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Lancaster General Health

RECEIVED 9/28/09 Hand delivered by Cheryl Sims

September 1, 2009

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OSORA, DIVISION
OF CORRESPONDENCE
MANAGEMENT

Charlene Frizzera
Acting Administrator
The 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 Complex Cost Report and Supporting Regulations

Dear Ms. Frizzera:

On behalf of Lancaster General Health, I want to express our appreciation for the opportunity to comment about 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*. We support CMS' efforts to improve the quality of data being reported and eliminate the collection of outdated information. We agree with a number of the proposed revisions to the cost report, including the simplification of the settlement worksheets, but are concerned that the proposed revisions are less than comprehensive in nature and require certain data that are virtually impossible for hospitals to provide.

We support HAP and the American Hospital Association's (AHA) recommendation 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. To be effective, this type of review and modification process should be conducted in collaboration with the hospital community. Lancaster General and our colleagues across the country are ready to work with CMS on comprehensive cost report reform.

The following are detailed comments about CMS' proposed modifications to the cost report:

- 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 which should be, instead, fully transparent.

Recommendation: Although not included in CMS' proposed changes to the hospital cost report; **we** recommend that CMS create a new worksheet to capture all of the DSH data elements in one place, as well as to provide for a complete calculation of a hospital's Medicare DSH percentage.

- When submitting cost reports, hospitals must submit Form 339—the Provider Cost Report Reimbursement Questionnaire. Form 339 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 this form, but would still require hospitals to report most of the information that it contains 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 primary purpose of these exhibits is 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.

  Recommendation: We suggest 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 pertinent to the data contained on the cost report.

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- If hospitals claim Medicare bad debt reimbursement, they currently must submit Exhibit 5. Although not included in CMS' proposed cost report changes, HAP recommends that the Form 339 bad debt exhibit be handled in a manner similar to the intern and resident information system (IRIS) diskette and have it be separate from the cost report.

  Recommendation: We encourage CMS to update the software that is used to complete and transmit the IRIS diskette, since the software is outdated and does not work well in today's electronic environment.

COMMENTS ON SPECIFIC WORKSHEETS

Lancaster General supports HAP's positions and recommendations on specific worksheets as outlined in their August 26, 2009 letter.

- 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.

Recommendation:
Lancaster General joins HAP in urging CMS to eliminate this proposed worksheet from the 2552-10 cost report.

- Charity Care

Because of the effort Lancaster General and so many other non-profit hospitals invest in charity care, I will be more specific in my comments about how charity care is calculated. Lancaster General has long held our commitment to charity care as integral to our mission and strategic plan. We are the safety net for a community of over 500,000 residents. We

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are an active and committed community partner supporting many efforts in our city, county, and region. We have designed our mission and community benefit work to meet AHA/CHI standards. We believe that any effort to modify how charity care is calculated should be based on the many sincere and successful working models that hospitals provide and not overly focus on only errors or anomalies.

CMS proposes to modify the way the cost of charity care is calculated that would impose extremely difficult and burdensome costs on hospitals. The current Internal Revenue Service's 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.

CMS' new, 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 and inconsistent with other federal government charity care data collection instruments.

Recommendation:

Lancaster General joins HAP in urging 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.

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Again, Lancaster General appreciates the opportunity to submit these comments. We stand ready to work with CMS 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 questions, or would like to discuss these comments in more detail, please contact Jo Ann Lawer at 717-544-4292 or jrlawer@lancastergeneral.org.

Sincerely,

Thomas E. Beeman

Thomas E. Beeman PhD, FACHE
President and Chief Executive Officer

c: Jo Ann Lawer, Director – Government Affairs

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CPAs & BUSINESS ADVISORS

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RECE 9/28/09

Hand delivered to Darryl Simms

August 26, 2009

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OSORA, DIVISION
OF CORRESPONDENCE
MANAGEMENT

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

RE: CMS 2552-10

Dear Ms. Frizzera:

Below are our comments on the proposed modifications to the Medicare cost report, form 2552-10 published in the July 2, 2009 Federal Register.

Worksheet S-3, part V
This report requires hospitals to separate the labor and benefits for contracted costs. Most contractors charge a flat rate which makes it virtually impossible to determine the labor and benefit portions, which would make it very difficult if not impossible to gather.

Medicare Disproportionate Share Hospital
The information for the calculation of the Medicare DSH is included in the cost report but the calculation is not. We recommend that this calculation be a part of the cost report.

Sole Community
Much like the DSH calculation, this is calculated outside of the forms and then the result is entered into the cost report. We recommend that this become part of the cost report. Lines for the Hospital-Specific rates and DRG weights could be added to E part A.

Worksheet K Series
Worksheets K-1 through K-3 are virtually the same as the old Home Health series H-1 through H-3. We recommend combining them on schedule K and eliminating K-1 through K-3, much like the recommendation for the H series.

Outpatient services

Outpatient services such as observation, is performed in a routine setting. This of course is handled on the S-3 and D-1 of the cost report. However, in rural facilities, it is quite common for services such as blood administration or IV therapy for example, to be completed in the routine area as well. Moving these patients to an outpatient setting to perform these services isn't efficient or cost effective. Currently, depending on the FI/MAC, the transfer of these costs is handled by making a post step-down adjustment on B-2. We recommend creating a mechanism to allocate routine costs for these services from the routine area to the outpatient area much like the observation calculation currently being used. This would also help with clarification between auditors on how this issue should be handled on the Medicare cost report.

Worksheet A-7

Continuing with the idea of eliminating worksheets no longer in use, Worksheet A-7 would seem to fall in this category. If we are eliminating the A-7 reference on A-6 which properly moves the interest, depreciation or taxes on A-7, and if we directly assign the other capital costs on Worksheet A to the proper line (i.e. line 1 building or line 2 equipment), then we shouldn't need this worksheet.

Wage Index

The proposed instructions for S-3 part II, line 28 state, "Do not include on line 28 any costs for contract home office personnel (these costs are currently not included in the wage index)." This would seem to force facilities to go outside their home office for these services which would more likely cost more than if they purchased them through their home office. It seems to be a double standard if independent facilities can report these services but those with a home office or related party cannot.

Health Information Technology (for meaningful EHR users)

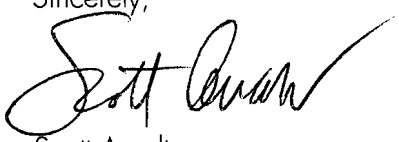
The Health Information Technology incentive in the Recovery Act beginning in 2011 is a cost report issue and it seems that this might be a good time to add a schedule to help gather the necessary information. This program will be in effect for eight years and it would seem that a schedule with clear instructions would help both the provider and auditor in tracking the necessary data.

Interim Rates

One of the first things FI/MAC's and providers calculate for CAH's is their interim rates based on the cost report. Would it be possible to have the cost report calculate those numbers in the report? Since all of the information is there, it seems this would save a great deal of time and money for everyone.

If you have any questions, please contact me at 701.239.8641 or sawalt@eidebailly.com.

Sincerely,



Scott Awalt
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CMS-2009-0060(e001)

FDMS.gov

1258 - posted # 1126 comment

OPPS/ASC final CMS-1414

DIXON HUGHES PLLC
Certified Public Accountants and Advisors

4/17/09 (20)
Hand delivered from Barry Sims

August 28, 2009

Centers for Medicare and Medicaid Services (CMS)
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

Dear CMS,

We appreciate the opportunity to comment on the proposed changes to the Medicare hospital cost report, Form 2552-10 that was published in the July 2, 2009 *Federal Register*. Our Firm prepares over 100 hospital cost reports from critical access hospitals to large tertiary care hospitals that are located throughout the United States.

We believe that CMS has made many changes to the draft cost report that has eliminated outdated sections and other changes that will improve the quality of information provided by the hospitals to CMS. We believe these proposed changes will produce a cost report that will require few changes so that the report will be applicable for many years to come as was the Form 2252-96

As with any undertaking that seeks to report information to CMS for hospitals of all sizes and organizational structure, it is very difficult for one organization to consider all of the possible changes that could be incorporated into this document. Consequently, we would like to make the following comments regarding the proposed hospital cost report, Form 2552-10 (2552-10).

Cost Reporting Software

While this comment is not directly related to the draft 2552-10, we believe this issue is significant enough to bring to the attention of CMS. There are several vendors that have developed software packages that have the capability to produce a hospital cost report including electronic file submissions that have been approved by CMS. Due to the complexity of the Medicare regulations that are incorporated into the hospital cost report, interpretations have to be made by these companies regarding the edits that should be incorporated into these packages.

We have noted numerous instances in which the fiscal intermediary may be using a hospital cost report software package developed from another vendor than the one our Firm uses, and the fiscal intermediary has rejected cost reports due to differences in the interpretation of the guidelines.

As a result, we recommend that if a hospital uses a hospital cost reporting software vendor approved by CMS and was able to produce an ECR file along with an encrypted Worksheet S, then this should be deemed to be an acceptable electronic filing regardless of differences in interpretations between the software vendors.

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Wage Index

The instructions for the 2552-10 propose that home office contract labor cannot be included in contracted administrative and general costs on Worksheet S-3. It is not clear why freestanding hospitals can include these costs for wage index purposes but home offices cannot. We recommend that hospitals be permitted to include these costs from home offices.

The instructions state that all wage-related costs (including payroll taxes) associated with provider-based physicians must be allocated between Part A and Part B. This contradicts how wage-related costs are allocated on Worksheet A-8-2. Existing regulations state that payroll taxes attributed to physicians do not have to be allocated to Part B. We propose that for the purposes of the wage index, that payroll taxes would not have to be allocated to Part B.

Medicaid Specific Worksheets

CMS has proposed to eliminate certain worksheets that are required to determine the amount of Medicaid reimbursement in certain states. There are states that utilize Worksheet C, Part II and Worksheet D-1, lines 66-82. Unless a state's Medicaid reimbursement system matches the Medicare program exactly, one cost report would have to be prepared for Medicare purposes and a second cost report would have to be prepared for Medicaid purposes.

Identification of Type of Hospital

On the existing 2552-96 and the draft 2552-10, on Worksheet S-2, the identification as to the type of hospital (for example critical access hospital or sole community hospital) is provided late in the form . There are questions asked earlier on this worksheet that do not pertain to all providers, but must still be answered even though the question does not apply to that type of hospital. For example, there are questions regarding Medicare Geographic Classification or Medicare Disproportionate Share that would not apply to a critical access hospital. Therefore, if the identification as to the type of hospital that is filing this cost report is identified earlier on in this worksheet, many questions could be deemed not to apply to this provider and would not have to be addressed. Therefore, we recommend that the identification as to type of facility or designation that a provider be asked early in this worksheet.

Worksheet S-10

We are concerned that the proposed Worksheet S-10 has removed certain types of uncompensated care that are provided by hospitals. Since this information may be compiled by CMS to report to Congress and other organizations regarding the amount of uncompensated care, we believe this worksheet as proposed, would understate the amount of uncompensated care. For example, this worksheet has removed the unreimbursed costs of state and local indigent care programs, CHIP and Medicaid from the bottom line. This proposed worksheet would also not obtain the amount of unreimbursed costs associated from bad debts.

This worksheet also requires the hospital to report the amount of charity care it provides to patients when 100% of the bill is written-off as well as the amount of charity care provided to patients when the full amount of the bill was not written-off. Other organizations such as the Internal Revenue System,

does not require this level of reporting. The requirement to provide the amount of charity care provided to patients when the full amount of the bill is not written-off would place an undue hardship on all hospitals.

Medicare Disproportionate Share (DSH)

The proposed 2552-10 gathers information used in connection with both the eligibility and determination of DSH and as to the amount of reimbursement the hospital should receive on multiple worksheets. In addition, the DSH percentage used to determine the amount of actual reimbursement is done outside the cost report by the provider. We recommend that a separate worksheet be developed that addresses all of data elements used in the determination of Medicare DSH, including the computation of the actual payment percentage as well as the application of the DSH cap.

CMS Form 339

Certain elements but not all of the existing CMS Form 339 have been incorporated into the 2552-10. Examples are worksheets dealing with physician allocations and the determination of ED physician availability costs. We believe if any information that is presently on the CMS Form 339 is included on the 2552-10; then, the entire form should be included. Any exhibits that are not applicable could be designated as such and would not be included on the 2552-10. Since Critical Access Hospitals (CAH) are not subject RCE limits, these exhibits should be modified since CAH are not subject to this limitation. When exhibits are completed in connection with the reimbursement of provider-based physicians, the instructions state that an allocation agreement should be submitted. Under existing regulations, the document is prepared at the beginning of the arrangement as opposed to the end of a cost reporting period. If an allocation agreement is required to be completed, this document should be used to allocate physician costs to professional, provider and availability services. If CMS believes a time study should be used to allocate these costs, the allocation agreement should be eliminated.

The 2552-10 does not include Exhibit 5 that is used to report Medicare bad debts. We agree that this information should be provided to CMS outside of the 2552-10 and should be reported in a similar fashion that interns and resident information is provided on the (IRIS) diskette.

CMS has provided a suggested format as to the information that would be required for a provider to be reimbursed for Medicare bad debts. This format has not been modified for many years, and we believe it violates the existing HIPPA regulations. CMS needs to develop a system so that hospitals can submit this information in such a fashion to be in compliance with these regulations.

Worksheet S-3, Part V

This worksheet requires the hospital to provide the amount of employee benefits attributed to contract labor. We believe that this information will be difficult to obtain since this information is not normally provided by contractors. In addition, it is not clear why this information is being obtained since these costs do not affect the amount of reimbursement at the present time.

Worksheet A-7

Except for new hospitals that will be paid for their capital costs, this worksheet has no relevance. We propose that this worksheet is not necessary even for new hospitals that are seeking to be reimbursed for it capital costs.

Worksheet E-3, Cost Reimbursement

Are the line references for line 6 of this worksheet correct? Line 6 says that total cost would be line 5 (primary payments) minus line 6.

Worksheet H-4

There are lines on this worksheet requesting data for Significant Change in Condition (SCIC) even though they no longer exist in the home health Medicare program.

In closing, we would like to commend CMS in efforts to improve the hospital cost report and to provide us with the opportunity to provide comments on the 2552-10.

If you have any questions related to our comments, please contact me at (336) 714-8138.

Respectfully,

J. Trent Messick

J. Trent Messick, CPA
Member