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August 25, 2009

Centers for Medicare and Medicaid Services
Acting Administrator Charlene Frizzera
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB Control Number,
Room C4-26-05, 7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS Proposed Changes to Hospital and Hospital Health Care Complex Cost Report (Form 2552-10)

Dear Acting Administrator Frizzera:

We are pleased to present the Centers for Medicare & Medicaid Services' (CMS) with the following comments on the proposed changes to the Hospital and Hospital Health Care Complex Cost Report (Form 2552-10), published July 2, 2009 in the Federal Register. HealthSouth Corporation is the nation's leading provider of inpatient rehabilitation care and service providers, operating 93 freestanding rehabilitation hospitals in 26 states and Puerto Rico.

We have reviewed the extensive changes being proposed to the Hospital Cost Report forms. Several of these changes have the potential to negatively impact the entire hospital community. We offer the following comments related to the particular areas of concern laid out in the proposed changes:

CMS 339:

The proposed revisions to the 2552-10 would eliminate the CMS Form 339 but would incorporate much of this same information into the body of the cost reporting forms. While we agree with the attempt to create efficiency as a result of the proposed electronic capture of data previously reported on the paper Form CMS-339, the instructions state the additional schedules are to be submitted either electronically or in hard copy. If the Exhibits are going to be required when submitting the cost report then the exhibits should be made part of the electronic cost report or the CMS Form 339 should not be eliminated. Further, we recommend that CMS propose a mandatory requirement to submit the exhibits electronically to be consistence with all data collections. We further recommend that the CMS Form 339 Exhibit 5 used to report Medicare Bad Debt be handled in a manner similar to the IRIS diskette and submitted separately with the cost report package. Many Medicare Contractors are requiring providers to submit a separate diskette for Medicare Bad Debt to address HIIPA concerns. Lastly, we believe the IRIS software be updated to better work in today's electronic reporting environment.

Discrepancies between Instructions and 2552-10

Our review of the instructions and the 2552-10 noted certain discrepancies that should be addressed when CMS finalizes the revision to the cost report form and instructions. Specifically, we noted discrepancies between the CR instructions and the Draft of Form 2552-10 as follows:

- The CR Instructions regarding whether GME costs are directly assigned to the Cost Report refers to line 11 on S-2, Part II, however, the Draft Form 2552-10 lists this question on line 33.

- The CR Instructions regarding "whether contract services are reported on S-3, Part II, line 11" should be reported on S-2, Part II, line 22 of Draft Form 2552-10. However this question was omitted from the Draft Form 2552-10. Similarly, CR Instructions for line 23 regarding "whether home office or related party personnel are reported on S-3, Part II, line 14" was also omitted from the Form.
- The Draft Form S-2, Part II, lines 11 through 42 do not match with the CR instructions as a result of the above mentioned errors.

Elimination of Worksheets No Longer Used for Medicare Reimbursement Purposes --Medicaid Programs:

Various states utilize Medicare cost report worksheets to calculate the reimbursement for their Medicaid programs. Some states specifically use Worksheet C, Part II (capital) to reduce capital costs for Medicaid reimbursement settlement. Unless a state Medicaid program's reimbursement methodology matches the Medicare program exactly, we believe that the elimination of cost report worksheets that are no longer used for Medicare reimbursement purposes, but still important for Medicaid reimbursement in various States, will cause an unnecessary burden to both the hospitals and the States that have relied on the reporting and collection of this information for many years.

Low Income Patient/Disproportionate Share (LIP/DSH) Reporting:

Worksheet S-2, lines 21 and 22 (Medicaid days) are new data elements added to the cost report. It is not clear from the cost report instructions as to the purpose of reporting the additional Medicaid day categories. The reporting of this additional information will be a burden to providers while at the same time has no impact to DSH/LIP Medicare payments. The Medicaid days input on S-3 remain the same. We recommend that the additional reporting on Worksheet S-2 be removed.

Revisions to 2552-10 Learning Curve:

Hospitals will be responsible for adequately preparing for this overhaul of the Medicare cost reporting forms. The significant changes will create substantial education hours to reimbursement staff as well as to the hospitals departments who report this information. To minimize the impact on having to relearn the entire cost center structure, we believe that changing the cost center line numbering structure could be minimized by simply eliminating lines 1 and 2 and not shifting all existing lines. Further, we believe line 90 should not move to line 3. These costs could be directly assigned to the appropriate capital cost centers or remain as a reclassification via Worksheet A-7.

We appreciate the opportunity to submit our comments to the proposed revisions to the hospital cost reporting form. If you have any questions, feel free to call me at (205) 970-5702.

Sincerely,

Rob Wisner

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August 27, 2009

Centers for Medicare & Medicaid Services
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Division of Regulations Development
Attention: Form CMS-2552-10 (OMB# 0938-0050)
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Draft Form CMS-2552-10
July 2, 2009, **Federal Register** Notice

We appreciate this opportunity to comment on the draft hospital cost report, Form CMS-2552-10, which CMS intends to implement for periods beginning on or after February 1, 2010. We are among the ten largest CPA firms in the nation serving approximately 400 hospitals nationwide. Our comments are as follows:

Worksheet S-2

Worksheet S-2, Lines 21 and 22 provide for reporting Medicaid days broken down into various categories of paid and eligible days, as well as HMO days. However, there is no apparent use of this data once it is reported. We would recommend a separate worksheet be developed to calculate disproportionate share reimbursement that would link to Worksheet E, Part A, as well as a calculation for rehabilitation low income patient reimbursement that would link to Worksheet E-3, Part III. This worksheet could include the Medicaid patient day information proposed for Worksheet S-2, Lines 21 and 22, as well as the SSI data needed to develop the reimbursement percentage used on the appropriate settlement worksheets.

Worksheet S-2, Line 94 requests information on a hospital's malpractice coverage. We are unsure how this data would be used, but do not believe it is relevant to the cost reporting process. Our hospital clients have expressed concerns about disclosing this information in a document that is available under the Freedom of Information Act, as it could be used by plaintiffs counsel in determining the desirability of pursuing litigation against hospitals. In other words, attorneys could use this data to determine which hospitals in an area have the highest malpractice coverage, and target those hospitals with frivolous lawsuits (hoping for out-of-court settlements),

increasing hospitals' cost of caring for patients. We request this question be eliminated, or that CMS demonstrate the need for obtaining this data.

Worksheet S-2, Part II, contains many of the questions included in the current CMS Form 339. While it is desirable to streamline the cost reporting process and eliminate unnecessary data, we are concerned that the proposed method of accomplishing this falls short of that goal. The instructions specify that Exhibits 2, 3 and 4 would still be filed manually. For most hospitals, we believe the data on these exhibits is not significant to the cost reporting process, and request CMS to reevaluate the need for this data. At a minimum, CMS could specify that the data need not be submitted with the cost report, but made available upon request from the Medicare administrative contractor (MAC).

Exhibit 5 is certainly necessary to provide detail data needed to support reimbursable bad debts claimed on the cost report. As most contractors now require the bad debt list in electronic format, we would suggest the instructions clarify that Exhibit 5 shows the necessary fields to report, to be submitted in a format as required by the MAC. In fact, the note at the end of the Worksheet S-2 instructions should be modified, as some MACs will no longer accept a hard copy of Exhibit 5.

While we understand this is beyond the scope of the cost reporting forms, when describing information filed outside of the cost report itself, we would request CMS revisit the IRIS software and update it to function more easily in today's environment. The current software is extremely difficult to complete and transmit, and could be greatly improved to simplify the compliance of teaching hospitals with the requirement to submit this data. This is a major burden that adds numerous hours to the reporting process for large teaching facilities, and should be easily fixed with an updated software program.

Wage Index Data

The instructions for Worksheet S-3, Part II, Line 28, specify that the costs for home office contract personnel should not be reported on the wage index survey. We believe this is inequitable for those providers operating under a home office. Obtaining contract administrative services at the home office level can be a very efficient means to obtain such services, generally at a lower cost than if each hospital in a system contracted separately for administrative services. We request CMS revisit this decision and allow home office contract personnel to be reported on Line 28.

Worksheet S-3, Part V is a new worksheet to report contract labor and benefit costs by provider component. However, CMS does not explain the purpose for this worksheet, as the data does not appear to be used elsewhere in the cost report. The instructions for the worksheet are very

unclear, and the data would be difficult to obtain. When hospitals contract with outside entities, the contract rate is normally a combined hourly rate that encompasses all compensation of the contracted individual, without designating how much is for direct labor vs. employee benefits. We request CMS work with the hospital industry to explain the purpose for this worksheet, and redesign it to request information that can be readily obtained related to outside contracts. As this information would only be useful for wage index purposes, as long as the reporting requirements are consistent across the country, there is no net change in Medicare program outlays. Thus, we request CMS provide for more simplified wage index reporting requirements, rather than increasing them.

Worksheet S-7

We are aware that SNFs were required to document the use of a special increase in Medicare payments implemented in 2003. However, this requirement is no longer meaningful six years later, and we request CMS deleted Lines 58 through 64 of this worksheet.

Worksheet S-10

We appreciate the significant revisions to Worksheet S-10, which help clarify the data required to complete this form. While the instructions for Line 2 specify that hospitals should include Medicaid managed care information, this is not clear in the instructions for Line 6. We suggest this be stated in the Line 6 instructions, and also believe this could be clarified on the form, by changing the description above Line 2 to read: Medicaid and Medicaid Managed Care (see instructions for each line).

The instructions for Line 19 are difficult to follow, and may lead to inconsistent reporting among hospitals. We request CMS clarify the instructions to require hospitals to report charity care charges consistent with generally accepted accounting principles and the instructions for the IRS Form 990, Schedule H. We are unclear as to the purpose for Line 20, and request CMS clearly state its purpose, or eliminate this line.

Line 30 summarizes the unpaid cost of charity care and bad debts from Lines 23 and 29. We request an additional total line be added to also include the unpaid costs from Lines 8, 12 and 16.

Worksheet A

Implantable Devices is established as a new cost center on Worksheet A, Line 69. We request revision to the instructions for this cost center, which read as follows: Include the expense of implantable devices charged to patients. The types of items includable on this line are high cost implantable devices chargeable and traceable to individual patients. This amount is generally not

input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 15 (central service and supply) based on the recommended statistic of charges requisitioned.

First, the description of implantable devices is vague. We request CMS clarify which devices, by revenue code, are to be included in this cost center, consistent with the descriptions CMS provided in several **Federal Registers** addressing the creation of this cost center. Second, the last sentence says this amount is generally not input on Worksheet A. We disagree with this comment. In discussing this with numerous hospital clients, all have indicated they intend to either capture the data directly on the general ledger, or in a supplemental report that could be used to record a Worksheet A-6 reclassification for the cost of implantables. We request CMS eliminate this last sentence to avoid confusion on this issue.

Worksheet A-7

We request CMS eliminate this worksheet. This worksheet is time-consuming, and does not provide relevant information useful in completion of the cost report or in determining hospital reimbursement.

Worksheet B-1

The Note at the top of Page 40-115 of the draft instructions mentions the applicability of the capital consistency rules. We do not believe these rules are relevant under the capital prospective payment system, and request this note be eliminated to avoid confusion.

Worksheet C and subsequent worksheets

CMS has made several changes to delete worksheets or sections of worksheets used by various state Medicaid plans. While we understand this is a Medicare cost report, we are also aware of the reporting burden imposed on hospitals in many states where Medicaid plans require cost report filings that include data not reported on the current Form 2552-96. To further eliminate schedules used by Medicaid agencies will just further increase the reporting burden to create extra schedules to work around these changes. We would encourage CMS to work with the American Hospital Association and/or state Medicaid agencies to gain an understanding of the forms used by the different states, and retain those forms in the Form 2552-10.

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 inpatient days on Line 2. However, the instructions for Line 40 state that PPS providers should report zero on this line. Therefore, by using Line 40 instead of Line 36 (which is used in the current Form 2552-96 instructions) CMS is understating program costs for PPS hospitals. This is significant, as the routine cost is used for certain calculations for sole community and Medicare dependent hospitals, as well as state Medicaid calculations. The data is also used in Medicare payment adequacy analyses conducted by MedPAC and other organizations. We request CMS revert back to the previous instructions for Line 38, that it equals the sum of Lines 36 and 37 divided by inpatient days 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.

Worksheet G Series

The instructions that accompany the Worksheet G series are brief and general, and the forms themselves have changed very little in the past 20 years. As this series of worksheets provides important information used by policymakers and others, we request CMS develop a more detailed set of instructions to assist hospitals in completing the worksheets, as well as modifying the worksheets to assist with consistent reporting. As an example, we are aware that bad debt expense is reported in a number of different places by hospitals on Worksheet G-2 or G-3. We believe it would improve consistency by establishing a separate line on which to record bad debt expense either on Worksheet G-2, Part II or Worksheet G-3.

An example of an issue where the forms could be streamlined is the fixed asset section of Worksheet G. Hospitals do not report this level of detail on their external financial statements, nor do we believe this detail is relevant since the implementation of the capital prospective payment system. We suggest this section be streamlined to show total cost and total accumulated depreciation as two lines, in place of Lines 12 through 27. Otherwise, we do not believe CMS needs to extensively revise the forms, but would suggest CMS work with the hospital community to perhaps collect a sample of hospital financial statements for review, and to assist with other possible modifications.

Typographical Errors

We appreciate the magnitude of the project CMS has undertaken to revise the cost report forms. In reviewing the draft forms, we noted the following apparent typographical errors:

- Worksheet A-8, Column 1, Lines 23, 24, 30 and 31 reference Worksheet A-8-4, which has been renamed Worksheet A-8-3. These references should also be changed to Worksheet A-8-3.
- Worksheet D-1, Part I and Worksheet H-2, Part II are both titled FORM CMS-2552-09. While we appreciate the optimism exhibited by the staff drafting these forms, the titles should be changed to 2552-10.
- Worksheet M-3, Line 26 – the parenthetical comment for this line should read "(lines 22 plus 23 plus or minus line 25)."

* * *

We appreciate the opportunity to comment on these draft forms. If you have any questions concerning our comments, or need further information, please contact Tim Wolters at 417.865.8701.

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August 25, 2009

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Attention: CMS-2552-10

Dear Sirs:

We appreciate the opportunity to comment on the proposed cost report changes for the fiscal periods beginning 02/01/10. We are focusing our comments on the proposed changes involving Medicaid days reporting on worksheet S-2. The proposed changes require a provider to break up the Medicaid days reported on worksheet S-3 into various segments on worksheet S-2 including paid and unpaid in-state days, paid and unpaid out-of-state days, HMO days and other days.

We would like for CMS to appreciate that this additional requirement could be burdensome for the providers. The Medicare DSH regulations do not require a distinction between paid and unpaid days, nor a distinction in the insurance coverage or residence location of their patients. The requirement is based upon the Medicaid eligibility of the patient.

For that reason, many (or most) providers do not accumulate their Medicaid days by the above segments. Some providers may not even possess the ability to readily obtain accurate data to break out these categories of days. Therefore, we request that CMS reconsider this proposed requirement on worksheet S-2 regarding the detailing of Medicaid days.

Thank you for the opportunity to comment on this proposed change.

Sincerely,

David P. Pfeil