MEDPAC Medicare Payment Advisory Commission

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Michelle Shortt
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Document Identifier CMS-2552-10

Dear Ms. Shortt:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed revisions to the Medicare cost report entitled Hospital and Health Care Complexes Cost Report and Supporting Regulations, Federal Register Vol. 74 No. 126, page 31738 (July 2, 2009). We appreciate your staff's ongoing efforts to administer and improve the payment systems for hospital services, particularly considering the agency's competing demands and limited resources.

Accurate information on hospital costs, including the costs of charity care and bad debt, is important for the operation of the Medicare program and for development of sound public policy. In our view, the proposed changes to the cost report would substantially improve the accuracy and completeness of the cost data hospitals report. CMS has appropriately removed forms that are no longer needed and retained the forms that are essential to the examination of hospitals' costs and payments. We believe, however, that several additional changes in the cost report are needed to address specific policy issues. In particular, we comment on how to calculate costs more accurately for specific types of services used in calculating relative weights for Medicare severity DRGs (MS-DRGs) and ambulatory payment classifications (APCs), and how to make reporting of hospitals' overall financial condition more consistent with their audited financial statements.

Revising Form S-10 – Hospital Uncompensated and Indigent Care Data

We fully endorse the proposed revisions to form S-10. The current form and instructions have produced unreliable data. The proposed changes would measure charity care costs as the uncovered cost of care for cases in which the hospital has chosen to furnish services in whole or in part without compensation. Each hospital would report its total charges for such charity cases. The total charity charges would be multiplied by the hospital's cost to charge ratio to estimate its related total charity care costs. Then the

hospital's net charity care costs would be calculated by subtracting any patient care revenues received for the same cases from the total charity care costs. The proposed method, which is currently used by others, such as the state of Texas, is both accurate and feasible. The alternative method that is also currently in use, instead calculates charity care costs by applying the hospital's cost to charge ratio to the charges it writes off for charity care cases. This calculation will overstate net charity care costs because any patient care revenues a hospital receives for these cases are ignored. This can lead to situations in which a hospital can claim charity care costs equal to the full cost value of charges written off even though patient care payments fully or partially cover the hospital's actual cost of care. We believe such overstatements would be inappropriate and uneven among hospitals, especially those that have high charge mark-ups. The revised form also allows the separation of uncompensated care into charity care for the uninsured, charity care for the underinsured, and the cost of bad debts. This detailed level of information will be critical for evaluating policies that consider linking Medicare disproportionate share (DSH) payments to hospitals' uncompensated care costs, as well as analyses of the distribution of uncompensated care costs among hospitals.

CMS has proposed requiring that all providers use the same cost-to-charge fields from their cost reports when computing the reported costs of charity care and bad debts. We agree that requiring a consistent methodology across hospitals is necessary to allow comparison of charity care costs across facilities. In addition, the use of a cost to charge ratio that reflects Medicare allowable costs provides the fairest and most consistent method for calculating patient care costs across facilities. This will make costs more comparable across facilities by removing some costs that hospitals incur that are not necessary for patient care such as interest expense that is offset by interest revenue. We fully support the changes you have made to the S-10.

Adding new standard lines for additional revenue centers

MedPAC believes that improving the accuracy and fairness of the relative weights for MS-DRGs in the inpatient prospective payment system (IPPS) and for APCs in the outpatient prospective payment system (OPPS) is an important goal. Therefore, we commend CMS for proposing to add a new standard revenue center line to the cost report to break out costs and charges for costly devices and implants from other supplies charged to patients. Hospitals will be able to use this line to report data that are essential to make substantial improvements in payment accuracy for device-intensive MS-DRGs and APCs.

The July 2008 final report to CMS from RTI International, entitled "Refining Cost-to-Charge Ratios for Calculating APC and MS-DRG Relative Payment Weights", however, also identified equally important opportunities for CMS to improve payment accuracy in both the IPPS and OPPS by adding several other standard revenue center lines to the cost report. The RTI report demonstrates convincingly that additional lines are needed for CT scans, MRI scans, cardiac catheterization, and drugs that require additional detailed coding (mostly chemotherapy agents).

These additional lines are needed to distinguish items and services that hospitals tend to mark up differently within existing revenue centers. For example, RTI showed that CT scans have a significantly higher markup than most other radiology services. When CMS uses the overall radiology cost to charge ratio, it overestimates the cost of these services, resulting in overstated relative weights for certain MS-DRGs in the IPPS and for corresponding APCs in the OPPS. Adding a separate line for CT scans would permit hospitals to separate charges and costs for these services, thereby correcting this problem.

Adding only one new revenue center line for devices and implants as proposed will not ensure equity across types of services, and it may impair payment accuracy for some MS-DRGs by correcting only one source of bias among several that are now partially offsetting. In our view, it is important to also provide new lines for CT scans, MRI scans, cardiac catheterization, and certain drugs.

Some might object that these additional lines may substantially increase hospitals' reporting burdens in completing the cost report. Evidence from the RTI report, however, suggests that roughly one-third of hospitals paid under the IPPS and OPPS are already separately reporting costs and charges for CT scans (1,174), MRI (969), and cardiac catheterization (1,035) on the few available non-standard lines in the current cost report. We believe that the value of increased payment accuracy stemming from more detailed reporting would offset the increased reporting burden on those hospitals that do not already separately report these costs.

New and separate worksheets for hospital-based units

The proposed addition of separate and distinct work sheets and cost center lines for inpatient rehabilitation units and facilities, inpatient psychiatric units and facilities, and long term care hospitals is another desirable revision. As these units and facilities are now paid differently from one another, separate worksheets designed specifically for each of these payment systems should help to simplify the reporting process and should also lead to more accurate reporting.

Renumber of lines and columns and removal of subscripted lines

In revising the cost report CMS proposed to renumber lines, columns, and some worksheets and to eliminate the use of subscripted lines. We support the proposed changes. The expanded use of section headers within worksheets is also a useful addition as it creates a more logical flow to the worksheets and encourages hospitals to use them appropriately. To lessen the burden on those who use the cost reports for analysis, we encourage CMS to develop for public use a cross walk between the old and new forms. Such a cross walk would help analysts and programmers correctly use data from the new cost report.

Revise and update Schedule G to be consistent with hospital audited financial statements

Schedule G of the cost report provides information from each hospital's financial statements. In the proposed revision of the cost report, CMS makes no substantive changes to this schedule. However, Schedule G was designed more than 25 years ago, and it is not consistent with the format and content of provider's audited financial statements, nor does it fully comport with generally accepted accounting principles that audited financial statements follow (see MedPAC 2004—Report to the Congress: Sources of financial data on Medicare providers).

We believe CMS should revise Schedule G to follow the format of standard audited financial statements. Accordingly, a revised Schedule G should include four forms: an income statement, a cash flow statement, a balance sheet, and a statement of changes in net assets. A revised schedule G that mirrors standard audited financial statements should be less burdensome for providers because they would present the same information as in their existing financial statements, which hospitals are already required to submit with their cost reports. With a revised schedule G, for example, hospitals would no

longer need to provide a breakdown of revenue into minor categories, such as vending machine rental and parking lot revenues, as is required on the current form. Instead, they would report standard broad categories of revenues: patient care revenues, other operating revenues, and nonoperating revenues, for example. Further, a revised schedule G should lead to improvements in reporting accuracy compared with the current forms that do not mirror their financial statements and lack detailed instructions.

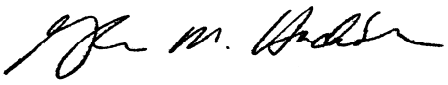
In our June 2004 report to the Congress on sources of financial data on Medicare providers we proposed adding a fifth worksheet to the schedule G series that would report by payer (Medicare, Medicaid, other insurance, and self pay) a breakdown of charges, discounts and allowances, and net patient revenues by payer for inpatient and outpatient services. This type of data would be helpful to better understand hospital finances and should be easily available from providers' financial records. We encourage CMS to consider adding a new worksheet that reports this information.

The lack of detailed instruction for the various worksheets for Schedule G is also problematic, and may lead to inconsistent reporting of data across providers. A revised schedule G with detailed instructions is vital for obtaining accurate financial data on providers. Schedule G data should also be reported from the smallest corporate entity that includes the hospital, and the instructions for filing schedule G should make this clear.

Conclusion

As we discuss in this letter, we commend CMS for its proposed revisions to the hospital cost report, which we believe will help improve the accuracy and fairness of Medicare's payments to providers. We also believe, however, that several additional changes to the cost report would yield substantial benefits by providing more detailed and more accurate information to help policy makers improve Medicare's payment systems and better understand hospitals' financial condition.

Sincerely,



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