for contractual discounts that are negotiated with or set by third-party payers. Few patients actually pay the chargemaster price. Information on the average amount *paid* for services is somewhat more useful to consumers, but it still falls short. The price information that is most useful to consumers is an estimate of their individualized out-of-pocket responsibility for the specific service(s) they seek as noted above.

Should health care providers be required to inform patients how much their out-of- pocket costs for a service will be before those patients are furnished that service?

HFMA believes that patients should receive information about their out-of-pocket costs for a service before the service is furnished, though as stated previously, we believe for insured patients, the health plan is best positioned to provide that information. For uninsured patients, the provider—i.e., the entity, organization, or individual that furnishes a healthcare service—should be the principal source of price information for uninsured patients or patients who are seeking care from the provider on an out- of-network basis.

Should we require health care providers to provide patients with information on what Medicare pays for a particular service performed by a health care provider?

Similar to "standard charges" the Medicare payment information for a particular purpose would not be useful for a patient as Medicare payments vary from provider to provider depending on a multitude of factors, and the majority of patients interested in price information are not Medicare patients. So, providing this information would likely be more confusing than useful.

What is the most appropriate mechanism for CMS to enforce price transparency requirements?

This question is difficult to answer without more information related to what requirements will be put into place, though HFMA supports administrative simplification and would stress the importance of clear and simple reporting for any price transparency requirement.

Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare-and Medicaid-Participating Providers and Supplier

HFMA generally supports effective efforts around improving interoperability and electronic healthcare information exchange initiatives. Our senior financial executive members of HFMA have rated interoperability as the most important prerequisite for increasing adoption of value-based payment. This need includes interoperability internally between disparate electronic medical record systems, as well as externally with other providers and/or health plans. The lack of accurate and timely data to manage value-based payment programs is a critical need that would benefit from enhanced interoperability. More details are available in HFMA's report on *Value Based Payment Readiness*[1], which highlights this need for interoperability as a critical part of continued progression into value based payment models.

Proposed Revision of Hospital Inpatient Admission Orders Documentation

HFMA supports the simplification and focus on medical necessity for inpatient admissions, and commends CMS for revising 42 CFR 412.3(a) to remove language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order to be paid for hospital inpatient services under Medicare Part A. This will alleviate the effort and resources currently utilized to manage the unnecessary denials.

(1) Source: http://www.hfma.org/ValueBasedPaymentReadiness/

DSH Payment Adjustment and Additional Payment for Uncompensated Care

HFMA appreciates CMS's clarifications and revisions to worksheet S-10 instructions, though as we have discussed in our comment letter on the FY2018 proposed IPPS rule, HFMA's members have significant concerns about the reliability of the data and the audit process and guidelines specific to the S-10.

Uncompensated Care: Audit Processes

While CMS stated in the FY2018 proposed rule that it is working on audit instructions for the Medicare Administrative Contractors (MACs), it will not make these (or any other audit guidance) publicly available. In general, HFMA's members have long considered this stance inappropriate and counter-productive. CMS has stated in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56964), for program integrity reasons, CMS desk review and audit protocols are confidential and are for CMS and MAC use only. We respectfully disagree that providing hospitals on how CMS will audit the S-10 would cause integrity issues. On the contrary, providing hospitals detail specifics on how to report items on S-10 and how they will be reviewed would aid hospitals in providing more accurate data. While we believe there is no malicious intent, the inconsistent reporting of the data could unknowingly damage another provider's payments. This policy of opacity results in the various MACs (and sometimes different offices of the same MAC) taking different interpretations of the Provider Reimbursement Manual (PRM), and other CMS guidance. This could also lead hospitals to make their own interpretations, creating inconsistencies in reporting.

Specific to the S-10, guidance for completing the worksheet is limited to vague instructions (as discussed above and in further detail below). Further, unlike other worksheets that have an impact on payment and are audited by the MACs, the PRM is silent on the treatment of non-Medicare bad debt and charity care. This silence is appropriate, as each hospital's financial assistance policy and broader community benefit strategy reflects the needs of its community. However, in this vacuum, our members who have undergone "meaningful use audits" report that MACs have disallowed charity care, citing justifications ranging from arbitrary federal poverty limits, to inappropriately citing section 312 of the PRM, which pertains to determining indigence for purposes of identifying Medicare bad debt. **Given HFMA members' experience with these audits, we strongly encourage CMS to recognize the uniqueness of the circumstances surrounding the S-10 and release the audit criteria for non-Medicare bad debt and charity care claimed on the worksheet.**

Uncompensated Care: Validity of Worksheet S-10 Data

CMS reiterated in the 2018 IPPS final rule that they will not subject the Worksheet S-10 for desk review by the MACs until FFY2017 cost reports are filed. HFMA and its members believe that it is unreasonable and unjust that CMS plans to distribute $8.2 billion based on un-audited data from FFY2014 and FFY2015. Our members have no control over the integrity of other hospitals' data, and must rely on CMS to perform its due diligence to ensure the proper payment is made to all providers. While hospitals were on notice that Worksheet S–10 could be the data source for calculating uncompensated care payments, the ambiguous and vague instructions led to the reporting of imperfect data across the hospital community.

In the FFY2019 IPPS proposed rule, CMS has stated that approximately half of the hospitals that receive uncompensated care payments have modified S-10 data. HFMA does not consider only fifty percent, or one-half of the hospitals, a large enough sample to assume the data is in fact accurate or reliable. HFMA

members' views this as half of the hospitals possibly submitted imprecise data based on vague instructions that impacts their hospital payments. While CMS may argue that the statute grants it flexibility to determine what "appropriate data" is for calculating Factor 3, HFMA believes it should not use data where it knows that only half of it is actually "appropriate."

Some members' hospitals have attempted to submit corrected S-10 data to the MAC, but some have had it rejected, or they have not had the corrections listed in Healthcare Cost Report Information Center (HCRIS) to be reflected in the Proposed Rule tables. While CMS has observed changes in the data for hospitals, many hospitals are still having challenges resubmitting and having the data accepted by the MAC. In some circumstances hospitals are failing to get the MAC to correct over-reported data. Therefore, the possibility that some hospitals are generally "doing better" with reporting data, or that data has become more stable over time, does not substantiate using this method for distributing the Uncompensated Care funds.

While half of the hospitals have indeed changed the data, there are many others trying to correct the data that have not been accepted**. HFMA and its members suggest an alternative means to the submission of a Cost Report to alleviate some of the administrative burden for hospitals and improve the accuracy of data submitted.**

In addition, there are a number of other Worksheet S-10 data elements in the proposed rule table which show questionable values of uncompensated care costs and indicate that the data continues to lack accuracy, consistency and completeness. By way of example, we want to call out that:

- Transmittal 11 changes are not applied to all the hospitals in the proposed rule tables. There are over 200 hospitals that have their Uncompensated Care Costs calculated under Transmittal 10 instructions and not Transmittal 11 instructions.
- We appreciate the fact that CMS is reviewing outlier amounts reported and adjusting the data. However, this review does not validate or confirm the accuracy of the remaining data. Due to the "zero-sum" situation, data must be considered reliable to avoid harm to an individual hospital. For instance, in the FY2014 HCRIS data there are over 550 hospitals that report higher charity care write-offs for insured patients vs. uninsured charges written off to charity care. In one specific example:

    - FY 2014 HCRIS data shows that one hospital reported $49,393,009 of charity care on line 20 in column 2 for the insured. vs. only $344,452 of charity care charges in column 1 for the uninsured. Additionally, this hospital had re-submitted data by the first deadline in September 2016. On top of this, the FY2014 HCRIS data is still applying the cost to charge ratio to column 2 for the insured population (See HCRIS Report Record Number: 584404).

Uncompensated Care: Bad Debt Expense and Release of FASB Update 2014-09 Topic 606

HFMA also requests CMS to issue guidance on Financial Accounting Standards Board (FASB) update 2014-09 Topic 606 that clarifies changes in revenue recognition standards for hospitals. Specifically, CMS should address if bad debt is still to be reported "net of recoveries" on Worksheet S-10. Under the clarifying guidelines issued by FASB, bad debt is to be reported on historical experience and recoveries may not correlate to reported bad debt expense on the general ledger. The unpaid patient balances are no longer reported as bad debt if the hospital historically has not collected on those respective amounts.

HFMA encourages CMS to comment on how the changes of bad debt reporting (on the Medicare Cost Report), as a result of FASB ASU 606, impacts the completion of Worksheet S-10 and if there will be an impact to the Uncompensated Care pool distributions.

Uncompensated Care: Discrepancies between IRS 990 and Worksheet S-10

CMS has claimed in prior rulemaking and for FY2019 that they have undertaken extensive analysis of the Worksheet S-10 data, benchmarking it against the data on uncompensated care costs reported to the Internal Revenue Service (IRS) on Form 990. Based on its findings, CMS has concluded that there is a high correlation between Worksheet S-10 and IRS Form 990 in the calculation of Factor 3 (.85). CMS has used that as an indicator that the S-10 data would be a statistically valid source for the calculation of uncompensated care payments in FY 2019. While there is a correlation between the data, it would not be prudent to validate the Worksheet S-10 data on this premise. There are differences in the reporting requirements for IRS Form 990 vs. CMS Worksheet S-10 that were not addressed in the Dobson-DaVanzo analysis. In addition, verifies hospitals concerns by stating, "although the Factor 3s are highly correlated, large hospital-level differences in uncompensated care costs, charity care, bad debt, and Factors 3 exist between measures calculated using the S-10 and 990 data" and that "For over 50 percent of the hospitals in 2011-2013, the differences between the S-10 and IRS 990 Factor 3s center around 40 percent."[(2)]

In an effort to mitigate the potential impact of unreliable or inconsistent S-10 data on the distribution of uncompensated care payments, HFMA urges CMS to require hospitals to re-submit S-10 data for FY 2014 and FY 2015 before the data is to be used in any fiscal year distribution. We strongly urge CMS to consider postponing the use of Worksheet S-10 data to give CMS time to perform additional analysis and address concerns of the hospital community.

(2) Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-NPRM-Update-of-Benchmarking-S-10-Data.pdf

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the FY2019 IPPS. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS, and advisory groups.

We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,

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

About HFMA

HFMA is the nation's leading membership organization for more than 38,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

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