SUMMARY OF COMMENTS AND RESPONSES

WORKSHEET S-2

Comment - Commenters questioned the need for the long-standing requirement to report Medicaid days in six categories on Worksheet S-2, Part I, lines 24 and 25. The commenters suggested reducing the reporting requirement to one column of Medicaid days. Alternately, some commenters requested that CMS clarify reporting out-of-state HMO days and HMO-eligible but unpaid days.
Response - We made no substantive changes to the policy for data required to be reported on Worksheet S-2, Part I, lines 24 and 25. Instead, we proposed clarifications to the instructions to provide guidance to providers to report accurate data on those lines. In response to the commenter's request that we clarify reporting of HMO-eligible but unpaid days, we note that the proposed clarification already instructs providers to report HMO-eligible but unpaid days in column 5.

Comment - A commenter appreciated the clarity and specificity of the revised instructions Worksheet S-2, Part I, lines 24 and 25, instructions related to DSH eligible days, and the layout of Exhibit 3A. A commenter suggested that CMS modify the proposed instructions for Worksheet S 2, Part I, lines 24 and 25, columns 1, 2, 3, and 4, to clarify that days not eligible for Medicaid but regarded as such under a 1115 waiver do not require a determination of DSH eligibility since neither the statute nor the regulations require an eligibility determination.
Response - We agree that days not eligible for Medicaid but regarded as such under a 1115 waiver do not require a determination of DSH eligibility under the statute or the regulations. Therefore, we modified the proposed instructions for Worksheet S-2, Part I, lines 24 and 25, columns 1, 2, 3, and 4.

Comment - Several commenters suggested that CMS clarify what is meant by permanent adjustments in the proposed instructions for Worksheet S-2, Part 1, line 88, and line 89. One commenter suggested that we cite a reference for permanent adjustments in order to enhance the cost report instructions.
Response - We agree with the commenters and modified the proposed instructions for Worksheet S-2, Part I, lines 88 and 89, by adding "See CMS Pub. 15-1, chapter 30, §3004.1 and §3004.2 for clarification on permanent adjustments."

Comment – Commenters suggested that CMS modify the Worksheet S-2, part I, line 89, by deleting the proposed column 2, the effective date of the permanent adjustment. Commenters noted that some hospitals may not know the date given the time passed since approval.
Response – We agree that identifying the effective date of a permanent adjustment for the proposed line 89 on Worksheet S-2, Part I may be difficult for some providers. We note that calculating the updated permanent adjustment amount for Worksheet D-1, Part II, line 55.01, requires the effective date in order to apply the proper update factor to the adjustment amount. As some providers may be able to provide the information requested on Worksheet S-2, Part I, line 89, column 2, we modified proposed instruction as follows: *In column 1, enter the Worksheet A line number upon which the approval of the permanent adjustment to the TEFRA target amount per discharge was based; in column 2, enter the cost reporting period beginning date that the permanent adjustment to the TEFRA target amount per discharge was effective, if available; and in column 3, enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge approved as of the date in column 2.*
Additionally, we modified the proposed instructions for Worksheet D-1, Part II, line 55.01, as follows: *If Worksheet S-2, Part I, line 88, column 1, is "Y", enter the amount of the permanent adjustment to the TEFRA target amount per discharge from Worksheet S-2, Part I, line 89, column 3, after applying the proper update factor (see 42 CFR 413.40) as obtained from your contractor. If the contractor approved more than one permanent adjustment to the TEFRA target amount per discharge (Worksheet S-2, Part I, line 88, column 2, is greater than 1), enter the sum of all permanent adjustments, i.e., the sum of the amounts entered on Worksheet S-2, Part I, line 89 and subscripts, column 3, after applying the proper update factors (see 42 CFR 413.40) as obtained from your contractor.*

Comment: Several commenters questioned the need for the proposed line 123 on Worksheet S-2, Part I, stating that the question adds significant administrative burden without improving the quality of data collected by the cost report. In general, the commenters opposed adding this proposed line and requested that CMS remove it from the cost report. Several commenters stated that almost all hospitals use purchased legal, accounting, tax preparation, bookkeeping, payroll, and management consulting services, and that hospitals do not track the percentage of services purchased from unrelated organizations outside the main hospital CBSA. The commenters stated that even determining this percentage is a complex undertaking. A few commenters stated that the firms providing these services are either regional or national. The commenters pointed out that 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. The commenters stated that this adds significant complexity to determining what percentage of purchased administrative services from unrelated organizations the hospital procured from outside of the hospital's CBSA. Several commenters stated that the proposed line 123 on Worksheet S-2, Part I, appears to be informational in nature and CMS does not provide any rationale for collecting this data. One commenter stated that the costs imposed by this data element would be vastly disproportionate to the value of the data collected. In the alternative, the commenter stated that if there is any rationale for collecting this data, it has not been presented to stakeholders for comment.

Response: We acknowledge the difficulty for hospitals to determine the exact percentage of professional services purchased outside the main hospital's CBSA. We note that the question does not request that hospitals report this exact percentage, but rather select the appropriate range (1% to 50%, 51% to 99%, or 100%). However, we acknowledge that this proposal may appear to suggest that hospitals calculate an actual percentage in order to answer this question. Therefore, we modified the proposed Worksheet S-2, Part I, line 123, as follows:

Line 123--Did the facility and/or its subproviders (if applicable) purchased professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, advertising, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is yes, were the majority of the expenses, i.e., greater than 50% of the total professional services expenses, for services purchased from unrelated organizations located outside of the main hospital's local area labor market? In column 2, enter "Y" for yes or "N" for no.

With this revised question, hospitals need only answer a yes/no question indicating whether the hospital purchased professional services from an unrelated organization and, if so, a yes/no question on whether the hospital purchased the majority of these professional services outside of the main hospital's local labor market. Modifying the proposed question reduces the burden on hospitals compared to our initial proposal as the revised question requires informed responses based on the hospital's accounting records, but does not require a separate detailed calculation. At the same time, the revised question collects more current information on the proportion of professional fees for labor-related services the hospital purchased outside of the local labor market, which will help ensure more accurate Medicare payments.

We disagree that the question is informational in nature. The requested information ultimately impacts the labor-related share of the wage index for IPPS hospitals, as well as the labor-related share for inpatient rehabilitation facility, inpatient psychiatric facility, and long-term care hospitals. We acknowledge that we did not thoroughly explain the need for the information. The rationale for the proposed line 123 on Worksheet S-2, Part I, is to obtain a more recent estimate of the proportion of legal, accounting and auditing, engineering, and management consulting services that meet our definition of labor-related services. As described in the FY 2018 IPPS/LTCH final rule, our current estimate of labor-related professional services is derived using a 2008 CMS survey of hospitals (82 FR 38167). A discussion of the composition of the survey and post-stratification can be found in the FY 2010

IPPS/LTCH PPS final rule (74 FR 43850 through 43856). Based on the weighted results of the survey, we determined that hospitals purchase, on average, the following portions of contracted professional services outside of their local labor market:

- 34 percent of accounting and auditing services;
- 30 percent of engineering services;
- 33 percent of legal services; and
- 42 percent of management consulting services.

Ultimately, in the 2014-based IPPS market basket, nonmedical professional fees that were subject to allocation based on these survey results represent 4.9 percent of total operating costs (and are limited to those fees related to Accounting & Auditing, Legal, Engineering, and Management Consulting services). Based on our survey results, we apportioned 3.1 percentage points of the 4.9 percentage point figure into the Professional Fees: Labor-Related share cost category and designate the remaining 1.8 percentage points into the Professional Fees: Nonlabor-Related cost category (82 FR 38167). With the proposed line 123, we intend to derive updated estimates of these percentages using data from Medicare cost reports submitted by all hospitals, as opposed to relying on the limited sample of 108 hospitals in the 2008 survey.

In fact, as discussed in the FY 2018 IPPS/LTCH final rule, we received several public comments where the commenters expressed concern about the methodology CMS used to remove a portion of professional fees from the labor-related share (82 FR 38167). Several commenters believed the information gathered for the Professional Fees Survey in 2008 is outdated and that the survey should be updated. In addition, a few commenters stated that they did not believe the survey could be statistically representative because it was based on 108 hospitals. Several commenters urged CMS to continue to investigate alternative methodologies for determining the proportion that is labor-related before implementing any changes. We provided detailed responses to these comments in the FY 2018 IPPS/LTCH final rule and indicated that we would continue to explore options for updating the Professional Fees Survey to reflect more recent data for incorporation into future market basket rebasing and labor-related share determinations (82 FR 38168).

In summary, we propose to collect purchased services information because it impacts the labor-related shares used in the geographic adjustments for the hospitals' Medicare prospective payment systems. The proposed line 123, modified as noted in the response to comments about the complexity of determining the percentage, will provide CMS with updated estimates for the labor-related professional services provided to all hospitals submitting the Medicare cost report.

WORKSHEET S-10

Comment - One commenter suggested that CMS modify the proposed Worksheet S-10 instructions to clarify that a provider must include explicit verbiage detailing the charity care eligibility criteria in the written charity care policy or financial assistance policy.
Response - We note that the FY 2021 IPPS/LTCH final rule (85 FR 58826) published September 18, 2020, stated "… CMS does not set charity care criteria policy for hospitals, and within reason, hospitals can establish their own criteria for what constitutes charity care in their charity care and/or financial assistance policies."

Comment - Commenters claimed the Worksheet S-10, line 20, language, "if such inclusion is specified in the hospital's charity care policy or FAP," as written, 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. The commenters requested that we remove the language from instructions for Worksheet S-10, line 20, and from Exhibit 3B to reduce the risk of arbitrary disallowances and

unnecessary administrative burdens. One commenter also suggested removing the language from line 24. Some commenters also claimed that the important facts in determining whether an amount is included on line 20 are that the patient has an outstanding balance related to services rendered and meets the financial criteria set forth in the hospital's charity care policy or FAP, not that the balance was the result of a payer's administrative policy. These commenters claimed that the instruction may result in arbitrary disallowances and unnecessary administrative burdens.
Response - We understand that commenters may perceive the phrase "if such inclusion …" as new text because it appeared as red italic text in the proposed information collection request. While we formatted the text as red italic to highlight that we revised the instructions for line 20 by applicable time period, we note that the phrase "… if such inclusion is specified in the hospital's charity care policy …" appears in the Worksheet S-10 instructions since the issuance of Transmittal 1, published December 2010. This language does not appear in line 24 instructions. We are not aware of any instances where auditors erroneously interpreted this language.

We agree that amounts included on line 20 result from outstanding balances related to services rendered to patients meeting the financial criteria set forth in the hospital's charity care policy or FAP. In consideration of the commenters' requests, we modified the proposed instructions for Worksheet S-10, line 20, to clarify that that amounts reported on line 20 are attributable to services specified in the hospital's charity care policy or FAP, as follows: "… if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria." We note this revision is consistent with the instructions for Exhibit 3B.

Comment - One commenter suggested that CMS modify the instructions for the proposed Worksheet S-10, §4012.7, paragraph A, to include amounts written off to charity care for any uninsured portion of an insured patient's hospital stay, for any insured patient who exhausted benefits, and for any non-covered services.
Response - We appreciate the comment and incorporated this revision in the instructions.

Comment - A commenter asked CMS to clarify that a SCH or MDH paid on its hospital-specific rate is exempt from the requirement to submit supporting documentation for Worksheet S-10, line 20, for an acceptable cost report submission and need not submit the proposed Exhibit 3A.
Response - We agree with the commenter that completion of the Exhibit 3A as well as 3B and 3C may be burdensome for a SCH paid on its hospital specific rate; therefore, we modified the instructions for each exhibit to indicate that when a SCH (WS S-2, Part I, line 35, is greater than zero) where Worksheet E, Part A, line 48, is greater than line 47, do not complete Exhibits 3A, 3B or 3C. However, an MDH must complete each of the appropriate exhibits.

Comment - Commenters suggested that CMS redefine Worksheet S-10, line 20, column 1, to report amounts subject to the CCR and redefine column 2 to report amounts not subject to the CCR. Commenters proposed limiting column 2 to deductible, copayment, and coinsurance amounts for insured patients that are written off to charity care; and limiting column 1 to gross charges written off to charity care for uninsured individuals, insured individuals with charges for non-covered services or days that exceed a length-of-stay limit, and gross charges other than deductible, copayment, or coinsurance amounts. One commenter suggested we also make corresponding changes to Worksheet S-10, lines 21 through 23, if these line 20 revisions are accepted. One commenter suggested revising the Worksheet S-10 to correspond with reporting on the new Exhibit 3B.
Response - Worksheet S-10, line 20, intentionally segregates charity care charges for uninsured patients and insured patients for use by various stakeholders. Likewise, line 25 and the proposed line 25.01 intentionally segregate charity care charges for days exceeding a length-of-stay limit for insured patients' liability other than deductible, coinsurance, and co-payment amounts, respectively. The current structure with separated columns based on insurance coverage is important for determining the application of the hospital CCR. When reporting insured patients' charity care charges, we note line 25 and the proposed

line 25.01 are subject the CCR, and are a subset of the amounts reported on line 20, column 2. The proposed line 25.01 collects amounts other than deductible, coinsurance, and copayment amounts; therefore, we are maintaining the revisions as proposed for lines 20, 21, 22, 23, 25, and 25.01, on Worksheet S-10.

Comment - One commenter claimed that CMS proposed language in the Worksheet S-10 instructions regarding "inferred contractual relationship" is not permissible, would rewrite contract law and eliminate any value of a contract between a provider and a payor. This commenter requested the proposed inferred contractual relationship provision be removed. One commenter requested an expanded definition of the term inferred contractual relationship, with examples, to ensure accuracy and reliability of the Worksheet S-10 data. Another commenter stated that the inferred contractual relationship proposal suggests that providers can only claim deductible, coinsurance, and co-payments, on Worksheet S-10, line 20, column 2; however, for many of these claims (such as auto insurances), providers cannot prove the amounts of deductibles, coinsurance, and copayments because remittance advices may report one patient responsibility amount, which can incorporate amounts other than deductibles, coinsurance, or copayments. The commenter encouraged CMS to reconsider inclusion of this language under the instructions for Worksheet S-10, line 20, column 2.

Response - We appreciate the commenters concerns and requests for clarification. We disagree with the commenter who requested the proposed inferred contractual relationship provision be removed. We received comments from stakeholders in the past asking whether hospitals could report charges for insured patients when the insurer has an out-of-network status with the hospital, i.e., when there is the absence of a contractual relationship between the hospital and the insurer. In such circumstances, for Worksheet S-10 purposes, we've expanded the instructions to address when a hospital does not have a contractual relationship with the insurer due to its out of network status. The instructions for Worksheet S-10, line 20, are more inclusive by allowing hospitals to report amounts written off to charity care for total charges, or the portion of total charges, for patients with coverage from an entity/insurer that does not have a contractual or an inferred contractual relationship with the provider. However, we agree with comments that the cost report instructions are not as clear as they could have been, so we defined an "inferred contractual relationship" in the proposed instructions as follows: For Worksheet S-10 purposes, a contractual relationship between an insurer and a provider will be inferred where a provider accepts an amount from an insurer as payment, or partial payment, on behalf of an insured patient (for example, payments from workman's compensation funds, payments from an automobile insurer for medical benefits, or payments from an insurer for out-of-network services). An inferred contractual relationship can be more than a deductible, coinsurance or co-payment, contrary to commenters suggestions. In situations where the provider accepts under an inferred contractual relationship, payment from the insurer as payment in full with no patient liability or a patient liability limited to deductible, coinsurance or co-payment, the patient liability amount is written off to charity care is reported on Worksheet S-10, line 20, column 2; however, any balance beyond the patient liability is considered a contractual allowance and may not be written off to charity care. On the other hand, in situations where the hospital receives only a partial payment under an inferred contractual relationship and the hospital does not accept the amount as payment in full, resulting in a patient liability, the hospital reports the amount written off to charity care on Worksheet S-10, line 20, column 2. For example, an inferred contractual relationship exists and the patient has a $1,000 deductible. Total charges were $20,000 and the insurer agrees to pay 60% of charges. The patient has a liability for 40% of the charges plus a $1,000 deductible. If the patient liability amount is written off to charity care the hospital would report $9,000 on Worksheet S-10, line 20, column 2 ($20,000 times 40%=$8,000 plus the patient's $1,000 deductible) and the hospital would also report $8,000 ($9,000 patient liability minus $1,000 deductible) on Worksheet S-10, line 25.01. The amount on line 25.01 identifies the amount on line 20, column 2, that is subject to the cost to charge ratio.

Comment - A commenter requested that Medicaid shortfalls be included in uncompensated care cost calculations. The commenter also suggested revising the Worksheet S-10, lines 2 through 8, instructions to include GME-related costs, intergovernmental transfers (IGTs), and certified public expenditures (CPEs).

Response - We refer readers to the 2021 IPPS proposed rule (85 FR 58432 at 58825), wherein we explained compelling arguments for excluding such shortfalls from the definition of uncompensated care. We also refer readers to the 2020 IPPS final rule (84 FR 42044 at 42374), wherein we explained that a stay exceeding the length-of-stay limit imposed on patients covered by Medicaid or other indigent care program does not mean a length of stay that just happens to be longer than an individual hospital's average length of stay, but is one that exceeds a Medicaid or other indigent care program's length of stay limit. We further explained that a DRG-based Medicaid payment that is less than the cost of the services furnished to a Medicaid patient is considered a Medicaid shortfall. A Medicaid shortfall, or a Medicaid contractual allowance, must not be re-characterized as charity care and must not be reported on Worksheet S-10, line 20. We continue to define uncompensated care costs as the amount on Worksheet S-10, line 30, which is the cost of charity care (line 23) and the cost of non-Medicare bad debt and non-reimbursable Medicare bad debt (line 29). The comment requesting revision to Worksheet S-10, lines 2 through 8, instructions to include GME-related costs, IGTs, and CPEs are outside of the scope of the proposals for the Worksheet S-10 in the PRA.

Comment - One commenter agreed with the CMS revisions to Worksheet S-10, line 20, instructions limiting reporting of costs and charges to those for services provided to patients within the acute care portion of hospital. Other commenters disagreed with our proposal to exclude charity care charges for services provided in IPPS-exempt units within the hospital, such as skilled nursing facilities, inpatient psychiatric units, and substance abuse services, from the amounts reported on Worksheet S-10, line 20. One commenter suggested that CMS include the cost of providing physician and other professional services when calculating uncompensated care. Commenters suggested this change reverses CMS' longstanding policy, understates charity care and bad debt cost for certain hospitals, requires breaking out uncompensated care costs for a patient for a given admission by the unit of the hospital where the patient received care, violates the principle of mental health parity, and inappropriately excludes substance abuse services amid the opioid crisis.

Response - We appreciate the commenters concerns and requests for clarification. Section 3133 of the Patient Protection and Affordable Care Act, which added section 1886(r)(2) of the Act, authorizes an additional payment for uncompensated care costs (UCC) for eligible section (d) hospitals (disproportionate share hospitals). In light of the comments received, CMS will not finalize the proposed changes to Worksheet S-10, lines 20 through 29. Instead we will re-designate the Worksheet S-10, to include Parts I and II. On Worksheet S-10, Part I, we will retain the original collection of UCC data, and in order to separately identify the UCC for the general short-term hospital inpatient and outpatient services billable under the hospital CCN, we will require hospitals to identify this data on Worksheet S-10, Part II. The Worksheet S-10, Part II data will be collected so that CMS may consider the general short-term hospital inpatient and outpatient detailed information, in future years, in determining the scope of the UCC data for purposes of the uncompensated care payment methodology.

Comment - A few commenters requested that CMS create an auditing threshold for amounts reported on Worksheet S-10, line 20, column 2, that are greater than 25% of total hospital charges. Commenters suggested that if CMS accepts this change, CMS also delete lines 24, 25, and 25.01 from Worksheet S-10. One commenter recommended that CMS propose a threshold to determine when an insured charity amount is likely a charity coinsurance and deductible amount as compared to other charity charges for the insured patient. The commenter stated that not all hospital systems capture patient coinsurance and deductible amounts from other liability amounts.

Response - Comments regarding a recommended threshold approach for audit purposes are outside the scope of the hospital cost report PRA. As discussed in past IPPS/LTCH PPS final rules, Worksheet S-10 audit protocols are for CMS and MAC use only and we continue to hold the audit protocols as confidential.

Comment - Many commenters opposed including the phrase "medically necessary" health care services to the Worksheet S-10 proposed revised definition of charity care and uninsured discounts and requested

the removal of the reference. However, some commenters agreed that uncompensated care costs reported on Worksheet S-10 should only be "medically necessary" care. A commenter requested further clarification of what constitutes "medically necessary care." The majority of commenters expressed concerns that there would be disallowances of charity care claimed on Worksheet S-10 due to differences of opinion between auditors and hospitals. A commenter stated that Medicare cost report auditors are not clinicians and will not know the underlying clinical details of a case, and the commenter expressed concern that this additional phrase could give rise to inappropriate reviews of medical necessity, diverting both hospital and auditor resources, without improving the accuracy of the data reported on Worksheet S-10. One commenter stated there are separate medical necessity audits that occur today, for which such determinations require medical records and medical expertise that Medicare cost report auditors simply do not possess, and which require more patient information than is necessary to perform the S-10 audits. The same commenter stated that their existing charity care policy provides that charity care is only offered with respect to charges related to medically necessary charges and the commenter stated that Medicare hospital cost report auditors are supposed to be auditing for adherence to such policy. A separate commenter asked for confirmation that this proposed revised definition for "medically necessary" health care services was not intended to re-adjudicate necessity determinations. One commenter suggested "medically necessary" be replaced with "health care services." Other commenters stated the terminology was not necessary because many providers already exclude cosmetic and other elective services from their charity care policies, and few, if any, hospitals charity care/financial assistance policies provide relief for health care that is not medically necessary, therefore adding the phrase "medically necessary" is redundant.

Response - In the past, CMS received questions from stakeholders asking whether there is a requirement that medically necessary care be reported on the Worksheet S-10. Pursuant to section 1862(a)(1)(A) of the Social Security Act, no payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The revised definition is consistent with this statutory requirement because the Worksheet S-10 data is part of the DSH uncompensated care payment calculations. We note that the Worksheet S-10 proposed definition clarification addresses a potential contradiction that could arise if a hospital's charity care policy were to specify that non-medically necessary services would be eligible for charity care and/or financial assistance at the hospital. Providers must only report medically necessary health care services on the Worksheet S-10; we recognize that the majority of hospitals already follow the clarified definition in their hospital specific charity care policy. The Worksheet S-10 audits review a provider's compliance with their own documented charity care and financial assistance policies (FAP) in effect during the cost reporting period. Regarding the concern of potential disallowances in future Worksheet S-10 audits and concern on re-adjudicating necessity determination, the revised definition clarifies that even if a hospital's charity care policy allows charity care for non-medically necessary services, those services are not allowed for Worksheet S-10 reporting of charity care.

Comment - Some commenters supported CMS' addition of the language on Worksheet S-10 which provides, "CMS does not mandate the eligibility criteria that a hospital uses under its financial assistance policy." Commenters recommended that CMS clarify that hospitals may qualify individuals as being eligible for their charity care/financial assistance policies using a presumptive eligibility tool, if the use of that tool is specifically referenced in the hospital's charity care/financial assistance policy.

Response - We appreciate the commenters who supported our addition of certain proposed language on Worksheet S-10. We disagree with commenters' request to revise the instructions to state that hospitals may qualify individuals as being eligible for their charity care/financial assistance policies using presumptive eligibility tools. We note that the FY 2021 IPPS/LTCH final rule (85 FR 58826) published September 18, 2020, stated "With regard to the comments regarding the use of presumptive eligibility tools to determine charity care, we note that CMS does not set charity care criteria policy for hospitals, and within reason, hospitals can establish their own criteria for what constitutes charity care in their charity care and/or financial assistance policies."

Comment - One commenter suggested that CMS remove line 24, line 25, and the proposed line 25.01, and treat length-of-stay limits in the same manner as any other partially covered stay. Another commenter suggested CMS modify the Worksheet S-10 to remove line 24, line 25, and the proposed line 25.01, and report the charity care charges for days exceeding a length-of-stay limit on either line 20 or a subscript of line 20. Another commenter supported CMS' proposal to create line 25.01 on Worksheet S-10 to distinguish charges that represent the insured patient's liability for medically necessary hospital services, other than deductible, coinsurance, and co-payment amounts from other charity care charges reported on Worksheet S-10, line 20, column 2.

Response - We appreciate the commenters concerns. Worksheet S-10, line 20, intentionally segregates uncompensated care data for uninsured patients and for insured patients' reporting charity care. We note line 25 and the proposed line 25.01 must be included in the amount on line 20, column 2, and are subject to the CCR. The proposed line 25.01 collects amounts other than deductible, coinsurance, and copayment amounts, subject to the CCR that are also included on line 20; therefore, we propose to maintain the revisions as proposed for lines 20, 25, and 25.01, on Worksheet S-10.

Comment - Commenters stated that the line 29 instructions contain a flawed calculation because line 28 (non-Medicare bad debt) includes amounts for deductibles, coinsurance, and copayments, that should not be subject to the CCR when calculating line 29. Some commenters suggested CMS create separate columns for lines 26 through 29 to report charges for insured and uninsured patients and apply the CCR only to the charges reported in the uninsured patients' column. Another commenter suggested not applying the CCR when calculating the amount of bad debt for uncompensated care. One commenter requested CMS clarify the instructions for bad debt expenses to treat all coinsurance and deductibles for non-Medicare bad debt the same—not multiplying them by the hospital CCR. A commenter disagreed with the instruction to multiply non-Medicare bad debt expense (line 28) by the hospital's CCR (line 29) because the non-Medicare bad debt expense includes deductibles, coinsurance and copayment amounts and are not hospital charges, but are amounts a hospital reasonably expected a patient to pay. The commenter requested that only bad debt charges (not deductibles, coinsurance and copayment amounts) be multiplied by the hospital's CCR.

Response - Bad debt for the hospital is not limited to deductibles and coinsurance as is Medicare bad debt. Bad debt for the hospital is comprised of components such as amounts that patients have not paid for an entire self-pay hospital stay, a non-covered service, and/or deductibles and coinsurance. The Medicare cost report does not identify bad debt for the hospital by components and collecting it would impose additional unnecessary burden on the hospitals and our Medicare contractors.

WORKSHEET S-12

Comment - Several commenters requested that CMS withdraw the market-based MS DRG relative weight data collection requirement, and subsequently withdraw or postpone the market-based MS DRG relative weight methodology, as finalized in the FY 2021 IPPS/LTCH PPS final rule, effective for FY 2024. These commenters requested that, if CMS continues the market-based MS DRG relative weight data collection requirement, CMS delay the effective date of the market-based MS DRG relative weight methodology until additional stakeholder engagement and provider education can be completed. Additional commenters raised a number of issues with the instructions provided for calculating and reporting the median payer-specific negotiated charge and that further information was needed in order to account for the various contract arrangements hospitals use to negotiate payments with MA organization payers, such as, but not limited to, per diem contracts, percentage of contract arrangements, quality based add-on payments and adjustments, capitated payment arrangements, and shared risk contract arrangements. These commenters asserted that without additional clarification, CMS would collect data that was not reliable, valid or standardized across hospitals. Several commenters also noted that CMS underestimated the administrative burden associated with the market-based MS-DRG relative weight

data collection requirement and the steps necessary to crosswalk the data to report it by MS DRG on the Medicare cost report, specifically during the COVID-19 public health emergency.
Response - We agree with commenters that additional clarification is necessary for the proposed Worksheet S 12 to assure that CMS collects reliable and usable data under the market-based MS DRG relative weight data collection requirement for use in the market-based MS DRG relative weight methodology effective in FY 2024. We agree with commenters that a delay is necessary to assure we are able to meaningfully consider and review public comments. As such, in conjunction with the proposal in the FY 2022 IPPS/LTCH PPS proposed rule to repeal the market-based MS DRG relative weight data collection policy and the market-based MS DRG relative weight methodology, we are holding in abeyance the requirement that hospitals complete the S-12 worksheet. Therefore, we removed the proposed Worksheet S 12 and instructions from the Form CMS 2552 10. We may publish additional changes, as necessary.

WORKSHEET A

Comment - Several commenters requested CMS clarify the instructions for Worksheet A, line 78. One commenter noted the changes are an important first step to ensuring appropriate calculation of CAR T-cell acquisition costs, and will help inform future rate setting and other policies relative to CAR T-cell therapy. Commenters asked if CMS intends to isolate the direct purchase cost of the CAR T-cell manufactured biologic on Worksheet A, line 78, and one commenter specified line 78 on Worksheets A, B, B-1, and C. Some commenters asked if CMS meant to exclude from Worksheet A, line 78, the expense of non-CAR T cell drugs, (e.g., ocilizumab, a drug used for CAR T-cell therapy complications), furnished to patients receiving CAR T-cell therapy. Several commenters requested CMS confirm that Worksheet A, line 78, is appropriate for reporting other direct, purchased services costs related to the cell collection, laboratory storing and processing of the cells.
Response - We appreciate the commenter who noted the importance of capturing CAR T-cell acquisition costs on the Medicare cost report Worksheet A, line 78. We agree with commenters' request to clarify the instructions and modified the Worksheet A, line 78, proposed instructions as follows: Effective for cost reporting periods beginning on or after October 1, 2022, enter the hospital acquisition costs for procuring, storing, and processing chimeric antigen receptor T cells (CAR T-cell) for immunotherapy infusion (FDA approved CAR T-cell immunotherapies only). This includes the cost of the CAR T-cell manufactured biologic, i.e., the cost paid to the manufacturer. Do not include costs for CAR T-cell immunotherapy transplants or the medication cost of the non-CAR T-cell drugs used for CAR T-cell therapy complications, e.g., Cytokine Release Syndrome, on this line.

We originally proposed to capture CAR T-cell acquisition costs on Worksheet D-6. After consideration of public comments, we propose to capture Medicare CAR T-cell acquisition costs on Worksheet D-3 and Worksheet D, Part V, as these amounts are billed on the claim, as opposed to determining the acquisition cost of all CAR T-cell transplants on the proposed Worksheet D-6. Therefore, we modified Worksheet D-3 to capture the Medicare inpatient ancillary CAR T-cell acquisition costs and modified Worksheet D, Part V, to capture the outpatient ancillary CAR T-cell acquisition costs. We modified the proposed Worksheet D-6 and instructions to remove references to CAR T-cell therapy so that Worksheet D-6 only captures acquisition costs for all allogeneic hematopoietic stem cell transplants to determine the Medicare acquisition cost.

Comment - A commenter suggested CMS clarify the proposed instructions for Worksheet A, line 102, for reporting opioid treatment program costs and specify whether to include the costs for Medicare patients.
Response - We added the proposed Opioid Treatment Program (OTP) cost center to the Medicare cost report to ensure that a hospital's OTP receives its appropriate share of hospital general service costs, e.g., capital costs. Furthermore, we do not intend to capture ancillary costs for services provided by the OTP nor calculate a settlement in the Medicare cost report for the OTP services because those services are paid bundled payment rates under the Medicare Part B benefit.

In response to the commenter's request that we clarify the description for the OTP cost center proposed on Worksheet A, line 102, we modified the proposed instruction as follows: *Effective for cost reporting periods ending on or after January 1, 2021, enter the cost of providing services for the treatment of Opioid Use Disorder furnished by a Medicare-enrolled Opioid Treatment Programs as defined in §1861(jjj) of the Act and as described in CMS Pub. 100-02, Medicare Benefit Policy Manual, chapter 17.*

WORKSHEET D-4

Comment - Commenters requested clarification of the phrase, "dates of service" on Worksheet D-4, line 63.01. Some commenters requested the instructions for line 63.01 be revised to state, "kidney transplants occurring on or after January 1, 2021," to align with line 75.02 instructions. Several commenters questioned if CMS intends for hospitals to report kidneys based on the patient's admission date, discharge date, or the organ transplantation date, during the transition year.
Response - The reasonable costs for procuring a kidney are reimbursable when billed in connection with a Medicare covered transplant. Therefore, CMS intends for transplant hospitals to report kidney acquisition costs based on the date the MA transplant occurs. We removed line 63.01 and included instructions for line 63 to include kidneys transplanted into MA beneficiaries effective for transplants occurring on or after January 1, 2021. We revised the proposed instruction for Worksheet D-4, line 63 and removed line 63.01. Line 75.02 will continue to identify the kidneys transplanted in MA beneficiaries that are reported on line 63.

Comment - A commenter requested that CMS use only one definition of "usable" in regards to research organs. This commenter suggested that research organs be included in the counts of both Medicare usable organs and total usable organs or excluded from both counts.
Response - In the FY 2022 IPPS final rule (86 FR 73416 at 73518) we codified under 42 C.F.R. 413.412(c), for Medicare cost allocation purposes, organs used for research are not counted as Medicare usable organs in Medicare's share of organ acquisition costs, with the exception of pancreata for islet cell transplants. Any further changes to the counting of research organs will need to go through notice and comment rulemaking.

Comment - One commenter stated that the proposed instruction for Worksheet D-4, line 66, improperly reduces the provider's reimbursement and suggested revising the proposed instruction by removing the parenthetical reference to Worksheet E, Part A, line 60, to avoid reducing the provider's reimbursement with no corresponding increase for Medicare's full DRG payment if Medicare had been primary.
Response - To clarify, when Medicare has a secondary payor liability for an organ transplant, the hospital must reduce the Medicare organ acquisition cost by the amounts received from the primary insurer for the cost to acquire organs (not the transplant). When a hospital submits a claim to Medicare, the primary payor payment amount is reflected on the provider's PS&R. This primary payor amount may be an amount for just the transplant or may be an amount for the transplant and the organ acquisition cost. Inpatient primary payor amounts are reported on Worksheet E, Part A, line 60. The amount pertaining to organ acquisition cost must not be used to reduce payments based on a DRG; this amount must be reduced from Worksheet E, Part A, line 60, and reported on Worksheet D-4, Part III, line 66 or 66.01 (as applicable). The remaining amount applicable to the organ transplant and reported on Worksheet E, Part A, line 60, must be reflected for informational purposes on Worksheet D-4, Part III, line 66.02. We refer the commenters to 42 CFR 413.414 for further information.

Comment - A commenter thanked CMS for including detailed instructions regarding Worksheet D-4 lines 62, 63, 66.01 and 66.02. This commenter stated that the addition of lines 66.01 and 66.02 provides a clearer cost report submission and audit process for stakeholders.
Response - We thank the commenter for their support.

WORKSHEET D-6

Comment - One commenter asked that CMS clarify the instructions for Worksheet D-6, lines 1 through 6, column 3, with examples, regarding what would constitute an inpatient day of care before the inpatient admission.
Response - In response to the commenter's request that we clarify the instructions for reporting inpatient days on Worksheet D-6, we modified the proposed instructions for Worksheet D-6, Part I, lines 1 through 7, column 3, as follows: An allogeneic hematopoietic stem cells acquisition day is an inpatient day of care rendered to a potential recipient or donor, before admission for the actual transplant, solely for a medical evaluation for an anticipated allogeneic hematopoietic stem cells transplant; or rendered to an allogeneic hematopoietic stem cells donor patient who is hospitalized for the allogeneic hematopoietic stem cells acquisition procedure.

Comment - Several commenters suggested expanding the Worksheet D-6, lines 8 through 40, to calculate both inpatient and outpatient costs related to hematopoietic stem cell acquisition costs and requested more detailed instructions.
Response - In response to commenters suggesting that CMS clarify the instructions for calculating inpatient and outpatient hematopoietic stem cell acquisition costs on the proposed Worksheet D-6, we modified the proposed Worksheet D-6 and instructions to calculate the inpatient and outpatient acquisition costs. In particular, we note that we modified the proposed instructions for Worksheet D-6, Part III, to compute shared costs in addition to ancillary costs for both inpatient and outpatient service. We also not that only inpatient service costs will be transferred to the appropriate worksheet for reimbursement under reasonable cost principles.

Comment - One commenter questioned whether the expenses calculated on the proposed Worksheet D-6 are included as allowable Medicare costs on the E worksheets. This commenter suggested that while there is no separate or cost-based reimbursement of CAR T-cell services, the calculated expense should allow for inclusion as Medicare allowable costs, and asked that CMS make changes in the E worksheets to include in Medicare allowable costs the costs from the Worksheet D-6 for CAR T-cell therapy.
Response - In response to public comments, we modified the proposed Worksheet D-6 and instructions to remove references to CAR T-cell therapy so that Worksheet D-6 only captures acquisition costs for all allogeneic hematopoietic stem cell transplants to determine the Medicare acquisition cost. That costs associated with CAR T-cell will be collected on Worksheet A and apportioned to Medicare on Worksheets D-3, and D Part V.

Comment - Some commenters expressed disagreement with utilization of the Worksheet D-6 for CAR-T cell acquisition costs because there is no cost settlement and the acquisition costs are reported for informational purposes only. One commenter cited provider burden in completing the worksheet and expressed that CMS has data to support the current DRG payment for CAR T-cell transplants because the manufacturer charges for CAR T-cells are well known in the industry. Another commenter expressed that the informational CAR T-cell cost acquisition data collection was not addressed in the proposed or final IPPS rules regarding reimbursement for CAR T-cell therapies, and requested that CMS propose and finalize the data collection through notice-and-comment rulemaking.
Response - We agree with the commenters and will only capture CAR T-cell acquisition costs on Worksheet D-3 and Worksheet D, Part V, to determine the Medicare's costs associated with CAR T-cell acquisition cost. We modified Worksheet D-3 to capture the Medicare inpatient ancillary CAR T-cell acquisition charges and modified Worksheet D, Part V, to capture the outpatient ancillary CAR T-cell acquisition charges. We also modified the proposed Worksheet D-6 and instructions to remove references to CAR T-cell therapy so that Worksheet D-6 only captures acquisition costs for all allogeneic hematopoietic stem cell transplants to determine the Medicare acquisition cost.

WORKSHEET E-3

Comment - Commenters suggested that CMS clarify the difference in the permanent adjustments to be reported on the proposed Worksheet S-2, Part 1, line 88, and line 89; and the adjustments that may be reported on Worksheet E-3, Part 1, line 17. Commenters further requested that CMS clarify the proposed instructions for Worksheet E-3, Part 1, line 17, to define the type of adjustments reported on line 17, specifically in light of the 2019 Medicare Administrative Contractors' (MACs') instructions to use this line to report acquisition cost of CAR-T for Medicare patients. Commenters further asked that CMS also allow subscripting of line 17 for other adjustments.
Response - We appreciate the commenters request to clarify the instructions for S-2 Part I L. 88 and L. 89. Line 88 was added to identify a provider's permanent adjustment to their TEFRA target amount. Because this can be more than one added permanent adjustment over the years, line 89 was added to track each individual adjustment that the provider may have received. This information is needed to ensure when calculating the adjustment amount on Worksheet D-1, Part II, line 55.01 that all permanent adjustment amounts are included in the calculation. This historical data does not currently exist in the cost report and it has been difficult at times to determine amounts that may have been approved in previous years or from previous contractors. We added additional instructions to these lines for further clarification. We also acknowledge that MACs have been using Worksheet E-3, Part I, line 17, for TEFRA adjustments, such as for the timely issuance of reimbursement for critical CAR T-cell therapy. Worksheet D-1, Part II, line 55.02 has been added to address the proper reimbursement calculation and to track the adjustment amount associated with the cost reporting period. We revised the instructions for line 17 to include the statement: *Do not report adjustments resulting from permanent or other adjustments to the TEFRA target amount per discharge on this line.*

WORKSHEET E-5

Comment - A commenter requested that the CMS Pub. 100-04, Chapter 3, §20.1.2.5, be updated to reflect the requirements for the outlier reconciliation amounts at tentative settlement, since the current instruction manual only references outlier requirements at final settlement. The commenter believed updating the manual would ensure contractors and providers understand the requirement.
Response - We removed the references to CMS Pub. 100-04, chapter 3, §§20.1.2.5, from the Worksheet E-5 instructions as the manual section applies to final settlement, not tentative settlement.

Comment - A commenter supporting the addition of Worksheet E-5 requested that CMS apply the outlier reconciliation adjustment at the time of cost report tentative settlement to eliminate interest accruals on outlier reconciliations.
Response - We thank the commenter for their support of Worksheet E-5 and their recommendation. We may consider the recommendation for future rulemaking.

Comment - A commenter urged CMS to make this worksheet available for use by providers.
Response - The contractor completes Worksheet E-5 to report outlier reconciliation amounts during the cost report tentative settlement if the hospital meets the criteria based on information available at tentative settlement. We continue to require that contractors complete the worksheet.

EXHIBIT 2A

Comment - We received numerous comments on the proposed Exhibit 2A. One commenter suggested revising the Exhibit 2A instructions to permit modifying the prescribed format of the template and allow entry of alternate data. Another commenter stated that column 12 of the proposed Exhibit 2A is unnecessary and suggested that CMS remove it from the exhibit. The commenter suggested that, alternately, CMS modify the instructions to clarify what is reported in column 12. Several commenters suggested column 16 (Collection Effort Cease Date) of the proposed Exhibit 2A is unnecessary and

suggested that CMS remove it from the exhibit. Additional commenters requested CMS modify instructions to clarify that the dates reported in columns 14, 15, 16, and/or 17 can be the same date. One commenter requested column 19 (FYE date of recoveries), be optional since only providers that seek to limit recoveries would complete this field. A commenter suggested consolidating columns 20 and 21 (Medicare Deductibles and Medicare Coinsurance, respectively). A commenter suggested deleting columns 22 and 23 (Current Year Payments Received Amount and Source, respectively) to reduce providers' reporting burden. Commenters requested CMS combine, modify, and/or eliminate columns from the proposed Exhibit 2A to streamline the exhibit and reduce burden. Commenters suggested removing columns 10, 11, 12, 14, 15a, 16, 17, 18, 19, 22, and 23; combining columns 20 and 21; and revising instructions. Another commenter suggested removing columns with HIPPA-related data, i.e., columns 1, 2, 3, and 7, and instructing providers to submit the information to the MAC during review. One commenter suggested modifying the instructions for column 23 to permit the entry of multiple payment sources.

Response: The proposed Exhibit 2A is a compilation of data elements that are currently reported on the Exhibit 2, with the addition of data elements that are historically requested by MACs in order to facilitate review of bad debts claimed in the Medicare cost report. The Exhibit 2A supporting documentation is often requested by the contractor, and must be submitted by the provider in order to assure proper payment, not delay payments, or prolong audits. In the 2019 IPPS final rule 83 FR 41681 (August 17, 2018) commenters suggested that a standardized format be established and required for the submission of the bad debt listing that corresponds to the bad debt amounts claimed in the provider's cost report. We developed the Exhibit 2A using internal and external stakeholders, including Medicare contractors and hospital providers. We believe that providing this added information on the bad debt listing will reduce the numerous data requests through the review process and will expedite the cost report settlement process. Exhibit 2A, columns 1, 2, 3, 4, 6, 7, 8, 9, 13, 16, 20, and 21, are columns that exist on the current Exhibit 2, and have been longstanding data requests. Column 5 was added as an additional source to identify a patients account. Columns 1 through 7, some of which a commenter suggested removing from Exhibit 2A, collect data identifying the Medicare beneficiary and the specific dates of service for whom the provider claims Medicare bad debt. In response to public comment we reorganized columns 1 through 7 so that all of the proposed exhibits collect this patient related information consistently. The data collected in columns 1 through 7 is needed to support Medicare bad debts claimed on the Medicare cost report. Column 10, was an added field to collect the Medicaid remittance advice date for dually eligible beneficiaries, if applicable; column 11, was an added field to collect the secondary payer remittance advice received date, if applicable; and column 12 of the proposed Exhibit 2A, while some commenters indicated that it was unnecessary, collects the deductible and coinsurance amounts for which a Medicare beneficiary that is dually eligible may have a state cost sharing responsibility. We clarified the instructions for column 12 to explain when this column is completed. Columns 12 is a subset of the amounts reported in columns 20 and 21, and the amount reported may be used to reduce the bad debt for a dually eligible beneficiary that has a state cost sharing liability. Several commenters noted that columns 14, 15, 16 and 17 were not necessary and that the same date may be reported in those columns. We agree with the commenters that the same date may be reported in these columns; however, it is important to provider the various columns in situation where they are not the same date. Providers have various write off dates for instance column 14 collects the date the Medicare beneficiary's liability was written off of the accounts receivable (A/R) in the provider's financial accounting system. This account may have been written off for financial purposes but for Medicare purposes collection effort continues until the debt met Medicare guidelines. Column 15 collects the date a collection agency ceases efforts and is used to determine the year in which the bad debt is eligible for reimbursement. If accounts are not sent to a collection agency this column would be blank. Column 16 is the date that all collection efforts ceased and column 17 is the date a beneficiary's deductible and coinsurance amounts are written off as Medicare bad debt. We modified the proposed instructions for columns 14, 15, 16, and 17, to clarify that the dates may be the same in each of those columns. While the dates may be the same, if they are different the date in column 17 must be greater than the dates in columns 14 through 16. Column 18 collects the amount of any recoveries to assist in identifying amounts that are used to reduce allowable bad debt and column 19 identifies the cost reporting period associated with the recovery amounts reported in column 18. This column was made option at commenters request, but in order to limit the amount of recoveries must be completed. In response to a commenter's request to combined columns 20 and 21 into one column, we

will continue to collect this data similar to columns 8 and 9 of Exhibit 2. Deductible and coinsurance amounts are reported separately on a provider's remittance advice and in their PS&R. There is no added burden to report these amounts separate, it provides for better comparison to the separate amounts that appear on the provider's PS&R, and it eliminates the need for adding the amounts together. Column 22 collects the payment amounts such as amounts received from a secondary payor, an individual or an estate, that are associated with the deductible and coinsurance amounts reported in columns 20 and 21. In column 23, some commenters suggested removing and one commenter requested clarifying the instructions, we propose to collect the payment source of the amounts reported in column 22. A payment source may payors such as a secondary payor, an individual, an estate or multiple payors. The information is needed to ensure all payments are applied correctly prior to a bad debt determination and more than one source may be listed.

EXHIBIT 3A

Comment - We received comments on the burden for Exhibit 3A and comments suggesting that we streamline the listing by consolidating the reporting of Worksheet S-2 data to eliminate the requirement to submit multiple listings; that we omit select data elements; that we clarify reporting State eligibility codes, and reporting Medicaid days and identification numbers for newborns; that we require hospitals to report the method used to determine the days reported on the listing; that we allow a hospital to update the listing after submission; and that we allow hospitals to enter additional data elements.
Response - Numerous commenters stated that the proposed Exhibit 3A listing is burdensome. The proposed Exhibit 3A listing provides the standardized format for a DSH eligible hospital to list the Medicaid eligible days that correspond to the Medicaid eligible days claimed in the hospital's cost report. We developed the listing as a result of discussion in the FY 2019 IPPS Final Rule, 83 FR 41681 and 41684 (August 17, 2018), where we agreed to develop standard formats for supporting documentation that correspond to amounts claimed in the provider's cost report and required for an acceptable cost report submission. As we stated in the FY 2019 IPPS Final Rule, 83 FR 41762 (August 17, 2018), providers are required under §§ 413.20 and 413.24 to maintain data that substantiates their costs. Requiring a provider to submit, as a supporting document with its cost report, a listing of the provider's Medicaid eligible days that corresponds to the Medicaid eligible days claimed in the DSH eligible hospital's cost report is consistent with the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24. This listing does not require hospitals claiming a DSH payment adjustment to collect additional data. Hospitals claiming a DSH payment adjustment already collect the data in order to report the hospital's Medicaid eligible days in the hospital's cost report. Because the existing burden estimate for a DSH eligible hospital's cost report already reflects the requirement that these hospitals collect, maintain, and submit this data when requested, requiring a DSH eligible hospital to submit this supporting document along with the cost report, and to ensure the supporting documentation corresponds to the days reported on the Worksheet S-2, Part I, line 24 or 25, in order to have an acceptable cost report submission imposes no additional burden. Some commenters stated that reporting Medicare eligibility information in the listing is unnecessary and burdensome because no Medicare days are included in the days reported on Worksheet S-2, Part I, lines 24 or 25. We agree with the commenters that Worksheet S-2, Part I, lines 24 or 25, should include no days for patients eligible for Medicare Part A. Therefore, the columns for Medicare eligibility should be blank and instances where a hospital enters Medicare eligibility should be rare; therefore, the columns impose no additional burden.

Several commenters suggested that we streamline the proposed listing to reduce the number of listings submitted. We agree and revised the listing by adding the column titled "WS S-2 COL #" to identify, for each listing entry, the Worksheet S-2, Part I, column number to which the days correspond, thereby eliminating the need for a separate listing for each column and reducing the number of listings to one for Worksheet S-2, Part I, line 24, and one for Worksheet S-2, Part I, line 25.

Some commenters suggested that we revise the listing so that columns common to the Exhibits 2A, 3A, 3B, and 3C listings, appear in the same order on each listing and one commenter suggested that we combine the "Last Name" and "First Name" columns. We agree with the commenters' suggestion to align common columns among the listings and revised the format of the proposed listing to present the first five columns in the same order and with the same column titles as presented on the proposed Exhibits 2A,

3B, and 3C listings; therefore, we could not accommodate the commenter's suggestion that we combine the "Last Name" and "First Name" columns.

Some commenters suggested that we omit select data elements, we eliminated the requirement to report each patient's date of birth and gender. All remaining data elements on the proposed listing are required to validate the amounts reported on the cost report. We could not accommodate requests that we remove the requirements to report state eligibility codes, Medicare eligibility information, or primary and secondary insurer or other payer names, as these are required to determine whether the days reported on the listing were Medicaid eligible days.

Some commenters suggested that we clarify reporting State eligibility codes. We revised the proposed instructions to state that the provider enters the State eligibility code if available. Furthermore, we revised the proposed instructions so that a provider reporting multiple State eligibility codes reports one code in the State Eligibility Code column and additional codes in the Comments column.

Numerous commenters requested clarification for reporting Medicaid days of newborns. We revised the listing to add the column "Newborn Baby Days" with instructions for reporting the number of newborn baby days for babies born to Medicaid eligible mothers. Additionally, we revised the instructions for the "Eligible Days" column for reporting the number of days for the newborn baby if the Medicaid eligible mother is discharged and the newborn baby remains in the hospital.

Numerous commenters requested clarification for reporting Medicaid identification numbers for newborns. We revised the instructions for the "Medicaid ID No" column of the proposed listing to be consistent with the Children's Hospital Insurance Program Reauthorization Act 2009 (Pub. L. 111-3) section (e), which authorizes the use of the child health or medical assistance eligibility identification number of the mother to also serve as the identification number of the child.

One commenter requested that we require hospitals to report the method used to determine the days reported on the listing. We note that Worksheet S-2, Part I, line 23, requires the hospital to identify the method for determining the days on Worksheet S-2, Part I, lines 24 and 25. The listing must correspond to the days reported on Worksheet S-2, Part I, lines 24 or 25, the days for both Worksheet S-2, Part I, and the listing must be determined on the same basis. Requiring a hospital to report the method on the listing unnecessarily duplicates the information already reported on the cost report. Therefore, we did not revise the proposed Exhibit 3A to include reporting the method used to determine the days reported on the listing.

A few commenters requested the ability to update the listing after cost report submission. We note that in the 2019 IPPS Final Rule, 83 FR 41683, we stated that the hospital is required to report on its cost report the Medicaid eligible days known by the hospital at the time of the cost report submission. If the Medicaid eligible days change once the hospital receives the documentation from the State, the hospital may amend its cost report. The contractor must accept the amended cost report with the amended listing of the Medicaid eligible days that substantiates the revised Medicaid eligible days reported in the amended cost report if the amended cost report and amended listing are submitted within 12 months after the hospital's cost report is due.

A few commenters suggested that we expand the listing to allow reporting additional data elements such as MCO-specific identification numbers in place of Medicaid numbers, date of birth and social security numbers. We note that the proposed listing already provides the "Comment" column with instructions to enter optional comments or additional information as needed and clarify that multiple entries are permitted. Additionally, we revised the instructions for the "Comment" column to exclude a patient's date of birth or social security number in order to decrease patient's vulnerability to identity theft.

Comment - A commenter requested that CMS clarify that sole community hospitals (SCHs) and Medicare dependent hospitals (MDHs) are excluded from the requirement to submit the proposed Exhibit 3A. The commenter claimed SCHs and MDHs are paid a hospital-specific rate and Medicaid eligible days have no impact on their reimbursement. The commenter noted that CMS clarified such in the past.

Response - As we stated in the 2019 IPPS Final Rule (83 FR 41683) published on August 17, 2018, the requirement to submit a listing of the Medicaid eligible days that corresponds to the Medicaid eligible days reported in the hospital's cost report is not applicable to SCHs that are paid under the hospital-specific rate and are not eligible to receive DSH payment adjustments. However, because MDHs are eligible to receive DSH payment adjustments, this proposal applies to them if they are claiming a DSH payment adjustment. Similarly, a SCH that is not paid under its hospital-specific rate and is eligible to receive a DSH payment adjustment must submit a listing of the Medicaid eligible days that corresponds to the Medicaid eligible days reported in the hospital's cost report if it is claiming a DSH payment adjustment." To clarify that hospitals claiming a DSH payment adjustment must complete the proposed Exhibit 3A, we modified the proposed instructions as follows: For hospitals claiming a DSH payment adjustment and reporting Medicaid days on Worksheet S 2, Part I, line 24, or line 25, for a cost reporting period beginning on or after October 1, 2022, complete Exhibit 3A to support the Medicaid days reported.

EXHIBIT 3B

Comment: We received numerous comments on the proposed Exhibit 3B Charity Care Listing, a listing that supports charity care amounts a hospital reports on the Worksheet S-10. Commenters described the listing as complex, attempting to capture a significant amount of extraneous information, and significantly increasing administrative burden. Commenters suggested revisions, deletions, and additions, with many of the suggestions designed to more closely match the proposed charity care listing currently required for Worksheet S-10 audits. Some commenters recommended continuing to require that hospitals complete the currently required listing rather than the proposed charity care listing. Other commenters requested that CMS mandate that auditors use this proposed listing as the audit document for charity care. Several commenters requested that CMS allow hospitals to update the listing to reflect subsequent changes in patient's insurance status prior to an audit. Another commenter suggested that CMS clarify that only hospitals that reported DSH on Worksheet E, Part A, line 34, need complete the listing.

Some commenters suggested that CMS modify the proposed Exhibit 3B listing, as well as the proposed Exhibits 2A, 3A, and 3C listings, to align common data elements for ease of completion and data extraction from patient accounting systems while other commenters suggested that CMS permit hospitals to modify the listing. Commenters suggested that CMS add a column to identify the patient's insurance status so that a hospital submits a single listing of all patients, with validations to ensure insured and uninsured amounts correspond to amounts reported on Worksheet S-10, line 20. A commenter recommended CMS specify that hospitals enter all dates using the MM/DD/YYYY format. A commenter expressed concern about size constraints when submitting large electronic files with charity care and uninsured discount data to contractors.

Commenters expressed concern about transmitting protected health information; some commenters suggested limiting the listing to the patient's name, dates of service, patient account number, payor name or type, Medicare beneficiary identifier (MBI), Medicaid number or equivalent, total charity care amount, write off date, and payments received, while other commenters suggested that CMS expand the listing to include data elements such as a patient's social security number, date of birth, payment transaction code, secondary payor plan, patient gender, revenue code and total charges for revenue code for claim, service indicator (inpatient or outpatient), and total third party payments. A commenter suggested that CMS require an attestation that the hospital includes no professional fees in the patient accounting system utilized to populate the listing.

Commenters suggested clarifying or removing the "Uninsured/Insured Not Covered," "Name of Insurer," "Medicaid Number," "Charity Care Determination - Approved," "Charity Care Determination - Policy Under Which Approved," "Gross Charges," and "Deductible/Coinsurance/Copayment," "Non-Covered Charges Covered by Medicaid," "Physician/Professional Charges," "Non-Covered Charges," "Uninsured Discount Amounts," "Contractual Allowance," "Courtesy Discount," "Gross Charges Net of Reductions," "Allowable Charity Care Charges," "Charity Care Approved Ratio," "Write Off Date," "Patient Responsibility Charges," and "Payments Received" columns as well as the duplicate "Uninsured Discount" column. One commenter suggested renaming the "Approved Charity Care" column as "Approved Charity Care and Uninsured Discounts."

Response: The proposed Exhibit 3B listing provides the standardized format for a DSH eligible hospital to list the charity care and uninsured discount amounts that support the charity care amounts claimed on the hospital's cost report and replaces the currently required listing of charity care and uninsured discount data. Significant efforts have been made to limit required data elements yet provide adequate support for charity care charges and bad debts claimed in the hospitals uncompensated care cost calculation. The purpose of the Exhibits is to create a nationwide standard template for consistent use by all hospitals. Currently, exhibits referenced by commenters have slight variations and this published requirement is intended to eliminate these slight differences. This will create consistency in Charity Care and Total Hospital Bad Debt data utilized in the distribution of Uncompensated Care Payments and this is something all stakeholders have requested. We developed the listing as a result of discussion in the FY 2019 IPPS Final Rule, 83 FR 41681 and 41684 (August 17, 2018), where we agreed to develop standard formats for supporting documentation that correspond to amounts claimed in the hospital's cost report and required for an acceptable cost report submission. As we stated in the FY 2019 IPPS Final Rule, 83 FR 41762, providers are required under §§ 413.20 and 413.24 to maintain data that substantiates their costs. Requiring a provider to submit, as a supporting document with its cost report, a listing of the provider's charity care and uninsured discount amounts that correspond to the amounts claimed in a hospital's cost report is consistent with the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24. Hospitals already collect the data in order to report the hospital's charity care and uninsured discounts data in the cost report. Because the existing burden estimate for a DSH eligible hospital's cost report already reflects the requirement that these hospitals collect, maintain, and submit this data when requested, requiring a DSH eligible hospital to submit this supporting document along with the cost report, and to ensure the supporting documentation corresponds to the amounts reported on the hospital's cost report, in order to have an acceptable cost report submission imposes no additional burden.

To streamline the listing, we rearranged, redefined, revised, and removed proposed columns. Consistent with revisions to the proposed listings in Exhibits 2A, 3A, and 3C, we rearranged columns so that those columns common to all the listings, i.e., the Last Name, First Name, Date of Service-From, Date of Service-To, and Patient Account Number, appear as the first five columns and in the same order on each listing. To maintain the continuity of the common columns of the schedules, we did not accommodate suggestions to allow hospitals to modify the listing. We revised the instructions for the listing to state that, a SCH (Worksheet S-2, Part I, line 35, is greater than zero) where Worksheet E, Part A, line 48, is greater than line 47, does not complete a listing. We revised the listing to encompass both uninsured and insured patients on one listing, thereby eliminating the need for a hospital to submit separate listings, and we added validations to ensure uninsured and insured amounts correspond to amounts reported on Worksheet S-10, line 20. We revised the instructions to specify reporting dates in the MM/DD/YYYY format.

In response to requests that CMS permit updates to the listing reflecting changes subsequent to cost report submission but prior to audit, we note that the hospital is required to report on its cost report the charity care and uninsured discounts data known by the hospital at the time of the cost report submission. We anticipate few instances when the data would change. However, if the data changes, the hospital may request to submit a revised listing with an amended cost report in accordance with 413.24(f). In response to the concern about contractors' ability to accept large listings electronically, we note that Medicare Cost Report e-Filing System User Manual provides guidance on file size limits and recommends that any individual file or total submission exceeding the limits specified be submitted via traditional methods (mail or hand delivery).

To refrain from collecting extraneous information, we removed the "Uninsured/Insured Not Covered," "Medicare Beneficiary Identifier," "Medicaid Number," "Charity Care Determination - Approved," "Charity Care Determination - Policy Under Which Approved," "Gross Charges," "Courtesy Discount," "Gross Charges Net of Reductions," "Allowable Charity Care Charges," "Charity Care Approved Ratio," and "Patient Responsibility Charges" columns as well as the duplicate "Uninsured Discounts" column.

We did not revise the "Name of Insurer" column to report the type of payor because the payor name provides a greater level of specificity; instead, to accommodate the request that we clarify reporting multiple payors, we redefined the name of the column as "Primary Payor" and added the "Secondary

Payor" column to report the names of the primary and secondary payers, respectively. We redefined the "Non-Covered Charges Covered by Medicaid" as "Charity Care Non-Covered Charges" and revised the instructions to include charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs, charges for non-covered days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs, and the portion of charges where the patient has exhausted their benefits.

We added the "Total Charges for Claim" column to report charges for both uninsured and insured patients and to exclude physician/professional charges; we also revised the instructions for "Physician/Professional Charges" to report any physician/professional charges included in the "Total Charges for Claim" column. Therefore, we did not accommodate the suggestion to require an attestation that the listing includes no physician/professional charges.

We revised the instructions for the "Uninsured Discount" column to clarify that the column does not apply to insured patients. We revised the title for the "Contractual Allowance" column to be "Insured Contractual Allowance Amount" and revised the instructions to clarify that hospitals report the sum of contractual allowance amounts for primary and secondary payers, if applicable. We did not add instructions for reporting sequestration adjustments as commenters requested because those amounts are not includable on Worksheet S-10. We did not revise the instructions to remove the phrase "not medically necessary" in the "Non-Covered Charges" column as commenters requested because those charges must be considered when determining the amounts reported in columns 17, 18, and 19.

We redefined the "Total Allowable Charity Care Amount" column as "Amounts Written Off to Charity Care and Uninsured Discounts" and revised the instructions to calculate the amount as the sum of uninsured discounts, charity care non-covered charges, and other charity care charges. We revised the instructions for the "Write Off Date" column to report multiple write-off dates within the cost reporting period of the Worksheet S-10 that the listing supports by entering each date as MM/DD/YYYY separated by a semi-colon. We redefined the "Payments Received" column as "Total Patient Payments" and revised the instructions to specify that the hospital reports payments received prior to the determination of amounts for charity care. We did not add a column to report payments received subsequent to the charity care write off as commenters requested because those amounts are reported separately on Worksheet S-10, line 22 and must not be netted against amounts reported on Worksheet S-10, line 20. We added the "Other Charity Care Charges" column to report any other allowable charges written off as charity care pursuant to the provider's written charity care policy or FAP and not reported as uninsured discount amounts or as charity care non-covered charges.

We did not add columns suggested by commenters to report a patient's social security number, date of birth, and gender, in order to decrease the vulnerability of identity theft; nor did we add columns to report whether services were inpatient or outpatient or to collect payment transaction codes as these columns would impose unnecessary burden. To avoid unnecessary burden, we did not add a column to report revenue codes and total charges by revenue code for each patient; contractors can request revenue code detail as needed when reviewing the listing. Neither did we accommodate the suggestion to require an attestation that the listing includes no physician/professional charges; we require the physician/professional charges data to validate that these charges are excluded from charity care and uninsured discounts charges. We did not accommodate the request to remove the "Deductible/Coinsurance/Copayment" column; we require this data to validate amounts reported on Worksheet S-10, line 20.

EXHIBIT 3C

Comment - Some commenters stated that patients often submit payments but do not identify the account or date of service to which the payment applies. In these circumstances, commenters recommended that providers complete the proposed Exhibit 3C, column 12, by applying any payments received to the oldest date of service first, as recommended in the Health Care Financial Management Association's Best Practices for Resolution of Medical Accounts Receivable, Best Practices for Resolution of Medical Accounts (hfma.org).

Response - In response to comments, the purpose of column 12 is to collect revenues received from accounts previously written off as a bad debt. The amount reported in this column must be associated with a bad debt write off amount that occurred in a previous or current cost reporting period. If there are multiple dates of service for a patient account and those accounts were written off to bad debt, if the payer did not identify the account or date of service to which the payment applies, apply the payment to the oldest date of service first.

Comment - A commenter requested that the instructions for the proposed Exhibit 3C, column 14, be clarified to specify that the amounts written off to charity care can relate to any year, and that it does not relate solely to the years S-10 reporting. Another commenter requested confirmation that column 14 includes both charity care and uninsured discounts as reported on Worksheet S-10, line 20.

Response - In response to this comment we are clarifying that the amounts reported in column 14, pertain to the charges reported in column 10. A provider may determine a portion of patient charges are eligible for charity care or an uninsured discount and write them off in one year then subsequently determine the patient's liability to be uncollectible and the provider writes off the remainder of charges to bad debt. The timing of the two write-offs may not be in the same cost reporting period; therefore, the amount reported in this column is relative to the charges reported in column 10, and the dates of service reported in columns 3 and 4, regardless of charity care write-off date. The charges reported in this column are also used in determining the amount of eligible bad debt reported in column 17.

Comment - Commenters requested that CMS clarify the instructions for the proposed Exhibit 3C, column 15, by providing examples of other amounts a hospital would enter in this column. Commenters specifically asked whether hospitals could include discounts to self-pay patients (e.g., uninsured discount) regardless of whether the self-pay patients qualified for charity care or financial assistance discounts.
Response - In response to comments, we modified the instructions for the proposed Exhibit 3C to clarify that column 15 includes amounts that represent discounts to self-pay patients (e.g., uninsured discount) regardless of whether the patients qualified for charity care or financial assistance discounts. The amount reported in this column is used in determining the amount of eligible bad debt reported in column 17.

Comment - Commenters requested that the proposed Exhibit 3C listing instructions define the accounts receivable write-off date in column 16 not as the date that all collections activities cease but as the date the account was written off the hospital's financial accounting system (and financial statements).
Response - The accounts receivable write-off date for the proposed Exhibit 3C, column 16, is the date that the provider writes off the account in the hospital's financial accounting system (and financial statements) following the collections pursuit activity.

Comment - Another commenter suggested that the Medicare bad debt requirement to write off bad debt to a contra revenue account not be applied to the proposed Exhibit 3C listing.
Response - Hospitals must follow the Financial Accounting Standards Board's (FASB) Accounting Standards Update (ASU) 2014–09, Revenue from Contracts with Customers (Topic 606), (hereinafter "ASU Topic 606"), when accounting for total bad debts and completing this listing. As we stated in the 85 FR 59004 (September 18, 2020), the ASU Topic 606, changed the national accounting standard for revenue recognition of patient-related bad debts and uncollectible accounts. Under the ASU Topic 606, an amount representing a bad debt would generally no longer be reported separately as an operating expense in the provider's financial statements, but would generally be treated as an ''implicit price concession," and included as a reduction in patient revenue. Additionally, under the ASU Topic 606 standards, bad debts treated as "implicit price concessions" are now considered to be "reductions in patient revenue" instead of "uncollectible accounts receivable and notes receivable" and the provider should have the usual "accounting recordation for the reductions in revenue."

Comment - Some commenters suggested that CMS revise the instructions for column 17 to report, instead of calculating, the patient bad debt write-off amount, which will account for bad debt recoveries, Medicare crossover claims for dual eligible beneficiaries, and discrepancies in data collected in columns 12 through 15, improving the accuracy of amounts reported in column 17.

Response - We appreciate the comment; this instruction is intended to identify a portion related to professional fees if it applies and should be considered. We modified the cost report instructions for columns 12 and 13 to identify recoveries and payments from third party payors such as Medicare crossover claims paid for dual eligible beneficiaries.

Comment - Commenters suggested that reporting primary and secondary payer information be optional as some hospitals may not have this information for older bad debt accounts.
Response - As we stated in the FY 2019 IPPS Final Rule, 83 FR 41681 and 41684 (August 17, 2018), where we agreed to develop standard formats for supporting documentation that correspond to amounts claimed in the hospital's cost report, providers are required under §§ 413.20 and 413.24 to maintain data that substantiates their costs We revised the instructions for the listing to state that the hospital reports the primary and/or secondary payor information for a claim with a date of service before January 1, 2021, if available.

Comment - A commenter requested that CMS modify the instructions to recognize implicit price concessions.
Response - We modified the listing instructions to recognize implicit price concessions as follows: For cost reporting periods beginning on or after October 1, 2022, IPPS hospitals eligible for DSH and UCC must complete an Exhibit 3C listing to support the amount of total bad debt, or implicit price concessions, reported on Worksheet S-10, line 26.

Comment - Some commenters requested that CMS clarify that the proposed Exhibit 3C is an optional submission or if failure to submit the Exhibit 3C will result in the rejection of the cost report.
Response - The proposed Exhibit 3C listing is not required for an acceptable cost report submission; however, a hospital that receives uncompensated care payments must support the total hospital bad debts claimed on Worksheet S-10. Submission of Exhibit 3C will help reduce requests from Medicare auditors asking the hospital for supporting documentation when reviewing the Worksheet S-10.

Comment - One commenter suggested that the data requested on the listing be the same as the data for the Worksheet S-10 audits while another commenter suggested that CMS abandon the proposed listing and use the Worksheet S-10 bad debt schedules instead.
Response - The Exhibit 3C listing is optional at cost report submission, unlike the Exhibit 3A and Exhibit 3B listings which are required for an acceptable cost report submission, and replaces the listing currently used for Worksheet S-10 audits. Currently, providers submit data in non-standard formats. The proposed Exhibit 3C listing provides the standardized format for a DSH eligible hospital to list the total bad debts that support the amounts claimed on the hospital's cost report. We developed the listing as a result of discussion in the FY 2019 IPPS Final Rule, 83 FR 41681 and 41684 (August 17, 2018), where we agreed to develop standard formats for supporting documentation that correspond to the Medicaid eligible days for a DSH-eligible hospital and the charity care and uninsured discount amounts claimed in the hospital's cost report. The listing represents significant effort to limit required data elements yet provide adequate support for total bad debt amounts claimed in a hospital's uncompensated care cost calculation. The proposed listing calculates the total bad debt write off amounts, something not calculated in the Worksheet S-10 audit bad debt schedules, providing a means to validate the total bad debts reported on Worksheet S-10, line 26.

Comment - A commenter suggested that additional data fields be added such as social security number, date of birth, revenue code and total charges for revenue code for the claim. However, the revenue code could be eliminated if the provider could attest that there are no professional fees included.
Response - We did not add columns to report a patient's social security number, date of birth, in order to decrease the vulnerability of identity theft; nor did we add a column to report revenue codes and total charges by revenue code for each patient as contractors can request revenue code detail as needed when reviewing the listing. Neither did we accommodate the suggestion to require an attestation that the

listing includes no physician/professional charges; we require the physician/professional charges data to determine the total bad debt amount.

Comment - A commenter requested that CMS format the proposed listing to organize data elements in common with the proposed Exhibit 3B in the same order for ease of completion. The commenter also suggested consolidating the proposed primary and secondary payor columns to report the patient's insurance status.
Response - Consistent with revisions to the proposed listings in Exhibits 2A, 3A, and 3B, we rearranged columns so that those columns common to all the listings, i.e., the Last Name, First Name, Date of Service-From, Date of Service-To, and Patient Account Number, appear as the first five columns and in the same order on each listing. We did not combine the primary and secondary payor columns to report the patient's insurance status as the commenter suggested; instead, we clarified the instructions for the insurance column for reporting uninsured and insured status.

Comment - A commenter suggested that CMS require date entries in the MM/DD/YYY format on Exhibit 3C.
Response - The instructions for the proposed Exhibit 3C already describe the required format for entering dates as MM/DD/YYYY.

EXHIBITS 3A, 3B AND 3C

Comment - Commenters suggested that CMS specify that hospitals submit the proposed Exhibits 3A, 3B, and 3C, in the Excel format for ease of data verification and to avoid duplication of data submissions.
Response - In response to comment, we recommend hospitals consult their MAC on the appropriate format for submitting supporting documentation.

BURDEN

Comment - Commenters suggested minimizing burden by limiting Medicare cost report changes to only those necessary and appropriate for efficient administration of the Medicare program. Commenters cited the proposed Worksheet S 12 and the proposed Exhibits 2A, 3A, 3B, and 3C, as imposing significant increased burden.
Response - We added exhibits for DSH, total bad debt and charity care pursuant to the amendments to 42 CFR § 413.24(f)(5) to allow providers a method to streamline submission of data required for an acceptable cost report submission. The data required are data the provider already has available to them for preparation of their cost reports. Facilitating providers' acceptable cost report submissions will save time and resources for providers and help ensure the cost report submission includes all data necessary for the eventual review and cost report settlement process.

We removed the proposed Worksheet S-12 from Form CMS 2552 10.