American Hospital Association

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October 10, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Recommendations and Clarifications to Form CMS-2552-10 for the Reporting of Uncompensated Care

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) would like to provide recommendations for changes and ask for specific clarifications to Form CMS-2552-10 Worksheet S-10 for the reporting of uncompensated care.

BACKGROUND

Data being reported on the new Form CMS 2552-10 Worksheet S-10 will be used to determine a variety of future payments to hospitals and will likely shape future health policy and funding decisions. Charity care charges reported on line 20 of Worksheet S-10 will be used as part of the calculation of payments to hospitals qualifying as meaningful users of electronic health records (EHRs). Beginning in 2014, when the Disproportionate Share Hospital (DSH) program is restructured, DSH payments will probably be apportioned among hospitals based on uncompensated care costs reported on this worksheet. For these reasons, it is essential that the data on Worksheet S-10 be reported accurately and consistently.

Last summer, the AHA convened a workgroup of state association and hospital experts on cost reporting to address issues related to the completion of CMS 2552-10 Worksheet S-10. The purpose of the workgroup was threefold:

- Discuss practical recommendations for the industry relative to best practices to ensure accurate and consistent data reporting.

- Make recommendations on how to use the data from Worksheet S-10 to calculate uncompensated care costs under the restructured DSH program.

- Identify areas in the instructions for preparing Worksheet S-10 that may be subject to interpretation and need clarification from CMS.

The workgroup's discussion produced several recommendations and requests for clarification that are detailed below:

DEFINITION OF UNCOMPENSATED CARE

The AHA recommends that the definition of uncompensated care should be broad based and include all unreimbursed and uncompensated care costs calculated and reported on lines 19 and 30 and summed on line 31 of Worksheet S-10. A broad definition of uncompensated care costs will be important in accurately measuring a hospital's unreimbursed costs, and it will ensure the most appropriate basis for calculating future uncompensated care payments as outlined in Section 3133 of the *Patient Protection and Affordable Care Act* (ACA). Currently, Worksheet S-10 contains two major categories of cost. The first, summarized on line 19, is defined as the unreimbursed costs of Medicaid, State Children's Health Insurance Program, and other state and local government indigent care programs. The second, summarized on line 30, is defined as the uncompensated care costs of charity care and bad debts. Because these categories appear in separate sections of the S-10 Worksheet, it is imperative that CMS combine them when considering any policy on uncompensated care costs.

INCLUSION OF GME COSTS IN COST TO CHARGE RATIO

The ratio of cost to charges calculation on line 1 of Worksheet S-10 flows from Worksheet C, column 3 (costs) and column 8 (charges). Column 3 costs do not include the cost of graduate medical education (GME), which is specifically excluded. **The AHA recommends that the formula calculating the ratio of cost to charges for Worksheet S-10 be modified to include GME costs.** This could be accomplished easily by using costs from Worksheet B, column 24, line 118.

GME costs are a significant part of the overhead of teaching hospitals and should be included in the cost to charge ratio. GME costs are allowable costs, but have been historically excluded on Worksheet C of the Medicare cost report since the Medicare program calculates separately an add-on payment for its share of those costs on Worksheet E-4. Hospital charges by definition are established to help cover GME costs, and payment rates are negotiated to reflect the higher costs of teaching facilities. These costs are not related to the costs and charges for physician professional services to patients, which are appropriately removed from the costs and charges used to calculate the ratio of cost to charges. Further, we understand that many state Medicaid plans provide payment to hospitals for GME services, either explicitly or built into the state fee schedule. **The AHA believes that including GME costs on Worksheet S-10 more accurately matches gross revenues, costs and payments, and would result in more accurate and appropriate calculation of non-Medicare uncompensated care costs.**

CLARIFICATION OF PURPOSE OF LINES 17 AND 18

Lines 17 and 18 of Worksheet S-10 appear to be informational only since the data on these lines are not included in any of the totals elsewhere on this worksheet. The AHA has received numerous questions regarding both the data to be reported on these lines and the purpose of reporting them since they are not utilized. The workgroup also identified line 18 as an area in need of further clarification.

Line 17 requires the reporting of grants, gifts and investment income that are related to uncompensated care. As such, this information appears to be consistent with the Worksheet S-10 purpose of calculating the cost of uncompensated care. By contrast, the instructions for line 18 require the reporting of a very broad scope of data related to the general operation of the hospital, whether or not they relate to uncompensated care. These data would seem better reported on Worksheet G-3.

The AHA supports the concept of reporting all revenues, costs, and payments related to uncompensated care on Worksheet S-10. However, data unnecessary for the calculations should not be included on this Worksheet. **The AHA asks CMS to clarify the purpose of these two lines, both in the near term and for the future. Pending further clarification of the purpose and possible future use of the data on lines 17 and 18, the AHA recommends that lines 17 and 18 be deleted from Worksheet S-10**.

REPORTING OF CHARITY CARE

AHA members have expressed significant concerns regarding the reporting of charity care on line 20, primarily due to the requirement that the amounts claimed relate to services rendered in the cost reporting year. In general, this reporting requirement will force hospitals to spend significant additional time documenting charity write-offs. The AHA believes that hospitals will not have identified and resolved all of the charity accounts related to services provided in the current cost reporting year by the time the cost report is due five months after the close of the hospital's fiscal year. In addition, documentation requirements have not been defined. Medicare administrative contractors (MACs) and fiscal intermediaries (FIs) may evolve different processes and reporting requirements to audit and "allow" the charity amounts reported. The AHA requests that CMS provide guidance on the following questions:

- Why are the actual write-offs for charity care that hospitals have traditionally recorded at the time that a patient account qualifies for charity care not acceptable to CMS? The AHA recognizes that charity write-offs in a hospital's accounting year include amounts related to services provided in both prior years and the current year. However, this is generally due to the realities and complexities of working with patients, including changes in specific patient circumstances and time involved in obtaining the necessary documentation from patients. Some hospitals even record a provision for charity care, consistent with the concept of the provision for bad debts. **The AHA requests CMS clarify why the agency will require that the write-offs for charity care amounts reported on Worksheet S-10 be only for services rendered within the current reporting period and not permit amounts recorded as charity write-offs consistent with a hospital's charity policy.**

- The AHA requests clarification on the plans for MACs/FIs relative to auditing the amounts reported on Worksheet S-10. Will each MAC be responsible for its own audit program and documentation criteria? **As discussed above, the AHA believes that accepting the charity write-offs included in hospitals' audited financial statements as the amount to be reported on Worksheet S-10 minimizes the need for significant documentation effort by hospitals and audit work by the MACs.**

- Most hospitals will need to submit additional documentation of charity care write-offs after the cost report is submitted due to the current requirement of reporting only amounts written off related to services during the cost reporting period. Charity write-offs related to the prior year will occur after the cost report has been submitted. This is similar to how final documentation for DSH and bad debts is done after cost report submittal and before finalization of the audit process. **Should hospitals estimate the amount to be written off and provide final documentation at the time of audit? Should hospitals disclose that they have included estimated amounts?** The AHA also would appreciate additional direction from CMS regarding how it plans to administer EHR and DSH payments and the related additional payments proscribed by Section 3133 of the ACA (discussed above) on an interim and final basis.

Thank you again for your consideration of our comments. If you have any questions, please contact me or Caroline Steinberg, vice president of trends analysis, at (202) 626-2329 or csteinberg@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President

Cc: Ing-Jye Cheng, CMS
Marc Hartstein, CMS