701 Pennsylvania Avenue, Ste. 800
Washington, DC 20004–2654
Tel: 202 783 8700
Fax: 202 783 8750
www.AdvaMed.org

AdvaMed
Advanced Medical Technology Association

August 31, 2009

**Via Electronic Mail**
Michelle Shortt, Director
Regulations Development Group
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: Document Identifier/OMB
Control Number, Room C4-26-05, 7500
Security Boulevard
Baltimore, MD 21244-1850

**Re: Centers for Medicare and Medicaid Services' (CMS) Agency Information Collection Activities: Proposed Collection; Comment Request Document Identifier: CMS–2552–10 and CMS–10097**

Dear Ms. Shortt:

The Advanced Medical Technology Association (AdvaMed) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Agency Information Collection Activities: Proposed Collection; Comment Request Document Identifier: CMS–2552–10 and CMS–10097,] *Federal Register*, Vol. 74, No. 126, Thursday, July 2, 2009, p. 31738).

AdvaMed member companies produce the medical devices, diagnostic products, and health information systems that are transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. Our members produce nearly 90 percent of the health care technology purchased annually in the United States and more than 50 percent purchased annually around the world. AdvaMed members range from the largest to the smallest medical technology innovators and companies.

In the July 2, 2009 *Federal Register*, CMS requested comments on changes to the Medicare Hospital Cost Report (FORM CMS-2552-10), in compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995. CMS invited public comments on the following topics:

(1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions;
(2) the accuracy of the estimated burden;
(3) ways to enhance the quality, utility, and clarity of the information to be collected;
(4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden; and
(5) Other aspects of collection of this information.

AdvaMed is pleased that CMS has committed to making the changes to Medicare's hospital cost reports to improve the accuracy of the data used to establish the Medicare inpatient and outpatient cost-based payment weights. These changes will address charge compression for advanced technology, high cost devices--a systematic bias in the calculation of the Medicare payment weights and rates for certain hospital services. AdvaMed supported the movement to cost-based weights and CMS's proposal to address the problem of charge compression by establishing a separate cost center in the Medicare cost reports for implantable devices. AdvaMed believes the proposed information collection is fully necessary and of high utility in achieving the agency's goal of payment accuracy.

**Changes to Hospital Cost Report Form CMS 2552-10**

In the July 2, 2009 *Federal Register*, CMS requested comments on changes to the Medicare Hospital Cost Report FORM CMS-2552-10. Changes were made to both the instructions and the cost report itself to address the problem of charge compression by establishing two separate cost centers in the report, one for medical supplies and a second for implantable devices.

**AdvaMed has the following specific comments on FORM CMS-2552-10:**

1. CMS-2552-10 instructions do not include the recommended revenue codes that identify the charges to be grouped on Line 69 of the Cost Report, "Implantable Devices." The instructions should be modified to incorporate reference to the specific revenue codes that should be used for this line of the Cost Report. Furthermore, CMS should advise hospitals regarding the definitions of revenue codes and the extent to which hospital determinations regarding the composition of specific revenue codes are appropriate. AdvaMed notes this issue in relation to certain advanced technology implants that are used during a procedure but do not remain in the patient at discharge—in essence, temporary implantables—and to certain higher cost supplies subject to the effects of charge compression. In such instances, making clear hospitals' discretion to use revenue code 278, "Other Implants" would improve the effectiveness of CMS's proposed policy.

2. The instructions assume that hospitals are unable to identify the direct costs of the chargeable supplies and report directly on Worksheet A prior to the overhead allocations of Central Supply to the supply cost centers based on the allocation statistic of supplies requisitioned by each department. CMS addresses the reporting process by stating, "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". AdvaMed believes that supply costs can be directly assigned on Worksheet A. AdvaMed further notes that CMS's proposal to recognize the supply costs on Worksheet B, which is used for the allocation of overhead, would understate the full costs of "high cost supplies." The more accurate approach would be to identify the direct expense for the supplies with an allocation of overhead costs prior to Column 15, Central Supply. Overhead costs such as Administration, Finance, Business Services, Quality, Infection Control and Corporate Compliance should be allocated to the supply cost centers prior to Central Supply. With this modification, both supply cost centers would be consistent with the direct and overhead allocations used for other patient service cost centers.

**Our comments translate into the following specific changes to the CMS 2552-10 instructions for Worksheet A:**

1. **Line 68 of the instructions for CMS-2552-10 should be amended to read:**

   Line 68--Include the expense of medical supplies charged to patients. The direct expense of medical supplies charged to patients may be identified through the facility's general ledger or through a Worksheet A-6 reclassification of expenses. ~~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.~~

2. **Line 69 of the instructions for CMS-2552-10 should be amended to read:**

   Line 69--Include the expense of implantable devices charged to patients. The types of items includable on this line are high cost implantable and other high cost devices chargeable and traceable to individual patients. The direct expense of medical supplies charge to patients may be identified through the facility's general ledger or through a Worksheet A-6 reclassification of expenses. ~~This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet be from cost center 15 (central services and supply) based on the recommended statistic of charges requisitioned.~~ Do not include low cost medical supplies on this line. When determining what costs are reported in this costs center, provider should use costs association with implantable devices bearing revenue codes identified in the FR, Vol. 73, No. 161, page 48462, dated August 19, 2008.

As noted in other public comment letters to CMS, AdvaMed recommends that CMS undertake outreach and educational activities for hospitals in order to ensure that cost report changes are implemented effectively and accurately. In addition, AdvaMed recommends that CMS monitor the progress of these important changes to ensure that the more accurate cost-based weights will not be delayed beyond FY 2013.

AdvaMed believes that these minor modifications to the Medicare Cost Report instructions, CMS outreach and educational activities, along with monitoring the will lead to improved payment accuracy in both the short term and the long term.

We would be pleased to answer any questions regarding these comments. Please contact Richard Price at (202) 434-7227 if we can provide assistance.

Sincerely,

Ann-Marie Lynch
Executive Vice President
Payment and Health Care Delivery Policy