ALLIANCE OF DEDICATED CANCER CENTERS

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August 31, 2009

By Electronic Submission

Acting Administrator
Ms. Charlene Frizzera
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201
Attention: CMS–1404-P

Re: CMS–2552–10 and CMS–10097; Agency Information Collection Activities: Proposed Collection; Comment Request

Dear Acting Administrator Frizzera:

The Alliance of Dedicated Cancer Centers (the "Centers"), an alliance of ten nationally recognized institutions focusing exclusively on the care of cancer patients, is pleased to submit the following comments on the above notice of proposed rulemaking, published in the *Federal Register* (Vol. 74 No. 126) on July 2, 2009.[1] The Centers, individually listed here, appreciate the opportunity to comment on the Proposed Rule that would revise the Medicare cost reporting system.

We appreciate the agency's willingness to consider our views and hope to see our recommendations implemented. If you have any questions or require additional information, please do not hesitate to contact me at 215-266-3497 or by email at RDL12@comcast.net.

Sincerely,

R. Donald Leedy
Executive Director
Alliance of Dedicated Cancer Centers

[1] 74 Fed. Reg. 31,738 (July 2, 2009).

The ADCC has identified that, with respect to the current 2552-96 cost reporting software, we are unable to subscript capital lines 1 - 4 more than 49 lines for capital buildings. In some instances, our Centers exceed this limit and need additional lines due to the number of buildings we own and lease. **The ADCC requests that CMS allow hospitals to subscript capital lines 1 and 2 in the new 2552-10 version of the cost reporting software to 99 lines**. This will enable us, along with other providers, to keep all of our capital costs on Worksheet A, rather than directly assigning part of our capital costs to Worksheet B, part III.

The ADCC also requests that CMS standardize the subscripting of radiology cost centers by breaking these cost centers into CT, MRI, and nuclear medicine. This will provide CMS with more precise information about the costs associated with imaging services while allowing hospitals to continue appropriately matching costs and charges when determining the ratio of cost to charges for each cost center. In turn, standardizing this subscripting requirement will result in CMS receiving more accurate, consistent, and reliable data from all providers to use in its rate setting calculations. As it stands now, some providers may report all of their imaging costs and charges on one line, thus diluting the ratio of cost to charges and impacting both DRG and APC payment rates. CT and MRI are capital-intensive cost centers; thus, the correct allocation is especially critical in order to derive accurate CCRs. If providers do not properly identify and allocate capital equipment costs to their CT and MRI cost centers, the costs in these cost centers will be *significantly* understated and will impact the resulting CCRs, while leaving greater costs in the diagnostic imaging cost center -- thereby overvaluing other imaging service APC payment rates.

In addition, it is not enough for CMS to release new standard cost centers without clearly defining how the cost centers will be used. It is a simple matter for CMS to issue new cost centers, but it is hard for all hospitals to use them in an accurate and consistent manner. The Centers cannot stress enough that CMS should not expect to generate accurate, complete, or consistent data by simply adding new cost centers (for CT, MRI, etc.) to the cost report, without defining how these cost centers should be used and the impact the data collected has on the rate-setting process.

Further, the Centers believe that CMS should require *all* providers to use these new cost centers. If all providers do not use the new cost centers for CT and MRI, then CMS should restrict its use of claims data from those who submit data in the new cost centers. Otherwise, CMS will continue to use incomplete and/or flawed data in its rate-setting process. We have seen evidence of slow provider uptake when new revenue codes and cost centers are released, but not required, and expect the same situation will occur with the release of any new cost centers, and the attendant problems should be carefully considered by CMS and addressed upfront.

CMS should help providers implement these changes by releasing additional guidance about the interplay between the cost reporting process and the development of APC relative weights. Specifically, hospital cost reporting experts need more information on how cost report data links to the Charge Description Master and billing data, and how this information is used by CMS to reduce billed charges to costs in the development of APC median costs and ultimately APC payment rates.

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