



December 28, 2016

Andy Slavitt  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1656-FC and IFC  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital**

Dear Acting Administrator Slavitt:

The American College of Radiology (ACR), representing more than 36,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) Final rule on Hospital Outpatient Prospective Payment System (HOPPS) and interim final rule with comment period.

The ACR provides comment on the following important issues:

- 1) APC Restructure of Diagnostic Radiology
- 2) Final Changes to Packaged Items and Services
- 3) Interim Final Rule with Comment Period on Section 603

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## APC Restructure of Diagnostic Radiology

Despite opposing public comments, CMS elected to finalize a restructure of the 17 CY 2016 imaging ambulatory payment classifications (APCs) down to 7 imaging APCs for CY 2017. These seven imaging APCs include four APCs for imaging without contrast and three for imaging with contrast and consist of cardiology, echocardiography, radiology and any other specialty that would provide imaging services.

We believe that with the restructuring of the imaging APCs, CMS has placed higher priority on a CMS directed regulatory criterion developed using its administrative authority over criteria mandated in the statute. Section 1833(t)(2)(B) of the Social Security Act provides general guidance to the Secretary of Health and Human Services for developing APCs:

The Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are *comparable clinically and with respect to the use of resources* and so that an implantable item is classified to the group that includes the service to which the item relates. [Emphasis added]

CMS further outlines criteria it uses to group procedures in the April 7, 2000 final rule implementing the OPPS (68 FR 18457). One of these criteria is “minimal opportunities for upcoding and code fragmentation.” CMS states, “the APC system is intended to discourage using a code in a higher paying group to define a case. Therefore, CMS strives to keep the APC groups as broad and inclusive as possible without sacrificing resource or clinical homogeneity.”

CMS’ motivation for the change to the imaging APCs appears to be “minimal opportunities for upcoding and code fragmentation” as it stated the following in the CY 2017 proposed rule (80 FR 39260):

- “The current level of granularity for these APCs results in groupings that are unnecessarily narrow for the purposes of a prospective payment system.”
- “Many of these APCs are currently structured according to organ or physiologic system that does not necessarily reflect either significant differences in resources or how these services are delivered in the HOPD.”

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Structuring APCs by organ and physiologic system is synonymous to “comparable clinically”—and is consistent with the statutory basis upon which the Secretary is required to structure APC groupings. CMS is giving less weight to the statutory criteria in this case and giving priority to its regulatory criterion when it states the current level of granularity is unnecessarily narrow for a prospective payment system.

***For the reasons explained above, ACR disagrees with APC consolidation that further moves away from clinical similarity by developing consolidated imaging APCs instead of clinically comparable diagnostic radiology APCs which would have offered stability of payment for radiology services for CY 2017 and moving forward.***

The ACR is concerned with the restructure on lung cancer screening services. Specifically that G0297 (Low dose CT scan (LDCT) for lung cancer screening) which is currently priced at \$112.49 will be cut to \$59.84 for CY 2017. In February 2015, CMS announced that it would cover CT lung screening for Medicare patients. However, at that time, codes had not been developed for CT lung cancer screening so facilities had to hold claims for the first coverage year awaiting CMS guidance on coding and claims submission. Once the claims were submitted, many claims denials followed due to the implementation of ICD-10 affecting claims, which included ICD-9 codes. Because of these issues, there were only 40 single claims identified in the 2015 claims data for the proposed rule. Newly covered services need at least two full years for hospitals to establish the programs and report appropriate costs. The ACR restates our prior recommendation that G0296 and G0297 be placed in level II APCs based on clinical similarity and to offer payment stability. ***We believe that maintaining payment stability for this new screening benefit for Medicare patients is critical at a time when hospitals are initiating this screening program. Without payment stability, Medicare beneficiary access to this important new screening benefit may be compromised.***

Another family of services affected is MR and MRA. CMS finalized the placement of MR and MRA codes into lower payment categories, which price them in the \$225.00 to \$265.00 price range. Because the Medicare Physician Fee Schedule technical component payment for diagnostic services is capped at the OPPS amount for the same service, this decision will undoubtedly have negative effects on their technical component payments in the physician fee schedule for CY 2017 creating potential access concerns outside the hospital setting.

We regret that CMS did not adopt ACR’s recommendations to stabilize OPPS payment for many other imaging studies and only made exceptions for a few creating the same concerns about potential access for these services. ***The ACR understands that this OPPS Final Rule is not subject to public comment, nevertheless, we believe it is very important to bring our concerns to the agency so CMS can make the necessary changes in future rulemaking. The ACR would like to work with CMS in CY 2017 to***

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*determine if stability of payment and improved clinical similarity can be restored. This is critical since Medicare patients need continued access to diagnostic radiology services in their communities, which greatly contributes to quality patient care.*

## Changes to Packaged Items and Services

### *Conditional Packaging Status Indicators “Q1” and “Q2”*

CMS finalized their packaging logic for status indicators Q1 and Q2, used to make the decision to package or pay separately at the claim level rather than based on the date of service. CMS believes this new packaging logic will result in a greater volume of conditionally packaged costs (and thus data) of items and services. The ACR submitted a technical appendix, prepared by The Moran Company, which outlined that the ACR could not replicate CMS’ packaging logic. ACR believes further detail is needed in the final rule so stakeholders may replicate CMS’ methodology and decipher how individual services are affected by the proposed and alternative policies. ACR is concerned that without being able to model CMS’ methodology, we are unable to discern the true effects of this new policy on hospital payments and do not know if data is being left out of rate-setting. This is important because in previous years ACR has been able to simulate CMS’ methodology, with the assistance of our consultants, and provide CMS with valuable input to help improve data capture. It is past analysis submitted by ACR, which allowed CMS to initially develop the conditional packaging concept and thus the Q1 and Q2 status indicators. As CMS continues to more aggressively package, radiology services continue to be affected. *The ACR hopes that CMS will allow for continued cooperative work in this area in the future and will improve the transparency of its packaging policies so that stakeholders like ACR can provide constructive comments and either support CMS’ efforts with a full understanding of its methodology or comment on potential improvements.*

### **Interim Final Rule with Comment Period: Establishment of Payment Rates under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital**

CMS establishes an interim final rule with 60-day comment period for stakeholders to provide comments on the new payment mechanisms and rates that will be paid for the technical component of all non-excepted items and services for new off-campus hospital outpatient sites and new outpatient hospital sites which are more than 250 yards from the inpatient unit on a campus that is not the main campus of the hospital. Hospitals provider-based departments will be paid under the physician fee schedule at a percentage of standard OPFS rates that CMS believes reflects the relative resources involved in furnishing the services.

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CMS notes that this percentage could be lower or higher than the percentage adopted in this interim final rule with comment period, and CMS will utilize billing data to the extent they are available, initially from CY 2017 and CY 2018, to determine the appropriate percentage adjustment, and then update the percentage adjustment annually based on the most recently available data, for future years.

The ACR is concerned about CMS internally and unilaterally developing a payment system that will pay nonexcepted items and services at approximately 50% of the OPPS rates. Radiology offices are struggling to cover their costs under the physician fee schedule and many services have been discontinued. Therefore, it will be difficult for hospital off-campus provider-based departments to cover their costs as well. This circumstance will continue to limit the access options for Medicare patients to receive care in their local communities.

The ACR believes there are many flaws in the OPPS data and do not agree with CMS' view that "the quality of the data currently used to develop payment rates under the OPPS, including hospital claims data and cost reporting, far exceeds the quality of data currently used for MPFS payments." The ACR has concerns with how the data and methodology in OPPS is underpricing advanced diagnostic imaging studies and inflating the prices for minor imaging studies therefore further exacerbating cost compression. This may incentivize the performance of less effective imaging studies with resulting missed diagnoses or need for repeat imaging raising costs. These flaws are also inappropriately tagging minor imaging studies as overpriced in OPPS when fixes in CMS' methodology would lower these rates and improve pricing for other studies which would make this payment system and hospital revenues more stable. This also would reduce the effects of the Deficit Reduction Act on the physician fee schedule and keep the availability of these studies steady in the office setting.

***The ACR recognizes that CMS does not have authority to exempt imaging centers from the site neutral policy. However, we believe it is important to note the context in which these payment reductions are being made. Imaging studies have been through multiple rounds of cuts since 2006 to the technical component in the Medicare Physician Fee Schedule (MPFS) causing many radiology offices to close because they cannot cover their costs. Indeed, hospital acquisition of physician offices may be attributed, in part, to physicians being unable to continue providing these services. If payment to hospitals is now being reduced under section 603 to the point where hospitals are unable to cover their costs, hospital imaging services may become unavailable as well, imperiling access for Medicare beneficiaries and other patients.***

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Thank you for the opportunity to comment on the HOPPS final rule and interim final rule. If you have any questions about our comments please feel free to contact Pam Kassing at 800-227-5463 ext. 4544 or via email at [pkassing@acr.org](mailto:pkassing@acr.org) or Dominick Parris at 800-227-5463 ext. 5652 or via email at [djparris@acr.org](mailto:djparris@acr.org).

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "William T. Thorwarth, Jr.", with a stylized flourish at the end.

William T. Thorwarth, Jr., MD, FACR  
Chief Executive Officer

cc: John McInnes, CMS  
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