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Association

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August 21, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Document Identifier CMS-2552-10, Hospital and Health Care Complexes Cost Report and Supporting Regulations

Dear Ms. Frizzera:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed modifications to the Medicare hospital cost report, Form 2552-10, published in the July 2 *Federal Register*.

The AHA appreciates CMS' efforts to improve the quality of the data being reported and eliminate the collection of outdated information. While we support a number of the proposed revisions to the cost report, including the simplification of the settlement worksheets (Worksheet E-3 series), we are concerned that the proposed revisions are less than comprehensive in nature and require certain data that are virtually impossible for hospitals to provide. **The AHA continues to advocate that CMS perform a comprehensive review of its data collection practices and modify the cost report to allow hospitals to report information in a manner that is fully aligned with current hospital protocols and reimbursement methodologies.**

In addition, as stated in our prior comments on the inpatient and outpatient prospective payment system (PPS) rules, such comprehensive cost report reform must be conducted in collaboration with the hospital field. We are disappointed CMS failed to work with the hospital field from the outset on its proposed changes to the cost report. Efforts to revise or replace the cost report should be mutual. We are ready to work with CMS on comprehensive cost report reform and urge CMS not to conduct such reform in a unilateral manner as the agency has done with Form 2552-10.

Below are our detailed comments on CMS' proposed modifications to the cost report.



ELIMINATING WORKSHEETS NO LONGER USED FOR MEDICARE REIMBURSEMENT PURPOSES

CMS proposes to eliminate certain worksheets related to Medicaid reimbursement in various states from the cost report. Specifically, the agency would eliminate Worksheet C, Part II (capital) and Worksheet D-1, Title 19 (skilled-nursing facility limits) that flow to the Medicaid settlement page (Worksheet E-3, Part VII), which would be maintained. Unless a state Medicaid program matches the Medicare program exactly, Worksheet E-3, Part VII would then be inaccurate. Therefore, hospitals in affected states would need to utilize two versions of the cost report software to prepare and submit their reports – one set for the CMS-approved version, and another set that would have to be created for the state-specific version.

For example, Florida uses Worksheet D-1, Title 19 to calculate observation bed per-diem; it does not use Worksheet D-1, Title 18 (which is retained in the proposed cost report) to do so. In addition, New Hampshire, South Carolina, Texas and Vermont use Worksheet C, Part II to reduce capital payments.

We are concerned that eliminating cost report worksheets that are no longer used for Medicare reimbursement purposes, but are still important for Medicaid reimbursement in various states, will cause unnecessary burden to both the hospitals and the states that have relied on the reporting and collection of this information for many years. The AHA is not asking CMS to create new forms to meet each and every state's Medicaid data collection needs, but the elimination of instructions and worksheets that already exist causes an unnecessary hardship that can be avoided. **We urge CMS to examine how the states use the Medicare cost report for Medicaid reimbursement purposes and then retain those worksheets that the states use.**

CREATING A SELF-CONTAINED MEDICARE DISPROPORTIONATE SHARE HOSPITAL WORKSHEET

The disproportionate share hospital (DSH) data elements on the hospital cost report are used in determining hospital reimbursement, and, as such, are important elements of the cost report. However, the data elements used for the Medicare DSH calculation currently are found on two different worksheets in the cost report, with the actual calculation of the Medicare DSH percentage completed “off the cost report,” as the details of the calculation are referenced only in the instructions and not included in the forms. Calculating such an important reimbursement element “off the cost report” obscures this important information and is not fully transparent. Although not included in CMS' proposed changes to the hospital cost report, **the AHA recommends that CMS create a new worksheet to capture all of the DSH data elements in one place, as well as provide for a complete calculation of a hospital's Medicare DSH percentage.**

INCORPORATING CMS FORM 339 INTO THE COST REPORT

When submitting their cost reports, hospitals must submit Form 339 – the Provider Cost Report Reimbursement Questionnaire – that is intended to ensure that the appropriate worksheets on the

cost report are completed, as indicated by the responses to the questionnaire. This form also contains accompanying exhibits that are intended to provide supporting documentation of information contained in the cost report and could be used as part of the audit process.

CMS proposes to eliminate Form 339, but would still require hospitals to report most of the information that it contains. The agency does so by incorporating parts of Form 339 into a proposed new worksheet – Worksheet S-2, Part II – and by requiring the submission of additional schedules that are described only in the instructions and are not part of the cost report forms. These schedules mimic the current Form 339 exhibits and, per the instructions, are to be submitted either electronically or in hard copy.

The exhibits that are part of Form 339 are intended to provide supporting documentation to the auditors related to information being reported in the cost report and could be used as part of the audit if deemed necessary. However, the auditors also may determine that they have already reviewed adequate supporting documentation, making the exhibits irrelevant. **Therefore, the AHA suggests that the additional schedules that mimic the current Form 339 exhibits should not be required to be submitted with the cost report.** Instead, the instructions should indicate that the information contained in the schedules may need to be made available upon request at the time of audit, if they are pertinent to the data contained on the cost report. If CMS is unwilling to make this change, either the additional schedules should be made part of the cost report forms, rather than only being described in the instructions, or Form 339 should not be eliminated. CMS' proposed approach of describing these additional schedules only in the cost report instructions and not including them in the cost report forms will likely result in data inconsistencies and an increased incidence of cost report rejection.

In addition, if hospitals claim Medicare bad-debt reimbursement, they currently must submit Exhibit 5. **Although not included in CMS' proposed cost report changes, the AHA recommends that the Form 339 bad-debt exhibit be handled in a manner similar to the intern and resident information system (IRIS) diskette.** That is, we suggest this exhibit remain separate from the cost report. With this exhibit specifically, describing it only in the cost report instructions and not including it in the cost report forms will lead to an inconsistent review and approval of bad-debt reimbursement by the auditors. In addition, we request that CMS clearly state in its instructions to the auditors that hospitals are required to provide only the information that is specifically requested in Exhibit 5 in order to obtain reimbursement for bad debts – auditors should not be able to require additional information.

Finally, the AHA encourages CMS to update the software that is used to complete and transmit the IRIS diskette. The software is outdated and does not work well in today's electronic environment.

COMMENTS ON SPECIFIC WORKSHEETS

Hospital and Hospital Health Care Complex Identification Data – Worksheet S-2, Part I. CMS proposes to add lines 21 and 22 on Medicaid days to Worksheet S-2, Part I. However, the purpose of these lines is not explained in the accompanying instructions, and they do not flow to any other worksheets, such as Worksheet E, Part A, line 28, which captures Medicaid days that are used in the DSH calculation. **The AHA suggests that CMS clarify the purpose of these data and their potential relationship to the DSH calculation.** In addition, in the proposed hospital cost report, the instructions for Worksheet S-2, Part I, lines 21 and 22 (Medicaid days) and Worksheet S-3, Columns 5-7 (as it relates to the reporting of Medicaid days), do not provide consistent definitions of Medicaid days. **We urge CMS to provide a consistent definition of Medicaid days between these two worksheets.**

Finally, as a result of moving data into different worksheets, two cross-reference errors are contained in Worksheet S-2, Part I on the proposed Form 2552-10. First, line 37 should reference Worksheet E-4, not Worksheet E-3, Part IV. Second, line 38 should reference Worksheet D-5, not Worksheet D-4. CMS should correct these two errors.

Hospital Wage Index Information – Worksheet S-3, Part II. CMS proposes to add an instruction to Worksheet S-3, Part II, Line 28, that appears to represent a significant change in policy. Specifically, CMS proposes to clarify that home office contract labor cannot be added to contract administrative and general costs for the wage index. However, this new instruction unduly penalizes hospitals with home office costs, as they will not be able to claim legal, consulting and similar fees paid by the home office. In contrast, freestanding hospitals paying those costs can claim them directly for wage index purposes. By stating that home office contract labor cannot be added to contract administrative and general costs for the wage index, CMS would essentially force hospital systems to contract for administrative and general services at the individual hospital level if they wanted to claim the costs for wage index purposes. However, home offices can typically contract for these services at a lower rate than individual hospitals in a system, which saves money for the system, and ultimately for the Medicare program. **Therefore, the AHA requests that CMS remove this proposed new instruction from the cost report.**

New Contract Labor and Benefit Cost Worksheet – Worksheet S-3, Part V. CMS proposes to create a new worksheet – Worksheet S-3, Part V – that requires hospitals to report separately the amount of their contractor costs that are attributable to labor and the amount attributable to benefits. However, this information is not collected as part of hospitals' normal business activities – hospitals pay contractors a flat rate and are not privy to what portion is attributable to labor and what portion is attributable to benefits. Contractors themselves are likely unable to accurately determine this division, making this information virtually impossible for hospitals to collect. Further, it does not affect the level of allowable costs being reported on the cost report, and the purpose of collecting it is otherwise unclear. **Therefore, the AHA urges CMS to eliminate this proposed worksheet from the 2552-10 cost report.**

Home Health Agency Statistical Data – Worksheet S-4. CMS does not propose changes to the “PPS Activity Data” section of Worksheet S-4 on home health agency statistical data. However, the AHA recommends that CMS eliminate columns 5 and 6 under the “PPS Activity Data” section that begins on line 21. The significant change in condition (SCIC) episode types were eliminated when the home health PPS was revised, effective January 1, 2008.

Provider-based Rural Health Clinic/Federally Qualified Health Center Provider Statistical Data – Worksheet S-8. The proposed Worksheet S-8 form and instructions are not consistent from lines 10 and forward. We recommend that CMS align the form and instructions for this worksheet.

Hospital Uncompensated Care Data – Worksheet S-10. To improve the data it collects on hospital uncompensated care, CMS proposes major changes to the hospital uncompensated care worksheet – Worksheet S-10. In general, the AHA supports CMS’ proposed changes, which provide for a more logical worksheet. However, it is imperative that this worksheet accurately capture the level of uncompensated care that hospitals are providing, as well as ensure that the data are reported in a consistent manner. Therefore, we wish to make several specific recommendations to help CMS attain this objective.

On the existing cost report, CMS includes the unreimbursed costs of state and local indigent care programs, the Children’s Health Insurance Program (CHIP) and Medicaid in its determination of the hospital’s total uncompensated care cost. However, for the proposed S-10 Worksheet, these costs (in lines 8, 12 and 16) are not included as part of the total on line 30. CMS includes only the costs of charity care and non-Medicare bad-debt expense in its determination of the hospital’s total uncompensated care cost. **The AHA is extremely concerned that CMS has removed the unreimbursed costs of state and local indigent care programs, CHIP and Medicaid from the “bottom line” of this worksheet.**

We urge CMS to add a line at the bottom of Worksheet S-10 that reflects the hospital’s total unreimbursed and uncompensated costs. This line should include all of the subtotal components of program unreimbursed costs (lines 8, 12 and 16), charity care costs (line 23) and bad-debt costs (line 29) that are determined throughout this worksheet.

Line 1 of Worksheet S-10 calculates a cost-to-charge ratio (CCR) that is then applied to charge data throughout the worksheet, including to charges for charity care (line 19) and non-Medicare bad debt (line 28), in order to reduce charges to cost. This CCR is based on data from Worksheet C and includes only Medicare-reimbursable costs. However, the CCR that is applied to charity care and non-Medicare bad-debt charges should include a hospital’s full costs, rather than only Medicare-reimbursable costs, as the vast majority of charity care is provided to non-Medicare patients, and non-Medicare bad debt is, by definition, never incurred for a Medicare beneficiary. Use of a CCR that does not include a hospital’s full costs understates the true costs of providing charity care and non-Medicare bad debt. **Therefore, we urge CMS to add line 1.01 to Worksheet S-10, which would calculate a second CCR that includes a hospital’s full costs and would be applied to lines 19 and 28.** We suggest this CCR be calculated as follows:

Numerator: Total costs obtained from Worksheet A, Column 3, lines 1-98, less physician patient care costs obtained from Worksheet A-8, Line 10. We suggest CMS add a line to Worksheet A, Column 3 that calculates a subtotal of lines 1-98.

Denominator: Total charges obtained from Worksheet C, Column 8, Line 200 (which already excludes physician patient care charges).

The proposed Worksheet S-10, lines 2 through 8, capture data on the unreimbursed costs of the Medicaid program. However, CMS proposes to allow hospitals to either include Medicaid DSH payments and other supplemental payments with the actual Medicaid patient payments on line 2, or to report them separately on line 5. We believe that all hospitals have the ability to separately track and account for this information. Therefore, to help ensure consistency and uniformity, **the AHA recommends that CMS require Medicaid DSH and supplemental payments be reported separately on Worksheet S-10.** In addition, CMS should clarify on the cost report form that Medicaid revenues should include managed care revenues. To accomplish this, we suggest that the Medicaid lines be modified as follows:

- Line 1: Cost to charge ratio.
- Line 2: Medicaid net revenues for patient services, including managed care net revenues. (Do not include payments reported on lines 3 and 4 below.)
- Line 3: Medicaid DSH payments.
- Line 4: Medicaid supplemental payments, not including DSH payments.
- Line 5: Total Medicaid net revenues (sum of lines 2-4).
- Line 6: Medicaid charges.
- Line 7: Medicaid costs (line 1 times line 6).
- Line 8: Difference between net revenues and costs for Medicaid services (line 5 minus line 7).

In addition, we recommend that the instructions for line 2, Medicaid net revenues, clarify that that line should include both inpatient and outpatient payments as indicated in the opening paragraph of the instructions.

As proposed by CMS, lines 8, 12 and 16 are identified as the “difference between revenues and costs” for Medicaid, CHIP, and state or local indigent care programs. We suggest CMS modify these lines to state they are the “difference between net revenues and costs.” This modification would make these lines consistent with line 2, clearly differentiate between payments (net revenues) and charges (gross revenues), and help ensure consistent reporting.

In the proposed cost report form, line 13 is for payments from “state or local indigent care programs.” However, the proposed instructions say this line is only for payments from “state or local government programs.” We suggest CMS specify in the instructions that this line is for payments from “state or local government indigent care programs,” to ensure that the correct payments are included.

To help ensure consistent reporting, we recommend CMS state in the instructions that the government grants, appropriations and transfers that are reported on line 18 should not include those already reported on lines 2, 3 and 4 (under our recommended revised lines above), or 13. In addition, since the Federal Section 1011 program was not reauthorized, the reference to this program should be removed from the instructions to line 18.

CMS proposes to calculate the cost of charity care in lines 19 through 23. This calculation requires that a hospital maintain information on the total initial obligation/charge for the patient, whether or not the patient was approved for full or partial charity care, any patient payments that have been made, and whether or not the patient has insurance. However, the data in a hospital's accounting system/general ledger does not capture this information. Therefore, hospitals cannot capture the data required for lines 19 through 23 unless they begin to maintain a detailed charity-care log for all patients for which charity care has been approved – a task that is extremely difficult and burdensome.

The Internal Revenue Service, Form 990, Schedule H, requires that charity care be reported as the amount of charity care charges the hospital has “written off.” This is consistent with hospitals' accounting systems/general ledgers, which include data on the amount of charity care charges the hospital has written off for a particular account. Hospitals collect data in this manner to comply with generally accepted accounting principles that require accounting for charity transactions separately from bad debts, contractual allowances and other deductions from revenues ledgers. The charity care charges a hospital has written off are the actual portion of a patient's charges that have been approved for charity care and by definition, do not have any patient payments associated with them since any patient payments are for the portion of the account that was classified as self-pay or third-party payer. For example, if a patient incurs \$1,000 in charges and is approved for 75 percent charity care, then the hospital will write off \$750 in charges.

Thus, CMS' proposed method of calculating the cost of charity care by starting with data on the patient's total initial obligation/charge is virtually impossible for hospitals to report. Further, it is inconsistent with other Federal government charity care data collection instruments. **The AHA urges CMS to calculate charity care costs by starting with the amount of charges a hospital has written off. This modification would help streamline and unify charity care reporting across the Federal government, ensure consistency of reporting, and avoid significantly increasing hospitals' administrative burden.**

In addition, CMS does not delineate the purpose for differentiating between the proposed line 19 (charity care related to the entire facility) and the proposed line 20 (charity care related to Section 1886(d) hospitals or critical access hospitals). As indicated above, few hospitals differentiate the type of charity care incurred in their general ledgers and will, in most cases, have one account for all of their patients.

We urge CMS to modify lines 19 through 23 as follows:

- Line 19: Total charity care charges written-off (as accounted for in the hospital's general ledger)
Line 20: Total charity care costs written-off
(Line 1.01 times Line 19)
Line 21-23: Delete.

Trial Balance of Expenses – Worksheet A. CMS proposes to redesignate line 90 (other capital-related costs) as line 3. However, costs on this line are reclassified to lines 1 or 2 prior to flowing to Worksheet B. We recommend CMS eliminate line 3 and instead instruct hospitals to include these costs on line 1 and 2, as appropriate.

Although CMS does not propose changes to the types of non-reimbursable cost centers that are listed beginning on line 190, the AHA recommends CMS update and possibly expand these cost centers to reflect the more current and common types of non-reimbursable costs that hospitals incur. We acknowledge that additional costs can be manually added as non-reimbursable cost centers, but it would be useful for CMS to incorporate the more common situations and/or those that cause the most confusion into the cost report. For example, marketing and fundraising are very common non-reimbursable costs, but are not listed.

In addition, in the fiscal year (FY) 2009 final inpatient PPS rule, CMS adopted a change to the cost report that would split the cost center of “Medical Supplies Charged to Patients” into two cost centers – one for relatively inexpensive medical supplies and another for more expensive devices (such as pacemakers and other implantable devices). While CMS finalized this change to the cost report in the FY 2009 final inpatient PPS rule, it only recently incorporated the change into the current version of the cost report – Form 2552-96. There was no opportunity to comment on this change, which now carries forward into the proposed Form 2552-10 on Worksheet A, lines 68 and 69. The instructions accompanying this change in both Form 2552-96 and Form 2552-10 make the assumption that the information for lines 68 and 69 is obtained from the statistical allocations performed on Worksheet B. We disagree with this assumption. Hospitals have reported to us that most of them would capture this information either by using specific hospital records (the general ledger) or accounting for these costs through a reclassification process using Worksheet A-6. **The AHA urges CMS to modify the instructions for Worksheet A, lines 68 and 69 accordingly, not only to provide clarity to hospitals, but also to ensure that the auditors understand how the information is obtained.**

When CMS adopted the change to split the “Medical Supplies Charged to Patients” cost center into two, the agency specified that revenue codes 0275 (pacemaker), 0276 (intraocular lens), 0278 (other implants) and 0624 (FDA investigational devices) should be reported in the “Implantable Devices Charged to Patients” cost center and all other supply revenue codes should be reported in the “Medical Supplies Charged to Patients” cost center. In the instructions regarding the split of the “Medical Supplies Charged to Patients” cost center into two that were put forth in Form 2552-96, CMS included a reference to the FY 2009 final inpatient PPS rule,

which listed the specific revenue codes above. However, the proposed instructions for Form 2552-10 do not contain that reference. **For consistency, the AHA urges CMS to detail the specific revenue codes that should be reported in line 68 and line 69 in the Form 2552-10 cost report instructions.**

Reconciliation of Capital Cost Centers – Worksheet A-7. **The AHA recommends that the agency eliminate Worksheet A-7.** This worksheet is complex, time consuming and no longer provides relevant data in the current reimbursement environment. However, if CMS is not willing to eliminate Worksheet A-7, it should again include Column 10 (which it had proposed to eliminate) in Worksheet A-6, because Worksheet A-7 uses the data in that column.

Adjustments to Expenses – Worksheet A-8. CMS proposes to incorporate Worksheet A-8-4 into Worksheet A-8-3, but did not eliminate all references to Worksheet A-8-4 that are in Worksheet A-8. Therefore, the AHA recommends that CMS change all references to Worksheet A-8-4 that are contained in Worksheet A-8 (see lines 23, 24, 30 and 31) to reference Worksheet A-8-3.

Provider-based Physician Adjustments – Worksheet A-8-2. The AHA recommends that the agency indicate on the Worksheet A-8-2 form, in Column 2, that the physician identifier should be an alphabetic code (as described in the instructions) to avoid any possibility that the physician might be identified on the worksheet itself.

Computation of Inpatient Operating Cost – Worksheet D-1. Worksheet D-1, lines 28 through 37, calculate the “Private Room Differential Adjustment,” which CMS states is completed by PPS hospitals “for data purposes only.” CMS proposes to change the PPS hospital instructions for calculating the inpatient routine cost per diem in line 38 of this worksheet so that it equals the sum of lines 40 and 37 divided by the inpatient days on line 2, instead of the sum of lines 36 and 37 divided by inpatient days. However, the instructions for line 40 state that PPS providers should report zero on this line. Therefore, by using line 40 instead of 36 in the calculation of the inpatient routine cost per diem in line 38, CMS is understating program costs for PPS providers. This understatement is significant because the inpatient routine cost per diem in line 38 is used to determine Medicare allowable costs, which form the basis for calculating sole community hospital and Medicare-dependent hospital hospital-specific rates, flow into Medicaid calculations in different states, and are used by the CMS actuary and others, such as the Medicare Payment Advisory Commission (MedPAC,) to calculate Medicare payment adequacy levels. **The AHA requests that CMS revert back to the prior instructions for line 38 – that this line equals the sum of lines 36 and 37 divided by the inpatient days reported on line 2. Alternatively, CMS could eliminate the requirement that PPS hospitals complete lines 28 through 37 and use routine costs on line 27 for the cost-per-diem computation on line 38. .**

Settlement Worksheets – Worksheet E-3 Series. CMS proposes to change the Worksheet E-3 series so that settlements are differentiated by provider type, such as skilled-nursing facility, rehabilitation, long-term care hospital, etc., and also to streamline the series. **The AHA supports CMS’ proposed revisions to the Worksheet E-3 series, which make the worksheets easier to follow.** In addition, for those using the Healthcare Cost Report Information System,

there will be less confusion as to which provider type is being referenced now that the different provider types no longer utilize the same worksheet.

Direct Graduate Medical Education (GME) & ESRD Outpatient Direct Medical Education Costs – Worksheet E-4. CMS does not propose changes to Worksheet E-4. However, the AHA recommends that line 38 reference the new Worksheet D-4, rather than Worksheet D-6, as D-6 was renamed as D-4 in the proposed Form 2552-10.

Hospital Financial Statements – Worksheet G Series. The instructions that currently accompany the Worksheet G series are brief and general, and CMS does not propose any changes to them. However, this series provides important information that the CMS actuary and others, such as the MedPAC, use to calculate Medicare payment adequacy levels and policy impacts. **Therefore, the AHA recommends that CMS develop a detailed set of instructions to assist hospitals in completing the Worksheet G series in a more accurate and uniform manner.**

Apportionment of Cost of Outpatient Rehabilitation Provider Services Furnished by Shared Hospital Departments – Worksheet J-2, Part II. In the FY 2009 final outpatient PPS rule, CMS stated that it would not adopt a policy to split the “Drugs Charged to Patients” cost center into two cost centers – one for drugs with low pharmacy overhead costs and one for high pharmacy overhead costs. However, the proposed Worksheet J-2, Part II, contains these two separate cost centers on lines 27 and 28. We believe this is an error, as these two cost centers are not listed in other worksheets or described in the instructions. **The AHA recommends CMS fix this error and combine these two cost centers back into one for “Drugs Charged to Patients.”**

Provider-based Hospice Costs – Worksheet K Series. The AHA recommends that CMS eliminate Worksheets K-1, K-2 and K-3. The information contained in these worksheets is generally contained in the summary worksheet – Worksheet K. Although Worksheets K-1, K-2 and K-3 have slightly more detail than Worksheet K, this additional detail is not used for any purpose.

The AHA appreciates CMS’ efforts to revise and improve the hospital cost report. We reiterate our desire to work with the agency to attain comprehensive reform that allows hospitals to report information on the cost report in a manner that is fully aligned with current hospital protocols and reimbursement methodologies

If you have any questions, please contact me or Joanna Hiatt, senior associate director for policy, at (202) 626-2340 or jhiatt@aha.org.

Sincerely,

Rick Pollack
Executive Vice President