Trinity Health

July 2, 2020

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Submitted electronically via http://www.regulations.gov

Dear Administrator Verma,

Trinity Health appreciates the opportunity to comment on the proposed policy and payment changes set forth in CMS-1735-P. Our comments and recommendations to the Centers for Medicare and Medicaid Services (CMS) reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 94 hospitals as well as 109 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns $1.1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with graduate medical education (GME) programs providing training for more than 2,000 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 133,000 colleagues, including more than 7,800 employed physicians and clinicians, and have more than 15,000 physicians and advanced practice professionals committed to 16 Clinically Integrated Networks (CINs) that are accountable for approximately 1.5 million lives across the country through alternative payment models.

Trinity Health participates in 11 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes five markets partnering as an MSSP Track 3 ACO. We also have three markets partnering as a Next Generation ACO and 2 participating in CPC+. In addition, we have 33 hospitals participating in the Bundled Payments for Care

Improvement Advanced (BPCIA) initiative, and three hospitals in the Comprehensive Care for Joint Replacement (CJR) program. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

Price Transparency

Trinity Health is committed to working with consumers, payers and policymakers to develop solutions for achieving price transparency. Delivering people-centered care requires consumers have access to meaningful information about the price and quality of their care. Our hospitals are regularly working with patients to provide a deeper understanding of their potential out-of-pocket costs. Depending on the hospital across our 22-state footprint, this is done either via an online price estimator or a call-center. Trinity Health hospitals also post important policies online, including financial assistance and charity care policies.

We continue to have significant concerns with the price transparency requirements as finalized in 2019, as it is incredibly burdensome and does not provide meaningful cost information to consumers.

Trinity Health supports the underlying goal to bring price transparency to patients; however, the regulation does nothing to ensure patients have access to up-to-date and meaningful cost information. Instead, CMS has created a significant new burden for hospitals to publish information, the type and volume of which will be exceptionally challenging for patients to use. Additionally, it will offer little to no insight on what they can expect to pay out-of-pocket for any given service.

Consider the following estimates pulled from our electronic health record platform: the average charge description master (CDM) has 33,000 codes, our average hospital has 50 contracts with insurers, and the average contract has 5 fee schedules. That's a spreadsheet with 33,000 rows and 250 columns—roughly 8.2 million individual rates per hospital.

What's more, this does not take into account codes with multiple rates within a fee schedule-related to bundled services that do not base off of the CDM, such as per diem and case rates. After expending exhaustive time organizing, this information will present patients with millions of data points to scroll through and compare—none of which will provide price transparency by reflecting what they can expect to pay for any given service. Further complicating this issue, CMS expects patients to know which health services may or may not be provided at the time of care.

We are in the midst of a pandemic and have had to divert precious resources to preparing to comply with the price transparency requirements. We expect the challenges of COVID-19 will remain with us throughout the remainder of the calendar year and all resources are needed to address the pandemic. **We urge CMS to delay the implementation date of the final hospital price transparency regulation by one year to January 1, 2022. As an alternative, CMS could require publication of COVID and COVID-related services and allow hospitals additional time to publish broader services since patients aren't seeking elective services during the pandemic. In addition, given the significant requirements, we urge CMS to provide a more detailed example than was provided in the final rule, including cross walking it to different payers to help hospitals refine their scope of work to be compliant.**

Price Transparency and DRG

In order to reduce the Medicare program's reliance on hospital chargemasters and to advance the Administration's goals of market competition, CMS proposes to require hospitals to report certain

market-based information on their Medicare cost reports. Under this proposal, hospitals would be required to report the median charge the hospital negotiated with MA organizations and the median charge the hospital negotiated with all third-party payers (including MA organizations) for each MS-DRG for cost reporting periods ending on or after January 1, 2021. CMS may use this information to revise how it calculates the IPPS MS-DRG relative weights in the future.

In the proposed rule, CMS highlights its concerns that hospital chargemasters do not reflect true market costs and that its reliance on this data to set rates can overstate Medicare payments. CMS proposal presumes that MA and commercial rates reflect competitive negotiations between hospitals and commercial plans, including MA. While this may be the case for some markets and individual hospitals, other factors may contribute to the rates that hospitals set, including whether rates are set based on Medicare fee-for-service or the level of competition (between either hospitals or payors) in the individual hospital's market.

CMS bases its proposal on the premise that MA rates are freely negotiated and reflect competitive market forces. However, many MA-specific rates are set based on Medicare fee-for-service, and therefore are reflective of the existing MS-DRGs.

Without insight into whether commercial rates are reflective of true market-based negotiations, CMS is committing itself to a new metric that could be less accurate than its current methodology. Section 1886(d)(4)(B) requires that the Secretary establish MS-DRG weights that reflect the relative hospital resources within a DRG relative to the average across all DRGs. This proposal may introduce new distortions into the MS-DRG methodology that will result in weights that no longer reflect the resources required to furnish care to the Medicare population.

CMS acknowledges that not all payer-specific charges will be based on MS-DRGs. For example, some hospitals may negotiate charges based on a per diem basis. As a result, hospitals will have to use their own discretion to crosswalk these other rate-setting mechanisms to MS-DRGs, which may not always be feasible. In doing so, hospitals may apply different methodologies, and may introduce new distortions into the rate-setting process.

Additionally, since non-MA commercial plans typically serve a different demographic the general Medicare population, commercial rates may not be truly reflective of the resource utilization needed to care for Medicare beneficiaries, who often have higher complications and comorbidities than the general population. Given that MS-DRG weights are set in a budget neutral manner, this proposal may have the effect of shuffling payments in a less informed and less precise manner.

The current proposal requires hospitals to report median negotiated rates based on MS-DRG, whereas hospitals are required to publicly report standard charges under the final hospital price transparency regulation. As a result, hospitals will likely need to calculate the median based on additional information or to go through a manual process of calculating MS-DRGs based on the price transparency data—CMS grossly underestimates the amount of time this will take.

This is a significant new burden as we are both working toward compliance of the initial price transparency requirements and dealing with the COVID-19 pandemic. For the reasons outlined above, we do not recommend CMS finalize this provision.

Medicare DSH

Determining Pool of Payments

Since FY 2014, hospitals that qualify for Medicare DSH payments receive two separately calculated payments. The first payment equals 25 percent of the amount they would have received under the Medicare DSH formula required by statute prior to the Affordable Care Act. The second payment is based on the remaining 75 percent of the total Medicare DSH payments that would have been paid under the old formula (Factor 1), adjusted by the change in the number of uninsured individuals since FY 2013 (Factor 2). The amount received by a given hospital from this aggregate pool of uncompensated dollars is based upon that hospital's share of national uncompensated care costs using Worksheet S-10 of the Medicare cost report.

Factor 1 is determined by taking Medicare DSH payments from FY 2017 and applying increase factors to estimate FY 2021 DSH payments and multiplying the result by 0.75. The increase factors account for the IPPS update, changes in fee-for-service discharges, case mix and an "other" or residual of all other factors affecting Medicare DSH payments including changes in Medicaid enrollment.

Unemployment began increasing in March of 2020 as a result of businesses being required to close to mitigate the spread of COVID-19 and we expect this economic impact to continue into 2021, thereby increasing Medicaid enrollment. In the proposed rule, CMS indicates that OACT intends to use more recent data that may become available for purposes of projecting the final Factor 1 estimates for the FY 2021 IPPS/LTCH PPS final rule. When updating its estimate for the final rule, **Trinity Health requests OACT consider the impact of the COVID-19 pandemic on Medicaid enrollment for determining Factor 1 of the uncompensated care determination.**

Factor 2 is determined by comparing estimates of the number of uninsured for FY 2021 to the number of uninsured in calendar year 2013, before the Affordable Care Act went into effect. **Similar to our concerns with Factor 1, we urge OACT to update Factor 2 with more timely and accurate data to reflect the increase of uninsured patients in FY2020 and FY2021 as a result of the COVID-19 pandemic.**

Distributing Payments

CMS proposes again to use a single year of uncompensated care data from Worksheet S-10 to determine the distribution of DSH uncompensated care payments for FY 2021. Specifically, CMS proposes using S-10 data from the FY 2017 cost report, which the agency has recently audited. In addition, CMS proposes to use the most recent available single year of audited Worksheet S-10 data to distribute uncompensated care payments in all subsequent years for all eligible hospitals except Indian Health Service and Tribal hospitals.

While we agree using audited FY2017 data makes sense, as it is the first cost report year filed under the updated S-10 instructions, **we continue to recommend CMS use a three-year average to mitigate impact of significant swings from year to year for future years**. We recommend that CMS work to transition back to a three-year average of S-10 data, using FY 2017 as the starting point for the FFY 2021 Final Rule, then FY 2017 and 2018 for the FFY 2022 Final Rule, then FY 2017, 2018, and 2019 for the FFY 2023 Final Rule. Thereafter use a rolling three-year average, as that would help eliminate year-to-year fluctuations and help ensure predictability for CMS rate setting and Provider budget planning.

Chimeric Antigen Receptor T-Cell Immunotherapies (CAR-T)

CMS is proposing to create MS-DRG 018 for CAR-T cell therapy cases.

Trinity Health appreciates CMS' attempt to standardize payment for CAR-T, as the proposed relative weight of 37.1412 better reflects the high costs of therapy and will help compensate hospitals for our costs in delivering necessary care to Medicare beneficiaries. However, this amount falls short of the cost to provide the service. **Trinity Health Recommends CMS establish a payment that at a minimum equals the maximum NTAP + DRG 16 payment, assuming the outlier payments would continue, to reduce losses.**

Proposals to Change the Calculation of the Wage Index

The area wage index is used to adjust Medicare operating and capital payments for geographic variations in labor costs. CMS proposes to continue its low-wage-index hospital policy as established in the FY 2020 final rule. Specifically, for hospitals with a wage index value below the 25th percentile, the agency would continue to increase the hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals. As it has done previously, the agency would reduce the FY 2021 standardized amount for all hospitals to make this policy budget neutral.

Trinity Health recognizes the need for policies to help support rural hospitals and the communities they serve. **We continue to urge the Department of Health and Human Services and Congress to develop a comprehensive, long-term approach to help these facilities in lieu of maintaining the wage index policy finalized in the FY20 IPPS rule.**

As disparities among geographic regions and challenges faced by rural hospitals continue to grow, **HHS should work with Congress to create a new designated pool of funding for low-wage hospitals that is not subject to budget neutrality.**

GME

Medicare regulations permit hospitals to temporarily transfer a portion of its hospital-specific direct GME and indirect medical education FTE resident caps to other hospitals when a teaching hospital closes or ends a residency program.

The proposed rule modifies the definition of "displaced resident" to be based on the day that the closure was publicly announced, rather than solely those who were physically present on the day prior to or the day of hospital closer. In addition, CMS proposes to consider as "displaced" those residents that were not physically present at the closing program/hospital.

Trinity Health supports this proposal, as this will provide more flexibility for residents and is an equitable solution to issues impacting both residents and new host hospitals.

Promoting Interoperability Programs (PIPs)

CMS includes a number of policies related to these programs in the 2021 proposed rule, including:

- an EHR reporting period of a minimum of any continuous 90-day period in CY 2022 for new and returning participants (eligible hospitals and CAHs);
- maintaining the Electronic Prescribing Objective's Query of PDMP measure as optional (was finalized as mandatory in prior rulemaking)

Trinity Health is supportive of both of these changes, particularly maintaining the Electronic Prescribing Objective's Query of PDMP measure as optional. PDMPS are still maturing and are not consistently integrated broadly into EHR workflow.

Hospital Quality Reporting and Value Programs

Inpatient Quality Reporting (IQR)

CMS retains the current IQR measure set, but proposes significant changes to the program's electronic clinical quality measure (eCQM) reporting requirements, including:

- requiring the use of electronic file submissions via a CMS-approved secure file transmission process and will no longer allow the submission of paper copies of medical records or copies on digital portable media (e.g. flashdrive)
- changing to the data validation process, including reducing the maximum number of hospitals selected for validation from 800 to 400.
- increasing the number of quarters for which hospitals are required to report eCQM data, from the current requirement of one self-selected calendar quarter of data, to four calendar quarters of data, over a 3-year period
- Publicizing eCQM measure results publicly in late 2022, starting with data from CY 2021.

Trinity Health supports the changes to the eCQM data validation process, including the reduction of the maximum number of hospitals selected from 800 to 400 and conducting education reviews with eCQM validation in alignment with chart-abstracted validation results feedback.

We do not recommend finalizing the proposal to increase eCQM reporting requirements to a full year by CY2023. Currently, the stability of the submission process and the ability for the timely transmission of data is a barrier. Many of the 150 hospitals that voluntary reported in 2019 found their data to be incomplete and have had to aggressively remap clinical data elements and institute changes in workflow to ensure complete and timely claims data. In addition, reporting for a full year will increase the amount of storage for the QRDA-1 files.

Deadline to report would also coincide with full year reporting of additional measures, including the Hybrid Hospital-Wide 30-Day Readmission measure which compares electronic clinical data elements along with the claims data. **Prior to finalizing this proposal, CMS should work to improve the submission process and ensure it doesn't increase provider burden.**

Trinity Health opposes public reporting of the eCQM data at this time. Most of the measures require a full-year of data to be reliable. As a result, given the shortened data period we are concerned that many of the measures may not be reliable. Additionally, as CMS acknowledges in the preamble, additional quarters of data are needed to capture meaningful trends in performance overtime. Publishing the existing data will be of limited use and may cause greater confusion for stakeholders. In addition, chart abstracted measures and eCQM measures are not aligned and improvements need to be made before this can be reported publicly in a meaningful way. **As a result, we recommend that CMS hold off publishing eCQM data until data improvements are made.**

Major Complication or Comorbidity (MCC) or Complication or Comorbidity (CC) Subgroups

CMS is proposing to apply the criteria for creating a subgroup under a base MS-DRG to the non-complication or comorbidity (NonCC) subgroup.

MS-DRGs contain base DRGs that are subdivided into one, two, or three severity of illness levels. To determine if the creation of a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within a base MS-DRG is warranted, CMS evaluates the following criteria:

- A reduction in variance of costs of at least 3 percent;
- At least 5 percent of the patients in the MS-DRG fall within the CC or MCC subgroup;
- At least 500 cases are in the CC or MCC subgroup;
- There is at least a 20 percent difference in average costs between subgroups; and
- There is a $2,000 difference in average costs between subgroups.

In order to warrant creation of a CC or MCC subgroup within a base MS-DRG, the subgroup must meet all five of the criteria.

For FY2021, CMS is proposing to expand the previously listed criteria to also include the NonCC subgroup. CMS believes that applying these criteria to the NonCC subgroup would better reflect resource stratification and also promote stability in the relative weights by avoiding low volume counts for the NonCC level MS-DRGs.

Trinity Health is concerned the proposed principles are limited and restrictive and would be more applicable to MCCs than CCs.

Provider Reimbursement Review Board Electronic Filing

CMS invites comments on the PRRB's planned mandatory use of the electronic filing system for appeals. CMS is revising various definitions to align with mandatory electronic filing, including the term "date of receipt".

While CMS is considering the changes to align with the mandatory use of electronic filing, **the provider is allowed only one representative for all appeal-related communications, and doing so electronically relies on that representative receiving the e-mail communications from the PRRB.**

If the representative were to terminate employment with the provider, with the old paper system any notice sent by the PRRB to the provider would be in the form of a hard-copy certified letter, which would still be received by someone at the provider. In the new electronic system, any notices would be delivered to the dead e-mail box of the representative, with no one at the provider actually receiving the notice.

When evaluating changes necessary to move to a mandatory electronic filing system, please consider this type of situation, and options to address it, such as monitoring by the PRRB of automated responses "out-of-office" or "non-delivery", so that a hard-copy letter to the provider's CEO or CFO could follow in that circumstance, to ensure delivery of notices actually occur. A provider's appeal rights should not be jeopardized by faulty service of notice of due dates and other correspondence.

Bad Debt/Other Changes

Proposed Changes for Hospitals and Other Providers

Medicare bad debts have long been governed by the Provider Reimbursement Manual (PRM) provisions. CMS now proposes to codify in the regulations the PRM provisions related to bad debts, along with their interpretation of these provisions.

The Bad Debt Moratorium Remains Effective For Cost Reporting Periods Beginning Prior To October 1, 2012 and Bars Retroactive Changes in Medicare Bad Debt Policy For Cost Reporting Periods Beginning Prior To That Date

CMS accurately states that the Bad Debt Moratorium was repealed for cost reporting periods beginning on or after October 1, 2012. 85 Fed. Reg. 32866. CMS states, however, that "the bad debt moratorium is no longer in existence." *Id*. This statement is inaccurate because the Bad Debt Moratorium remains in force for cost reporting periods beginning prior to October 1, 2012.

Apparently overlooking that the Bad Debt Moratorium remains effective for cost reporting periods prior to October 1, 2012, CMS proposes to amend certain provisions of the bad debt regulation with retroactive effect. "We are proposing that the clarification and codification of our longstanding Medicare bad debt policies, where indicated herein, be effective for cost reporting periods *beginning before, on, and after the effective date of this rule*, because of the important public interest it would serve to do so as set forth in section 1871(e)(1)(A)(ii) of the Act." 85 Fed. Reg. 32866 (Emphasis added).

CMS rationalizes this proposal as follows:

> The clarification and codification of longstanding Medicare bad debt policies into the regulations with a retroactive effective date does not affect prior transactions or impose additional duties or adverse consequences upon providers or beneficiaries, nor does it diminish rights of providers or beneficiaries. The clarification and codification of longstanding Medicare bad debt policies into the regulations with a retroactive effective date also serves an important public interest to assist providers and beneficiaries by avoiding confusion as to which longstanding policy should be applied for which cost reporting period, as might arise if the effective date was instead proposed for cost reporting periods beginning on or after the effective date of this rule.
>
> 85 Fed. Reg. 32866.

The proposal, however, ignores that the Bad Debt Moratorium remains in effect for cost reporting periods beginning prior to October 12, 2012. The United States District Court for the District of Columbia has explained as follows that the Bad Debt Moratorium applies to any Medicare bad debt policy changes made either by the Secretary or by a provider:

> The Bad Debt Moratorium, thus amended, imposes a two-pronged restriction on the Secretary: "First, the Secretary is prohibited from making any changes to the agency's bad debt policy in effect on August 1, 1987. Second, the Secretary is prohibited from requiring a provider to change bad debt policies it had in place on August 1, 1987." Dist. Hosp. Partners, L.P. v. Sebelius, 932 F. Supp. 2d 194, 198 (D.D.C. 2013) (internal citations omitted).

Winder HMA LLC v. Burwell, 206 F.Supp. 3d 22 (D.C.D. 2016).

Thus, the Bad Debt Moratorium bars CMS from making any changes in bad debt policy for cost reporting periods beginning prior to October 1, 2012.

Finally, retroactive rulemaking has been invalidated by the federal courts. The lead case, *Bowen v. Georgetown Univ. Hosp,* 488 U.S. 204 (1988) held that a retroactive rule must be supported by the Medicare Act. No provision of the Medicare Act supports the proposed retroactive promulgation of the bad debt regulation. CMS should also recall the decision in *Mason General v Sec of HHS*, 809 F.2d 1220 (6th Cir. 1987), which held that retroactive application of the 1986 Malpractice Rule was unlawful.

Requiring Similar Collection Efforts for Non-Medicare Payors Is Inconsistent with Case Law And Is Not Sound Policy

CMS proposes to require a provider to use similar bad debt collection efforts for Medicare and other payors. For example, if a provider uses a collection agency for non-Medicare bad debt it must use a collection agency for Medicare bad debt.

First, this requirement is inconsistent with case law resulting from provider challenges to this very policy. See, e.g., *Detroit Receiving Hospital v. Shalala*, 194 F.3d 1312 (6th Cir. 1999) (holding that Bad Debt Moratorium barred change in policy), *Mercy General Hospital v. Azar*, 410 F.Supp.3d 63 (D.D.C. 2019).

Even if this policy is applied prospectively, it entirely overlooks that the Medicare population is comprised of an elderly, indigent and minority population, which should not necessarily be subjected to conventional collection efforts.

Further this policy is unlikely to result in meaningful collections since it is highly unlikely that the Medicare population has the ability to satisfy bad debt, notwithstanding suffering the rigors of collection practices.

The Proposed Indigent Bad Debt Policy Is Inconsistent Judicial Interpretation

CMS proposes to codify the guidelines in Section 312 of the Provider Reimbursement Manual ("PRM") regarding indigent bad debt. PRM Section 312.B, referred to as the "total resources test," provides as follows:

> The provider should take into account a patient's total resources, which would include, but are not limited to, an analysis of assets (only those convertible to cash and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis, the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence

To date, two federal district courts have invalidated the "total resources test." *Harris County Hospital District v. Shalala,* 863 F. Supp. 404, 412 (S.D. Tex. 1994); *Baptist Healthcare System v. Sebelius*, 646 F. Supp. 2d 28 (D.D.C. 2009)

Consistent with these judicial determinations, CMS should refrain from adopting the total resources test. Note as stated in PRM 312.B, this requirement is a permissive, *i.e.*, it is phrased as "should." The federal courts have rejected the interpretation of CMS that "should" means "shall." **If CMS in fact codifies the "total resources test," it should remain permissive, not mandatory.**

The Proposed Crossover Policy Is Irrational and Inconsistent with Judicial Interpretation And Requires An Exercise In Futility

In the section discussing the CMS "must-bill" policy for dual eligible (Medicare/Medicaid) patients, CMS is codifying in the regulations the existing Joint Signature Memo (JSM) 370 guidance, that in the case of dual eligible patients, the Provider must bill Medicaid for the Medicare deductible/coinsurance and obtain a Medicaid remittance as evidence of the amount Medicaid has or has not paid toward the Medicare deductible/coinsurance. **This has been the subject of litigation for a number of years. The JSM 370 did not go through notice and comment rulemaking, and this current FFY 2021 IPPS proposed rule is not affording the commenters the proper background and reasoning behind the proposal, but rather couching it in terms of a "longstanding policy" and as required by the PRM 312, which PRM 312 does not explicitly state that a bill to the state Medicaid program is required.** In the PRRB decision, *Various Genesis Health Care Corporation Providers vs. BCBSA/Highmark Medicare Services*, PRRB Dec. No. 2011-D12 (issued December 2, 2010), the PRRB's reading of CMS Pub 15-1, section 312, focused on the use of the word "Otherwise", which "… effectively makes the application of the guidelines applicable to patients other than dually eligible beneficiaries." The PRRB points to CMS Pub 15-1, section 322 as controlling where "… deductible and coinsurance amounts are not covered by Medicaid may be claimed as Medicare bad debts…." The Board concluded in their decision and order that the "… absolute 'must bill' policy has no foundation in law or regulation and is beyond the requirements of the regulations and manuals." The Administrator overturned the PRRB decision, focusing on the need for a provider to bill the State in order to demonstrate that the amount is unpaid and uncollectible from the responsible party when considered worthless. For proper Notice & Comment rulemaking to occur in this proposed rule, this is the type of discussion that needs to be had, not language telling the reader/commenter that this proposal is merely codifying "longstanding" existing rules and guidance.

The procedural validity of the must bill policy recently was called into question in light of the decision of the United States Supreme in *Azar v. Allina Health Services*. *Select Specialty Hosp.-Denver, Inc. v. Azar*, No. CV 10-1356 (BAH), 2019 WL 5697076, at *4 (D.D.C. Nov. 4, 2019).] Following the *Allina* requirement that CMS comply with notice and comment rulemaking, the *Select Specialty Hosp. Denver* court held that the policy was required to be codified.

Retroactive rule making does not necessarily cure the procedural defect. As noted above, the Bad Debt Moratorium remains effective for periods prior to October 1, 2012. And, CMS lacks either statutory or "public interest" support for such retroactive rule making.

Even if the procedural defect could be cured via codification, however, the must bill policy always has been and remains irrational. In most instances, the Medicaid program has no secondary liability, and thus this process places form over substance. No interest is served by requiring a provider, as well as the Medicaid program, to undergo the time, effort and cost to prove what in the overwhelming majority of cases is the obvious, i.e., that the Medicaid program has no liability for the bad debt.

In the section discussing reasonable collection efforts, CMS states "the provider's collection effort may include using or threatening to use court action to obtain payment." Nowhere does the proposed rule that mentions IRS section 501(r)(6), where the IRS limited the use of Extraordinary Collection Actions (ECAs), and recommend that CMS take into account the IRS rules which also impact non-profit healthcare facilities. In the example given by the IRS on 79 FR 79012, the provider

had to wait until the end of the Notification Period (120-days from first post-discharge billing statement) to give a written notice that ECAs would begin no sooner than 30-days from the written notice date, total of 150-days. The ECA used in the example was a lawsuit in court. Therefore, per the IRS 501(r)(6), court action would not be reasonable before 150-days, and Medicare bad debts can be claimed after 120-days. I would caution that MACs not read the CMS statement that reasonable collection effort may include court action as giving them leave to question why court action is not pursued in any particular case.

In the section discussing timely billing to patients of their cost sharing amount, CMS proposes a time frame of 120 days after receipt of the Medicare remittance. For most cases, that is a reasonable timeframe, and as CMS points out, they "… have found that to be the upper parameter of most providers' billing practices…." **We would recommend that an exception be included for the cases of uncooperative patients, where obtaining secondary insurance information, or a completed charity application delay the process.**

Accounting Standard Update Topic 606 and Accounting
In this section, CMS discusses two related items, updating terminology to match the FASB ASC Topic 606 related to bad debts and to clarify and codify how hospitals should account for bad debts on their general ledger. The FASB ASC Topic 606 is focused on revenue recognition rules, not just for healthcare providers, but for all industries. The FASB wants bad debts taken into account as part of revenue recognition. CMS also states in the proposed rule that bad debts are to be viewed as a reduction in revenue, that it is not a cost of providing services. However, as CMS transitions to the accounting for Medicare bad debt and insisting that any bad debt included in contractual allowance would not be allowed, they continually state that bad debts must be written off to a bad debt "expense" account. CMS states that it will amend section 413.89(c) to add paragraph (c)(3) to specify "… Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts." **To aid in eliminating any confusion, we request that in the FFY 2021 IPPS Final Rule, that CMS expand its discussion of this topic and provide further clarification of just where the bad debt adjustment should be recorded in the general ledger, since being an "expense" would not comply with FASB ASC Topic 606 revenue recognition, nor be consistent with the CMS comment that bad debts are a reduction in revenue.**

Conclusion
We appreciate CMS's ongoing efforts to improve payment systems across the delivery system. If you have any questions on our comments that follow, please feel free to contact me at granttw@trinity-health.org or 734-343-1375.

Sincerely,

Tina Weatherwax Grant, JD
Vice President, Public Policy and Advocacy