NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

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Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
7500 Security Boulevard
Room C4-26-05
Baltimore, Maryland 21244-1850

Attention: Document Identifier CMS-2552-10

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to convey our observations regarding proposed modifications of the Medicare cost report, as published in the *Federal Register* on July 2, 2009.

Over the years, NAUH has interacted extensively with CMS regarding the Medicare cost report in general, and regarding the manner in which it collects certain data in particular. We have met with CMS staff to express our views, written letters, and found ourselves pleased on a number of occasions to find our concerns reflected in subsequent changes.

We have paid so much attention to the Medicare cost report because of how very important some cost data is to the manner in which Medicare pays urban safety-net hospitals for the services they provide to their elderly patients. For this reason, this letter focuses on two parts of the Medicare cost report that are of the greatest current importance to urban safety-net hospitals: the S-10 and the S-3.

The S-10

The S-10 is overwhelmingly important to urban safety-net hospitals because of the manner in which its documentation of hospitals' uncompensated care is used. In the immediate future, these figures will be a vital part of the calculations that determine the allocation of health care IT funds to hospitals as set forth in the American Reinvestment and Recovery Act of 2009. Hospitals that fail to account for the full extent of the uncompensated care they provide to their low-income and uninsured patients risk receiving less than the full amount of IT funds for which they should qualify – a sacrifice that private, non-profit urban safety-net hospitals, whose financial health is so seriously compromised by the overall public reimbursement system and the current, slumping economy, simply cannot afford to make.

At the same time, NAUH also recognizes that the uncompensated care data reported in the S-10 may very well be used to guide additional public policy decisions in the near future. It could, for example, be used in future efforts to reform the Medicare disproportionate share hospital (DSH) eligibility and payment formula – a potential

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undertaking that has been discussed for a number of years. Accurate data is essential to ensuring that urban safety-net hospitals are treated fairly in any such policy-making endeavor.

Similarly, some signs point to the possibility of hospitals' provision of uncompensated care becoming a key consideration in determining future Medicare and Medicaid DSH payments as policy developments and funding formulas change and evolve at both the state and federal levels of government. With so much at stake for urban safety-net hospitals in light of their high uncompensated care burden, it is absolutely essential that the Medicare cost report accurately and comprehensively capture the full extent of hospitals' uncompensated care.

With this in mind, NAUH would like to convey our observations about the proposed changes in the S-10 form.

Recommendations

NAUH would like to offer a number of recommendations regarding proposed changes in the S-10.

1. NAUH recommends that the instructions reiterate – for each line – that sums should include both inpatient and outpatient services.
2. On the form, several categories are totaled to quantify hospitals' uncompensated care. Even if the sum of these various categories is ultimately comparable among hospitals, NAUH believes that differences in how individual hospitals perform their accounting and interpret these guidelines could result in the different categories having significant variations in amounts that are not reflected in the final totals. For this reason, NAUH recommends that CMS not use the figures in the individual categories for any other purpose and use only the sum of these categories.
3. The IRS form 990 calls for hospitals to include shortfalls associated with programs (such as psychiatric services) that hospitals operate at a loss because they believe they must offer such programs as a service to their communities. NAUH believes such efforts speak to the heart of mission-driven, non-profit urban safety-net hospitals and that the S-10 therefore should mirror the IRS form 990 by including such services as part of hospitals' uncompensated care.
4. As noted, individual hospitals may account for some costs and revenue in different ways and interpret the S-10 instructions differently. For these reasons, NAUH recommends that CMS establish a mechanism or source through which hospitals can ask questions and seek guidance on such matters.
5. On line 1 (cost-to-charge ratio), NAUH believes that using Medicare allowable costs is an inappropriate means for determining the cost of delivering care. The proposed approach, for example, excludes medical education, transplants, and other legitimate hospital costs. NAUH recommends using a total hospital cost-to-charge ratio.

Objections

NAUH objects to several proposed changes in the S-10 form.

1. On line 19 (total initial obligation of patients approved for charity care for the entire facility), NAUH does not understand why it should matter whether a hospital's written charity care policy addresses continuing to care for Medicaid patients once their hospital stay has exceeded a Medicaid length-of-stay limit. In many states, balance-billing Medicaid patients is illegal, so there is no reason for hospitals in those states to address this matter in their written charity care policies. Hospitals should not be penalized for having charity care policies that fail to address situations that are irrelevant based on their states' Medicaid laws. NAUH believes these charges should be considered charity care or a Medicaid shortfall in all instances – regardless of whether hospitals' charity care policies address this matter.
2. On lines 19-20 (total initial obligation of patients approved for charity care for the entire facility/total initial obligation of patients approved for charity care for §1886(d) hospitals or critical access hospitals),

NAUH does not understand why these obligations need to be reported separately. Also, unless hospitals have a charity care log, they may not be prepared to report full charges for charity care patients. Consequently, hospitals will need a transition period to ensure their ability to provide this data accurately. NAUH also is concerned that the methodology for accounting for charity care outlined in these instructions differs from that on the IRS form 990. This constitutes burdensome, duplicative paperwork for hospitals, and NAUH urges the adoption of a uniform methodology.

3. On line 21 (cost of initial obligation of patients approved for charity care), NAUH questions the value of reducing beneficiary cost-sharing by a cost-to-charge ratio.
4. On lines 19-23 (charity care), NAUH views distinguishing between charity care for the insured and the uninsured to be unnecessary in this situation because in the end, CMS's interest is the sum of those two figures. NAUH urges CMS to simplify this paperwork by permitting hospitals to make this calculation once instead of twice by not requiring hospitals to distinguish between charity care provided to the uninsured and care provided to the insured.

Concerns

NAUH has a number of concerns about proposed changes in the S-10.

1. On lines 2, 5, and 13, hospitals in some states, we believe, will have difficulty separating their federal Medicaid and their state-only Medicaid services among the Title XIX, DSH, and other government programs categories. This area may benefit from more detailed instructions and the development of the guidance mechanism recommended above (number four under "recommendations").
2. Hospitals that receive non-Medicaid appropriations and grants from their local, county, or state governments to support operations and pay for care for the uninsured may conclude that such payments that are not tied to specific patients do not fall into any specific category (such as line 13, which only includes revenue directly tied to specific patients, or line 18, which is for grant appropriations and transfers of funds to support hospital operations). This could lead to a mistaken perception that some hospitals are providing far more uncompensated care than they actually are and, at the same time, misleadingly suggest that other hospitals are doing far less in comparison to other providers. This area, too, would benefit from more detailed instructions.
3. On line 2 (net revenue from Medicaid), removing physician costs is a process that would need to be performed differently according to different physician-provider relationships at individual institutions, and this would practically ensure that the data reported on this line would differ significantly from hospital to hospital. NAUH hopes CMS will address this concern.
4. On Line 18 (government grants, appropriations or transfers for support of hospital operations), NAUH believes these instructions should specify that hospitals should not include any payments they have already reported on another line.
5. On lines 8 (difference between revenue and costs for Medicaid program), 12 (difference between revenue and costs for stand-alone SCHIP), and 16 (difference between revenue and costs for state or local indigent care program), NAUH believes these instructions should specify "net revenues" so that figure is not confused with gross revenues (charges).

Requests for Clarification

NAUH hopes CMS will provide additional clarification on several S-10-related matters.

1. This form's definition of uncompensated care does not include Medicaid and SCHIP shortfalls. NAUH believes such shortfalls are vital aspects of uncompensated care and that they should be included in this definition. Because they are not in the proposed changes, however, NAUH hopes CMS will explain why these measures are on the form and how it intends to use this data.

2. NAUH believes it is not clear what is meant by the "initial obligation of charity care patients" for patients who are retroactively eligible for charity care or retroactively identified as eligible for charity care. NAUH seeks further clarification of this terminology and how it will be used.
3. On lines 13-16 (other state or local indigent care program), it is not clear whether payments and costs associated with care delivered to prisoners belongs in this category. NAUH seeks further clarification of this matter.

The S-3

Like the S-10, the S-3 form is very important to private, non-profit urban safety-net hospitals because the data reported in this section is critical to the calculation of hospitals' Medicare area wage indexes. Even small changes in hospitals' Medicare area wage index can have significant implications for hospitals' overall revenue – and can even be the difference between individual hospitals making money or losing money in any given year.

This data is especially important in the current policy environment. In recent years, a number of policy-makers in Washington – both elected and appointed – have called for reforming the Medicare wage index system. Whether this takes the form of regulatory reform, free-standing legislation, or inclusion in broad health care reform legislation or another bill, any change in the manner in which hospitals are classified, and their wage indexes calculated, can have an enormous potential impact on hospitals. For these reasons, the collection of data in the Medicare cost report, and specifically on the S-3 form, is extremely important to urban safety-net hospitals.

In this context, NAUH would like to raise three issues regarding the proposed changes in the S-3.

First, hospitals already face a difficult challenge breaking down contract labor hourly costs; requiring them to do so based on contract employees' labor costs and their benefit costs would be even more difficult. This would have be done on an invoice-by-invoice basis. One NAUH member reports that it spends at least 80 hours compiling this information alone. Consequently, NAUH objects to this proposal as ill-advised and burdensome.

Second, it appears as if hospitals that cannot provide the level of detail requested in this section of the cost report will not be able to include their contract labor costs at all. This point needs further clarification.

Third, it is not clear where hospitals should report the hours associated with the wages and benefits of contract employees. This point, too, needs further clarification.

Other Issues

NAUH would like to bring several other matters to CMS's attention.

First, we would like to thank CMS for proposing what we believe to be a number of worthwhile improvements in the Medicare cost report, including the elimination of all of the forms' subscripts and unused worksheets; the elimination of the distinction between old and new capital; the addition of a settlement page for psychiatric services; and the incorporation of the 339 form.

Second, NAUH appreciates CMS's assertion that the data on the S-10 will not be used for hospital-specific DSH upper-payment limit calculations and hopes CMS will remain true to this promise.

Third, we are concerned, as is often the case, about the challenges inherent in new reporting requirements. In some cases, the proposed changes call for reporting data in new ways; in others, they call for reporting data that hospitals do not collect at all or do not collect in the manner envisioned in the cost report. Ideally, the cost report should not require hospitals to report any data they do not collect; this is unnecessarily burdensome. If it must,

however, NAUH believes it is only fair that hospitals be given a reasonable transition period to develop the capacity to meet new CMS reporting requirements.

Fourth, many of the new requirements place a considerable new paperwork burden on hospitals – either to report existing data in new ways or to develop new data collection and reporting methods. Further, NAUH believes that CMS's estimates for how much time will be needed to prepare this data are very conservative and significantly underestimate the time and effort that will be needed for hospitals to comply with new requirements.

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The National Association of Urban Hospitals advocates for adequate recognition and financing of private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These private, urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private, urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

NAUH appreciates the opportunity to present these comments to CMS. We also invite questions about the concerns we have raised and would welcome an opportunity to meet with CMS officials, discuss our concerns and objections in greater detail, and work with agency officials to develop better ways to collect data that will have such a profound impact on the financial health of private, non-profit urban safety-net hospitals in the years to come.

Sincerely,

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Executive Director