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VIA ELECTRONIC SUBMISSION

August 31, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-2552-10 (OMB#: 0938-0050)

Dear Ms. Frizzera:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed modifications to the Medicare hospital cost report, Form 2552-10, about which an announcement was published in the *Federal Register* on July 2, 2009. 74 Fed. Reg. 31738. The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 general acute nonfederal major teaching hospitals and health systems that receive Medicare payments under the inpatient prospective payment system (IPPS). The Association also represents all 130 accredited U.S. medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical students and residents.

The AAMC appreciates that CMS has undertaken an effort to amend the cost report to improve the flow and instructions for hospital data reporting. However, we have several important concerns we feel must be addressed before cost report changes are finalized. In particular, with members that provide forty-one percent of the nation's hospital charity care, we have a number of serious concerns regarding the proposed changes to Worksheet S-10, which requests significant data on Medicaid and indigent care costs and payments.

With members that train the vast majority of residents in the country and that receive the bulk of Medicare indirect medical education (IME) and direct graduate medical education (DGME) payments, we also have several comments on the proposed changes to worksheets E Part A (which contains data used to compute IME payments) and E-4 (which contains data used to compute DGME payments). Below, please find our comments on the proposed modifications to these worksheets.

WORKSHEET S-10

Worksheet S-10 collects Medicaid, uncompensated and indigent care data. In general, the AAMC appreciates CMS's efforts to revise this worksheet and finds it to be a significant improvement over the prior form. The proposed form has a more logical layout and collects data

that are more relevant to capturing hospitals' total uncompensated care costs. However, the AAMC encourages CMS to continue to improve this worksheet so that it accurately captures the level of uncompensated care that hospitals are providing and allows hospitals to report data in a consistent manner. As outlined in detail below, the AAMC has specific concerns regarding various lines of the proposed worksheet.

Line 1

CMS's proposed Line 1 of Worksheet S-10 requires hospitals to provide their cost-to-charge ratio (CCR) from Worksheet C, Part 1. This CCR is used to convert charity care and uncompensated charges into costs on the revised worksheet. The AAMC has several concerns with this line.

First, flat rate providers are not able to compute a CCR calculation. Because these providers' charges are equal to their costs, any CCR calculation for these providers is not meaningful. The AAMC recommends that CMS determine an alternate calculation for these providers to enable them to complete Worksheet S-10.

Second, the proposed CCR is based only on Medicare reimbursable costs. The AAMC believes that to more accurately reflect charity care and uncompensated costs, CMS should instead use a CCR based on total costs that reflect the charity care provided to *both* Medicare and non-Medicare patients. The AAMC proposes that CMS adopt a second line immediately following Line 1 (for example, Line 1.01) to reflect a second CCR based on total costs. CMS should then use this Line 1.01 to calculate Lines 29 and our suggested Line 20 (see below). In developing this second line, we encourage CMS to take into consideration that:

- Inpatient charges vary from outpatient charges, such that an inpatient CCR could be significantly different from an outpatient CCR;
- CCRs are not reflected in the current or revised cost report at the departmental level;
- Costs from the proposed Worksheet C Part I are limited to Medicare allowable expenses; and
- Organ acquisition and home health are not represented on the proposed Worksheet C Part I.

With a second CCR, Worksheet S-10 will more accurately reflect true charity care and uncompensated care costs, as many patients that receive charity care are not necessarily Medicare patients.

Line 2

CMS's proposed Line 2 collects information on Medicaid net revenue and specifically instructs hospitals to include Title XIX payments. The AAMC is concerned that hospitals in several states (e.g., Pennsylvania, Minnesota, Illinois) will not be able to obtain an accurate calculation for this line, because they are unable to exclude general assistance patients from their Title XIX

payments. (General assistance patients receive care funded by a state plan that is not approved for federal matching dollars.) It would be highly burdensome for these providers to attempt to remove these general assistance patients from their total Medicaid net revenue.

Additionally, CMS should clarify that Line 2 should also include managed care net revenues and inpatient and outpatient payments. Since some hospitals may have prior-year Medicaid net revenue, CMS should specify in the instructions what hospitals should do in these circumstances since prior-year revenue can distort current year results.

Lines 3 - 5

CMS's proposed Lines 3 through 5 collect information on disproportionate share hospital (DSH) or supplemental payments from Medicaid. To reduce confusion, the AAMC proposes that Lines 3 through 5 be changed to:

- Line 3: Medicaid DSH payments
- Line 4: Non-DSH Medicaid supplemental payments (including IME and DGME payments)
- Line 5: Total Medicaid net revenues (sum of lines 2 through 4)

Should CMS adopt these suggested changes, the Agency should also make conforming changes to Lines 2 and 8.

To reduce confusion, the AAMC strongly encourages CMS to define exactly what payments hospitals should include as DSH payments, as varying interpretations of the term currently exist. CMS should also instruct hospitals that are unable to separate DSH and non-DSH payments from their Medicaid net revenues to simply enter their total Medicaid net revenue in Line 5.

Lines 8, 12, and 16

CMS's proposed Lines 8, 12, and 16 collect information on the difference between revenue and costs for the Medicaid program, State Children's Health Insurance Program (SCHIP), and state or local indigent care programs respectively. The AAMC recommends that CMS clarify the language in these lines to reference the "net" revenue.

The AAMC is also concerned that these lines are not included as part of the total in Line 30. We encourage CMS to add a line at the bottom of the Worksheet S-10 that reflects the hospital's total unreimbursed costs (Lines 8, 12, and 16) and uncompensated costs (Line 23 for charity care costs plus Line 29 for bad debt).

Line 13

CMS's proposed Line 13 collects net revenue from state or local indigent care programs. However, the instructions for this line are not clear that payments should be limited to "indigent

care” programs. The AAMC recommends that CMS clarify the language in the instructions to state that the payments are from “state or local government indigent care programs” to ensure that the correct payments are included.

Line 18

CMS’s proposed Line 18 collects information regarding government grants, appropriations, or transfers. Given that the Federal Section 1011 program was not reauthorized, the reference to this program in the instructions should be removed. The AAMC recommends that CMS clarify the language in the instructions to state that only government grants, appropriations, or transfers used for uncompensated care are included.

Lines 19 - 23

CMS’s proposed Lines 19 through 23 collect data regarding the costs and charges for charity care. The AAMC has several concerns about the data CMS proposes to collect in this section and believes that the instructions lack clarity and may affect hospitals’ ability to provide this information.

First, and generally, the AAMC believes that because CMS has not articulated a purpose for collecting this data, providers cannot be certain exactly what data the Agency desires to collect. For example, on proposed Line 19, it is difficult to determine whether CMS intends to collect data regarding the hospital’s full charges or the patient’s discounted obligation. Greater clarity in CMS’s purposes will allow for better feedback from the AAMC and its members on how CMS might best collect the relevant information.

Second, the AAMC believes that the information CMS solicits on Lines 19 through 23 places an administrative burden on providers, particularly with respect to outpatient charity care charges. AAMC members treat over 130 million total outpatient encounters (or approximately 371,000 outpatient encounters for the typical AAMC member), and these providers find it extremely difficult to separate charity care patients from those who are self-pay or uninsured. While hospitals have more time to attempt to collect this information from inpatients, the short duration of outpatient encounters leads to difficulty in collecting the required data before an outpatient leaves the hospital.

Third, CMS’s proposed instructions for these lines are conflicting regarding insured patients versus uninsured patients. For example, on Line 19, CMS should not be collecting data on full charges for insured patients, when insurance will be paying a portion of the patients’ charges. The proposed revisions AAMC recommends below would remove these insured and uninsured columns.

Line 19

CMS's proposed Line 19 collects the "total initial obligation of patients approved for charity care (at full charges) for the entire facility." First, as discussed above, the AAMC is concerned that this line is subject to multiple interpretations. It is not clear, for example, whether the full charges – regardless of discount – should be entered into this line or whether only the patient obligation should be entered here.

If CMS's intent is to capture the true value of charity care costs, then, in the example above, the hospital should be directed to enter the full charity care charges without discount in Line 19. We recognize, however, that many hospitals may not have a complete charity care log and this type of information may be difficult if not impossible for some hospitals to collect.

CMS should also be aware that similar information is also being collected on the Internal Revenue Service Form 990, Schedule H, which collects information on charity care and other community benefits. Schedule H requires that charity care be reported as the amount of charity care charges the hospital has "written off" pursuant to the hospital's charity care policies. This method 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. Any patient payments would be counted as revenue. So, for example, if an uninsured patient incurs \$1,000 in charges and is approved for full charity care, the hospital will write off \$1,000 in charges on Line 19. Alternatively, if an uninsured patient is approved for a 50 percent discount, then the hospital will write off \$500 on Line 19.

The AAMC believes it is important that the charity care data collected on Form 990, Schedule H, and Worksheet S-10 be consistent with one another. Currently, the CCR in Line 1 of Worksheet S-10 is inconsistent with the CCR used in Schedule H. Therefore, the charity care costs calculated in Worksheet S-10 will not be in agreement with Schedule H or a hospital's audited financial statements. CMS should also be aware that Schedule H is an evolving document that is still in its early stages of use and that it may be necessary for Worksheet S-10 to evolve consistently with Schedule H. CMS should clearly articulate the reason for any differences between its own Worksheet S-10 and the IRS Form 990, Schedule H, or inconsistencies will lead to confusion for policy makers and providers alike.

Line 20

CMS's proposed Line 20 collects the "initial obligation of patients for charity care (at full charges) for §1886(d) hospitals or CAHs." The AAMC is concerned that the difference between Lines 19 and 20 is not clear and may result in incorrect data reporting.

To address the concerns articulated above regarding Lines 19 through 23, the AAMC suggests amending Lines 19 and 20 as follows and deleting Lines 21 through 23:

Line 19: Total charity care charges (as accounted for in the hospital's general ledger)
Line 20: Total charity care costs (AAMC's proposed Line 1.01 times Line 19)

Lines 25 - 30

CMS's proposed Lines 26 and 27 collect information regarding total bad debt and Medicare bad debt. Total bad debt and Medicare bad debt may not necessarily be comparable, as Medicare bad debt must follow CMS guidelines not required for non-Medicare bad debt. Subtracting Medicare bad debt from total bad debt to calculate the cost of non-Medicare bad debt and uncompensated care may, therefore, result in under- or over-stating these costs.

WORKSHEET E PART A

Worksheet E Part A collects reimbursement settlement information for payments including the indirect graduate medical education (IME) adjustment and the Medicare DSH adjustment. The AAMC has the following concerns regarding specific lines of Worksheet E Part A:

- **Line 6:** This line captures information regarding the full time equivalent (FTE) resident count for new programs. In the instructions for this line, CMS should add clarifying dates to conform to the language of the regulations. The sentence describing the requirements for hospitals qualifying under 42 CFR 413.79(e)(2) should read as follows: "For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2) the cap for each new program accredited or begun on or after January 1, 1995 and before August 6, 1997 is effective in the fourth program year in each of those new programs."
- **Line 8:** This line captures information regarding the reduced IME FTE cap. The instructions and the title of the line incorrectly reference DGME instead of IME. The corresponding regulatory reference should also be changed from 42 CFR 413.79(c)(3) to 42 CFR 412.105(f)(1)(iv)(B).
- **Line 10:** This line captures the FTE count for the current year. In the second sentence of the instructions for this line CMS should:
 - Reference Line 6 instead of Line 5;
 - Change the reference to Lines 3.13 and 3.14 to instead reference Lines 3.15 and 3.16; and
 - Change the reference to Lines 11 and 12 to instead reference Lines 13 and 14.
- **Line 13:** This line captures the total allowable FTE count for the prior year. In the first sentence, CMS should replace the language "line from" with "the prior year cost report."
- **Line 14:** This line captures the total allowable FTE count for the penultimate year. To improve clarity, CMS should replace the phrase "for the penultimate" to "from the penultimate."

- Line 17: This line captures the prior year resident-to-bed ratio. To improve clarity, CMS should include additional instructions to take into account that on the prior year cost report, residents in the initial years of each new program are not included in the FTE count until after computation of the rolling average. Therefore, in calculating the numerator of the prior year resident-to-bed ratio in the year following expiration of each new program's exemption from the rolling average, the FTE count from Line 12 of the prior year cost report needs to be adjusted. This FTE count should include FTEs from each new program now in its first year after loss of exemption from the rolling average under which its resident FTEs were added back, after calculation of the rolling average in the prior year cost report. The AAMC suggests adding the following instructions: "For each new training program, in the first cost reporting period following expiration of the period of years during which those residents were exempted from the rolling average, add to the numerator (Line 12 for Form 2552-10 or Line 3.14 for Form 2552-96) of the prior year resident to bed ratio the number of FTE residents in that specific program included in line 15 of the prior year cost report (Line 3.17 if the prior year cost report was Form 2552-96)."
- Line 19: This line captures the IME payment adjustment. In the payment formula, the reference to line 3.18 should be changed to Line 18.
- Line 28: This line captures Medicaid days used for the DSH payment calculation. The AAMC is concerned that CMS also proposed to add Lines 21 and 22 in Worksheet S-2, Part 1, on Medicaid days, but that this information does not flow to Line 28 of Worksheet E Part A. The AAMC recommends that any data related to the DSH calculation be collected solely in Worksheet E, Part A.
- Lines 32-39: These lines are reserved for future use but are incorrectly labeled as Lines 31-39 in the instructions. Line 31 should be changed to Line 32.
- Line 45: This line captures the average weekly cost of dialysis treatment. To improve clarity, CMS should reiterate in the instructions that hospitals should enter the average *weekly* cost.
- Line 48: This line captures hospital-specific payments. CMS should append the last sentence of the second paragraph of the instructions for this line to include FY 2006 in the list of years.
- Line 57: This line captures "routine service other pass through costs." CMS should amend the phrase "lines 42 through 42" in the instructions for this line to read "40 through 42."

WORKSHEET E-4

Worksheet E-4 collects DGME and ESRD outpatient DGME costs. The AAMC has the following concerns with specific lines of Worksheet E-4:

- Line 3: This line captures the unweighted FTE count for new programs. The regulatory reference listed in the instructions should be changed from 42 CFR 413.79(f) to 42 CFR 413.79(e).

- Line 12: This line captures the total weighted FTE count for the prior year. In the first paragraph of the instructions for this line, the reference to Line 18 should instead be to Column 1, Line 17. To improve the clarity of these instructions, CMS should also move the last two sentences of the first paragraph to follow the first sentence of the first paragraph and move the last two sentences of the second paragraph to follow the first sentence of the second paragraph. In the second paragraph, the reference to Line 18 should instead be to Column 2, Line 17.
- Line 13: This line captures the total weighted FTE count for the penultimate year. In the first paragraph of the instructions for this line, the reference to Line 18 should instead be to Column 1, Line 17. To improve the clarity of these instructions, CMS should also move the last two sentences of the first paragraph to follow the first sentence of the first paragraph and move the last two sentences of the second paragraph to follow the first sentence of the second paragraph. In the second paragraph, the reference to Line 18 should instead be to Column 2, Line 17.
- Line 28: This line captures the “ratio of inpatient days to total inpatient days.” CMS should amend the phrase “divide line 4 by line 5” in the instructions to read “line 26 by line 27.”
- Line 29: This line captures the program DGME amount. The AAMC is unclear as to why CMS has excluded Section 422 DGME payments in the calculation of this line.
- Line 30: This line captures the reduction in nursing/allied health payments. The AAMC is unclear as to why CMS has instructed hospitals to use the reduction factor referenced in the Federal Register dated August 1, 2000 when the reduction factor has since been updated in the CMS Program Memorandum A-03-043, dated May 23, 2003.

CONCLUSION

Thank you for the opportunity to present our views. We recognize that this is a complex area, particularly as these changes relate to charity care and indigent care policies, and we would be happy to arrange for you to meet with several of our members to discuss the issues we have outlined here. If we can arrange such a meeting or if you have questions regarding our comments, please feel free to contact Erika Steinmetz at 202-828-0490 or at esteinmetz@aamc.org.

Sincerely,



Karen Fisher, J.D.

cc: Erika Steinmetz, AAMC
Lori Mihalich-Levin, J.D., AAMC