National Association *of* Public Hospitals *and* Health Systems

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Ms. Michelle Shortt
Director, Regulations Development Group
Office of Strategic Operations and regulatory Affairs
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard, Room C4-26-05
Baltimore, Maryland 21244-1850

Ref: CMS–2552–10: Agency Information Collection Activities: Proposed Collection; Comment Request

Dear Ms. Shortt:

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-captioned Proposed Collection. NAPH represents more than 140 metropolitan area safety net hospitals and health systems. NAPH members predominantly serve the uninsured and patients covered by public programs—23 percent of the inpatient services provided by NAPH members is to Medicare beneficiaries, another 34 percent to Medicaid recipients, and 19 percent to uninsured patients. About 20 percent of NAPH members' revenues are derived from treating Medicare patients, and another 50 percent from payments for treating low-income, uninsured, and Medicaid patients.

NAPH recognizes the importance of collecting accurate and consistent data and applauds the Centers for Medicare & Medicaid Services' (CMS) efforts to improve and streamline the Hospital and Health Care Complexes Cost Report. The following comments offer suggestions for improving the quality of data collected by CMS and identify new reporting requirements that may impose a significant burden on hospitals given their existing accounting systems. NAPH focuses here on Worksheet S-10, which is of particular concern to safety net hospitals because data reported on this worksheet are used to make changes to the Medicare disproportionate share hospital (DSH) formula.

1. <u>Worksheet S-2 – New Requirement to Report Medicaid Days</u>

The draft Worksheet S-2, part I, line 21 proposes that hospitals report the number of Medicaid days during the cost report period. Hospitals already report this information, which is used in the disproportionate patient percentage (DPP) calculation, on Worksheet S-3, part I. This

proposal seems contrary to CMS' efforts to streamline the cost report by imposing a redundant requirement on hospitals to report the Medicaid days information used for the DPP calculation on two different worksheets.

The draft Worksheet S-2, part I, line 21 also requires hospitals to keep track of and report Medicaid days with a level of detail that is not required for the calculation of the DPP. Specifically, the draft worksheet requires hospitals to report the number of in-state and out-of-state Medicaid paid and eligible days, as well as Medicaid HMO days and other Medicaid days. Since CMS has not changed its policy with respect to the calculation of the DPP for purposes of determining the Medicare DSH adjustment percentage, there is no reason to increase the reporting burden on hospitals by adding line 21 to Worksheet S-2. Additionally, because such details are not required for the DPP calculations, most hospitals do not track Medicaid days in the detail that CMS is requesting. For example, whether Medicaid paid for days is irrelevant in determining the number of Medicaid days for the DPP calculation because so long as the patient was eligible for Medicaid, the days associated with that patient count as Medicaid days. Also, since both in-state and out-of-state Medicaid days count as Medicaid days for purposes of the DPP calculation, there is no additional benefit to be gained by reporting this information separately. NAPH urges CMS not to add to the burdens on hospitals and eliminate line 21 from Worksheet S-2.

2. Worksheet S-10 – Data Collection Regarding Uncompensated and Indigent Care Data

NAPH strongly supports CMS' efforts to collect accurate uncompensated care data and to fulfill the mandate contained in Section 112 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). The BBRA requires CMS to collect "data on the costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated"[1] in order to reexamine the adequacy of the existing Medicare DSH formula in targeting payments to hospitals that serve a disproportionate share of low-income patients in accordance with the DSH statute.[2] NAPH further supports efforts to revise the initial S-10 efforts, since that worksheet did not collect useful data. NAPH believes that the proposed Worksheet S-10 is much improved, although we have a number of comments that we think will further improve the worksheet as a data collection instrument.

a. Uncompensated and Indigent Care Cost Computation

The draft Worksheet S-10 requires hospitals to use the cost-to-charge ratio calculated using Worksheet C, part I, line 202, columns 3 and 8 for determining the cost of Medicaid, state Children's Health Insurance Program (CHIP), other state or local indigent care programs, and uncompensated care. This is the cost-to-charge ratio that Medicare uses to determine the cost of the Medicare program based on Medicare's reasonable cost methodology and it excludes significant costs. For example, this cost-to-charge ratio does not include teaching costs because Medicare pays for these costs using a separate methodology. However, because the purpose of Worksheet S-10 is to determine the true total "costs incurred by the hospital for providing

[1] H.R. 3426, § 112(b) (1999), enacted by reference in Pub. L. 106-113, 113 Stat. 1501, Div. B, § 1000(a)(6) (1999).
[2] 42 U.S.C. § 1395ww(d)(5)(F).

inpatient and outpatient hospital services," there is no reason to use the Medicare reasonable cost methodology; instead a broader cost-to-charge ratio should be used so that the entire cost of patient care is captured.

To better account for the full cost of treating Medicaid, CHIP, other state and local indigent care, and uncompensated care patients, NAPH proposes that CMS use an amount from Worksheet A that includes all patient care costs as the cost portion of the cost-to-charge ratio. We suggest using the total of Worksheet A, column 3, lines 1 through 98, reduced by the amount on Worksheet A-8, line 10. This amount more accurately reflects the true total cost of hospital services provided, as opposed to the Medicare reasonable cost methodology, and is more consistent with the statutory mandate in the BBRA. For the charge portion of the cost-to-charge ratio, we suggest Worksheet C, column 8, line 200.

Alternatively, for hospitals that already report the cost of uncompensated and indigent care to the state, CMS could allow these hospitals to input the cost-to-charge ratios they use for state Medicaid and indigent reporting purposes. These cost-to-charge ratios better reflect the cost of treating indigent patients and can be verified by the state. If these cost-to-charge ratios are not available, hospitals can also report the cost information they generate for compliance with the DSH reporting and audit rule.[3]

b. Medicaid Revenues

The draft Worksheet S-10 requires hospitals to report Medicaid revenues on lines 2, 3, 4, and 5. As drafted, line 2 can include either all Medicaid net revenue, including DSH and supplemental payments, or only base Medicaid net revenue—i.e., without DSH and supplemental payments. For consistency and uniformity purposes, NAPH believes that line 2 should be changed to include only base Medicaid net revenue, line 3 should include DSH net revenue, line 4 should include non-DSH supplemental net revenue, and line 5 should be the sum of lines 2, 3, and 4.

With respect to line 2, the draft instructions specifically permit hospitals to subtract associated provider taxes or assessments from any payments received in determining the hospital's net revenues from Medicaid. NAPH strongly urges CMS to also allow hospitals to subtract associated intergovernmental transfers. From a hospital's perspective, money that the hospital transferred to the state should be offset against payments received by the hospital because, similar to provider taxes and assessments, transfers reduce the value of revenue received by the hospital. If CMS does not allow intergovernmental transfers to be deducted from payments received from Medicaid, then Worksheet S-10 would overstate Medicaid net revenues and understate the difference between payments and costs of the Medicaid program. Similarly, in situations where public hospitals certify public expenditures as representing Medicaid payments, hospitals should be permitted to only include net payments received from the Medicaid program rather than the full value of the amount certified.

[3] Medicaid Program Disproportionate Share Hospital Payments Final Rule, 73 Fed. Reg. 77904 (Dec. 19, 2008) (to be codified at 42 C.F.R. pts. 447, 455).

In addition, the draft instructions for line 2 define "net revenue" as "payments received or expected for Title XIX covered services delivered during this cost reporting period." Hospitals typically account for payments when received, which may include services provided during a preceding cost reporting period. In general, we urge CMS not to depart from usual hospital accounting practices when defining "net revenue" or other terms. Although we understand CMS' desire to match net revenues with services, complying with CMS' definition would require significant alteration of existing accounting systems. NAPH urges CMS to consider the additional burden (both time and money) this requirement would place on hospitals.

NAPH also urges CMS to be specific with its use of the term "revenue". For line 8, CMS should use the term "net revenue" rather than "revenue" in order to clearly differentiate between payments (net revenues) and charges (gross revenues). Using these terms interchangeably causes unnecessary ambiguity and would render the data collected useless for analytical purposes. (This comment also applies to lines 12 and 16.)

c. Charity Care Charges, Costs, and Associated Issues with Bad Debt

NAPH understands that collecting information regarding charity care charges and costs is necessary to implement the statutory mandate to examine "costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated."[4] Accordingly, the draft Worksheet S-10 endeavors to obtain the full uncompensated cost of charity care patients, as opposed to the cost of the charity care provided by the hospital. The draft Worksheet S-10 requires hospitals to report the value of their charity care at full charges along with payments by patients approved for partial charity care. For patients approved for partial charity care, the draft instructions for lines 19 and 22 would require hospitals to report the entire value of all services provided to the partial charity care patients (at full charges) on line 19 and any payment these patients make on line 22. NAPH believes that this method would appropriately capture the most complete and accurate value of charity care provided and is most consistent with the statute.[5]

In order to appropriately determine the costs associated with charity care patients, we believe that CMS should further clarify that full charges associated with a charity care patient are to be included on line 19 and not on line 26, even if the charity care patient receives a partial discount and does not pay the patient's obligation (what would normally be considered a bad debt). Otherwise, a charge inappropriately could be included on both line 19 and line 26. In conformance with this recommendation, we strongly suggest that the draft instructions for line 22 be revised to only include payments ***received*** from patients approved for partial charity care services, and not also payments ***expected*** from these patients. Despite the existence of a patient share, many charity care patients may not pay their share, and it makes no sense to count ***expected*** payments in the context of determining the costs which remain uncompensated.

[4] H.R. 3426, § 112(b) (1999), enacted by reference in Pub. L. 106-113, 113 Stat. 1501, Div. B, § 1000(a)(6) (1999).
[5] NAPH recognizes that the proposed S-10 methodology differs from industry guidelines geared toward determining the value of charity care provided. Methodologies geared toward determining the value of charity care, as opposed to uncompensated costs, record only the charity care eligible portion of full charges for a charity care patient that receives a discount on charges and do not take into account payments by that patient. However, this method does not truly determine the uncompensated cost of caring for the charity care patient.

d. Grants, Donations, Endowment Income, Government Appropriations or Transfers

The draft Worksheet S-10 requires hospitals to report private grants, donations, or endowment income restricted to funding charity care on line 17 and government grants, appropriations, or transfers for support of hospital operations on line 18. While both of these lines are under the heading of uncompensated care, the instructions are silent as to how the information from these two lines will be used. NAPH strongly urges CMS to clarify that lines 17 and 18 are for informational purposes and not for use in determining the value of uncompensated care provided by hospitals. Accounting for these voluntary funding sources in the determination of the full uncompensated cost of charity care patients understates the true cost of these patients and could jeopardize the future availability of these funds if grantors and donors realize that their contributions will be offset against any supplemental funding from the Medicare program. Alternatively, CMS should clarify its purpose for these two lines and allow for public comments before requiring hospitals to submit additional information.

In addition, while line 17 is appropriately limited to private grants, donations, or endowment income restricted to funding charity care, it neglects to account for the cost of complying with rules associated with receiving these funds. NAPH believes that CMS should only count the net value of these funds as being available to supplement a hospital's charity care.

Line 18, as drafted, would require hospitals to report all government grants, appropriations, or transfers for support of hospital operations. Because this line is under the heading of uncompensated care, NAPH strongly urges CMS to limit the reporting of government funding sources specifically restricted to funding charity care. Moreover, in order to ensure that funds are not double counted, CMS should clarify in its instructions that DSH payments reported under lines 2 and 5 should not be reported here again. Funds from charity care pools also should not be reported here if the underlying sources are DSH funds previously accounted for in lines 2 and 5. Similarly, any other funds already included in lines 2, 5, 9, and 13 should not be reported here.

NAPH also strongly urges CMS to exclude funds received from the Section 1011 program[6] because undocumented immigrants seeking emergency services may not have the necessary documentation to be deemed eligible for charity care under hospitals' charity care policies. If charges associated with these patients cannot be included in overall charity care charges, then funds received to offset these charges should not be used to offset a hospital's overall charity care charges. Furthermore, the Section 1011 program has not been reauthorized.

e. State or Local Indigent Care Programs

The draft Worksheet S-10 collects uncompensated costs of other state or local indigent care programs above the uncompensated care section and does not include these costs in the total of all non-Medicare uncompensated care in line 30. Unlike Medicare or Medicaid, many state or local indigent care programs are not insurance programs, but rather sources of funding to help

[6] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011, 117 Stat. 2066, 2432.

subsidize hospitals' overall uncompensated costs. As such, NAPH urges CMS to include the uncompensated portion of state or local indigent care programs in line 30 as part of total uncompensated care.

f. Exclusion of Physician and Other Professional Services

The draft Worksheet S-10 excludes physician and other professional services when calculating charity care and bad debt expenses (lines 19, 22, and 26). In addition to employing physicians and paying community specialists directly for providing care to patients, many NAPH member hospitals also subsidize the cost of physician services to ensure that vulnerable patients continue to have access to necessary physician care. To the extent that CMS is trying to determine the full uncompensated cost of charity care and other low income patients, CMS should allow hospitals to include, in the calculation of charity care and bad debt expenses only, the portion of hospitals' uncompensated costs arising from the provision of physician and other professional services. Because these are actual costs incurred by hospitals in caring for charity care and other low-income patients, NAPH suggests that CMS add additional lines to capture these costs, along with all other uncompensated care costs.

g. Exclusion of the Cost of Treating Underinsured Patients

The draft Worksheet S-10 specifies that for patients covered by a public program or private insurance who would otherwise qualify for charity care, only unpaid deductible and coinsurance payments required by the payer can be included as charity care. It is unclear whether services that are not covered by the public program or private insurance plan can be included here. Because these patients are in essence uninsured for these uncovered services, NAPH strongly urges CMS to clarify that insured patients with uncovered services are deemed uninsured. The value of these services should be included as charity care if they are unpaid.

h. Bad Debt Expenses

The draft Worksheet S-10 requires hospitals to reduce bad debt expenses to cost using a cost-to-charge ratio. When bad debt refers to copayments and deductibles that are not calculated based on charges, this may be inappropriate. For example, many insurance companies have agreements with hospitals to pay a portion of the cost of the services provided to their members and members may be responsible for a copayment amount also based on cost. If the patient doesn't pay this copayment amount after reasonable collection efforts, then the value is written off as bad debt. However, the amount written off is already valued at cost; applying a cost-to-charge ratio to this amount would be inappropriate and would significantly undervalue total bad debt expenses. NAPH suggests that CMS eliminate line 29 and alter line 30 accordingly.

The draft Worksheet S-10 also specifically prohibits hospitals from including obligations of the insurer rather than the privately-insured patient as part of bad debt. This would include nonpayment by the insurer due to lack of prior authorization and late billing. Because not every element of this process is within the control of hospitals, it would be unfair to penalize hospitals for real expenses incurred in providing patient care. So long as a hospital made a reasonable effort to bill the insurer for its portion, CMS should allow all associated unpaid debt to be

counted as bad debt. NAPH strongly urges CMS to clarify that the exclusion of the insurer's obligations from total bad debt expenses applies only if a hospital did not make an attempt to bill the insurer.

i. Medicare Shortfall

Worksheet S-10's stated purpose is to collect data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including uncompensated and indigent care data. NAPH believes that costs for services rendered to all indigent patients should be included, including those eligible for both Medicare and Medicaid. NAPH urges CMS to consider including a section in Worksheet S-10 for the Medicare program.

j. Charity Care Charges for EHR Technology Incentive Payments under ARRA

The draft Worksheet S-10 instructions note that "Charity care charge data, as referenced in section 4102 of the American Recovery and Reinvestment Act of 2009, may be used to calculate the EHR technology incentive payments made to §1886(d) hospitals and critical access hospitals." If CMS intends to use Worksheet S-10 for this purpose, we believe that there are other modifications that are appropriate. Under ARRA, EHR technology incentive payments must be calculated for a "hospital." For Medicare, ARRA uses the term "eligible hospital," which is defined as a subsection (d) hospital,[7] and for Medicaid, ARRA uses the terms "children's hospital" or "acute care hospital."[8] Given that multiple hospitals may operate under one provider number, NAPH believes that data should be collected at the hospital level, as opposed to the provider number level. To allow for such a conclusion with respect to both the Medicare and Medicaid programs' EHR technology incentive payments, CMS should facilitate the reporting of charity care charges; total discharges; and Medicare, Medicaid, and total inpatient bed days on a separate line for each hospital operating under a single provider number.

CMS also should ensure that lines 19 and 20 capture the full scope of charity care provided. As mentioned above, hospitals' costs associated with offering and providing physician and other professional services should be included in lines 19 and 20 to fully account for the value of a hospital's charity care.

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[7] 42 U.S.C. § 1395ww(n)(6)(B).
[8] 42 U.S.C. § 1396b(t)(2)(B).

NAPH appreciates CMS' consideration of these comments. Our members, who are dedicated to serving entire communities, including poor and uninsured individuals, are acutely sensitive to changes in Medicare payment policy that have the effect of reducing payments or increasing the administrative burden on our hospitals. If you have any questions about these comments, please contact Lynne Fagnani or Claudine Swartz at (202) 585-0100.

Sincerely,

Larry S. Gage
President