August 31, 2010

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1503-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Proposed Rule; CMS-1504-P

Dear Administrator Berwick:

The American College of Radiology (ACR), representing more than 37,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, is pleased to submit comments on the proposed changes to the 2011 Hospital Outpatient Prospective Payment System (HOPPS). Below we offer comments on the Research Triangle Institute’s (RTI) cost compression study, composite ambulatory payment categories (APCs), myocardial Positron Emission Tomography (PET) APC 0307, changes relating to payments for direct graduate medical education (GME) and indirect medical education (IME) costs, the FB modifier and the hospital outpatient quality data reporting program (HOP QDRP).

RTI Cost Compression Study

Briefly stated, we oppose the creation of these new cost centers at this time. The Centers for Medicare and Medicaid Services (CMS) proposal is based in large part on a report by the Research Triangle Institute. Our analysis of this report indicates that the measured cost-to-charge ratios (CCRs) for advanced imaging may reflect a significant misallocation of capital costs on the cost report. Until this problem can be examined more fully and remedied, the risk of inaccurate payments under both the inpatient and outpatient hospital payment systems is significant. Further, the outpatient prospective payment system (OPPS) payment rates are now the basis of payments for imaging services in ambulatory surgical centers and, as a result of the Deficit Reduction Act, also serve as a cap on payments under the physician fee schedule for the technical component of imaging services. While we support the CMS goal of refining the MS–DRG relative

weight calculation by improving the accuracy of the cost reports, we cannot support the proposal at this time because the potential adverse impact on the payments for imaging services under four major payment systems is simply too great. The cost data is incomplete and does not reflect accurate allocation of costs to the hospital radiology cost centers.

**ACR Analysis of RTI Report**

On June 13, 2008 we submitted comments on the January 2007 and April 2008 Research Triangle Institute reports on charge compression that showed low cost-to-charge ratios for advanced imaging services such as magnetic resonance (MR) and computed tomography (CT) scans. One set of RTI estimates suggested that hospitals on average mark up CT services by more than 1800 percent over cost (CCR of 0.054), compared to an average markup of just over 300 percent for routine radiology costs (CCR of 0.308). This roughly five-fold differential in markup is clearly too large to be an accurate reflection of typical hospital charging behavior and, accordingly, we expressed our concern that the RTI CCRs are unrealistically low and would result in substantial distortion of payments if used for calibrating Medicare rates.

Our concern is that the use of these CCRs for setting Medicare payment rates for the inpatient prospective payment system (IPPS) would significantly reduce payment for imaging-intensive DRGs such as those for trauma services. But the impact on OPPS, ambulatory surgical center (ASC) payments and physician payments would be more dramatic. Currently, CMS uses a CT- or MR-specific CCR for about a third of hospitals in the OPPS rate calculation. Expanding that, by using the RTI CCRs throughout, would cause a significant reduction in the OPPS rates and the associated ASC rates. Also, the OPPS payment rates serve as a cap on payment under the physician fee schedule for the technical component of imaging services due to the requirements of the DRA. Thus, these inappropriate OPPS reductions would lead to further inappropriate payment reductions for services performed in physicians’ offices and other non-hospital outpatient settings.

We hired Christopher Hogan, Ph.D. to examine this issue briefly for us in 2008. His conclusion was that the measured CCRs for advanced imaging may reflect a misallocation of capital costs on the cost report. That is, a significant number of hospitals report little or no capital costs for MR and CT. These hospitals may be treating CT and MR machines as hospital fixtures (allocated to hospital overhead) instead of equipment (allocated to radiology cost). If this is true, RTI’s estimate of the costs and CCRs for CT and MR are substantially too low. We did not hire Christopher Hogan, Ph.D. to re-analyze this issue based on the final RTI report and more current OPPS CCRs. However, we do not believe the main RTI findings and recommendations in the final RTI report were significantly different from their initial reports and it is our understanding that an analysis Dr. Hogan performed for other clients reached the same basic conclusions described in this section of our comment letter.
Regardless of the actual reason for the low CCRs, the use of the RTI CCRs could result in some highly anomalous payments. They could result in higher payment for plain film X-rays than for CT scans. They could also result in physician payment rates for technical component costs of CT scans that are less than CMS’s own estimate of cost of the CT scanner alone (let alone all other costs associated with the service), even under the assumption of full-time use of the scanner. This would effectively prohibit physicians from providing these services. This also strongly suggests that hospitals would find it highly unprofitable to provide these services at those rates.

To illustrate this we performed a payment rate and cost calculation for X-ray versus CT scan of the head. These services image the same part of the body and take roughly the same amount of time (24 and 26 minutes respectively, based on the 2008 physician practice expense data). Because the treatment of capital cost may be the key issue, we compare projected OPPS payments using the RTI CCRs to the estimated direct (no overhead) equipment cost per procedure from the physician fee schedule practice expense calculation.

Table 1 shows what the use of these CCRs would imply for Medicare OPPS rates and physician fees. To calculate the projected OPPS rates, we started from the OPPS rates in effect at that time (2008). We adjusted the rates using the ratio of the RTI CCRs to the actual OPPS CCRs used to create those rates (the average CCR on single-procedure claims using calendar year 2006 OPPS claims).

Table 1 shows that the use of the RTI CCRs would create several anomalies in the rates. First, the RTI regression-based CCRs would result in paying more for X-ray ($99) than for the corresponding CT service ($65). In effect, that set of CCRs says that X-ray is more costly than CT. Second, while the RTI rates always exceed the equipment cost of the X-ray service, they are often substantially below the equipment cost of the CT service. Using CMS’s current assumption of an average 50 percent use rate, neither of the OPPS rates based on the RTI CCRs would be enough to pay for the cost of the equipment alone. (We emphasize that this is just the cost of amortizing and maintaining the equipment, and does not include the additional personnel, supplies, and overhead costs actually involved in providing that service.)

Even at an assumed full-time (100 percent) use rate, the RTI-based OPPS rates would barely cover the CT equipment cost or would fall just below the CT equipment cost. The clear implication here is that using the RTI CCRs to calculate the OPPS rates (and hence the DRA physician fee caps) would make it impossible to offer CT services in stand-alone outpatient settings such as physician offices, and would make those services substantially unprofitable in hospital outpatient settings.

Sources: Physician cost calculated from 2008 physician final rule PE data, using CMS methodology, at 50 percent and 100 percent use rate. Current OPPS CCRs calculated from single procedure claims extracted from the Propose Rule 2008 OPPS file. RTI CCRs taken from the April 2008 RTI report to CMS on charge compression. Projected rates calculated as current rate time ratio of RTI to current CCR.
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Cost-to-Charge Ratio</th>
<th>Payment Rate Using 2008 RTI CCR, cost report</th>
<th>Payment Rate Using 2008 RTI CCR, regression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>70450 Ct head/brain w/o dye (26 minutes)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost-to-Charge Ratio</td>
<td>0.160</td>
<td>0.066</td>
<td>0.054</td>
</tr>
<tr>
<td>Actual or Projected OPPS Rate</td>
<td>$192</td>
<td>$79</td>
<td>$65</td>
</tr>
<tr>
<td>Phy. Equipment Cost, 50% Use Rate</td>
<td>$144</td>
<td>$144</td>
<td>$144</td>
</tr>
<tr>
<td>Difference, Payment less Eq. Cost</td>
<td>$48</td>
<td>-$65</td>
<td>-$79</td>
</tr>
<tr>
<td>Phy. Equipment Cost, 100% Use Rate</td>
<td>$72</td>
<td>$72</td>
<td>$72</td>
</tr>
<tr>
<td>Difference, Payment less Eq. Cost</td>
<td>$120</td>
<td>$7</td>
<td>-$7</td>
</tr>
<tr>
<td><strong>70260 X-ray exam of skull (24 minutes)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost-to-Charge Ratio</td>
<td>0.230</td>
<td>0.191</td>
<td>0.308</td>
</tr>
<tr>
<td>Actual or Projected OPPS Rate</td>
<td>$74</td>
<td>$61</td>
<td>$99</td>
</tr>
<tr>
<td>Phy. Equipment Cost, 50% Use Rate</td>
<td>$14</td>
<td>$14</td>
<td>$14</td>
</tr>
<tr>
<td>Difference, Payment less Eq. Cost</td>
<td>$60</td>
<td>$47</td>
<td>$85</td>
</tr>
<tr>
<td>Phy. Equipment Cost, 100% Use Rate</td>
<td>$7</td>
<td>$7</td>
<td>$7</td>
</tr>
<tr>
<td>Difference, Payment less</td>
<td>$67</td>
<td>$54</td>
<td>$92</td>
</tr>
</tbody>
</table>
ACR Recommendation

The ACR supports the CMS goal of refining the MS–DRG relative weight calculation by improving the accuracy of the cost reports. However, we are compelled to recommend that CMS delay establishing new standard cost centers for CT and MRI until the causes of the payment distortions associated with the RTI methodology that are described above are understood and remedied. This is critically important because the impact of the proposed new standard CCRs is not limited to inpatient and outpatient hospital services. Specifically, ASC payments and the technical component of imaging services paid under the physician fee schedule are also affected.

An important first step would be for CMS to continue working with the hospital community to develop guidance on how to improve allocation of the large capital costs of CT and MRI to the radiology cost center. Once new cost reporting practices are in place and the data is shown to be reliable and stable, CMS could then reconsider its proposal to create separate cost centers for CT and MRI.

Composite APCs

The ACR appreciates CMS not developing any further imaging composites at this time. The ACR is in agreement that CMS should evaluate the data on whether the purpose and methodology in developing these composites are effectual before expanding this concept any further to other studies or into episodes-of-care.

The ACR is concerned with the low number of claims used to determine the proposed 2011 payment rate for Low Dose Rate Prostate Brachytherapy composite APC 8001. In the proposed rule, CMS states that they were able to use 788 claims that contained both CPT codes 55875 and 77778 to calculate the median cost for composite APC 8001. This is an extremely low amount as compared to how many of these procedures are performed in hospitals for cancer patients. The ACR encourages CMS to explore alternative ways to capture more multiple procedure claims to be used in future rate setting for composite APC 8001.

Proposed Payment Changes for Myocardial PET

The ACR is very concerned about the proposed decreases in the payment rate for Myocardial Positron Emission Tomography imaging APC 0307. It does not make sense that hospital costs for PET dropped by almost 25% in one year. The large swings in reimbursement for PET over the past few years makes it difficult for hospitals and even offices to adequately set a business plan to evaluate revenue versus costs when deciding to provide this service. This is especially true for physician’s offices and other payment systems that are affected by the changes in the HOPPS rates due to the DRA.
The ACR recommends that CMS further examine the underlying data to determine the cause of the unstable payment rates for APC 0307 and to take appropriate steps to stabilize the rates.

Hospital Reporting of Free Diagnostic Radiopharmaceuticals

The ACR supports CMS’ proposal to instruct hospitals to use the “FB” modifier on the line with the code for the nuclear medicine study in which the no cost/full credit diagnostic radiopharmaceutical is used. The ACR supports efforts that improve data collection and thus appropriate APC payments.

Proposed Changes Relating to Payments to Hospitals for Direct Graduate Medical Education and Indirect Medical Education Costs

The ACR supports the proposed changes by CMS relating to the payments to hospitals for direct graduate medical education and indirect medical education costs. We believe the following proposals will all be beneficial to the academic hospitals and their residency programs:

1. to allow any time spent by residents training in a non-provider setting to count toward direct GME and IME costs if the hospital incurs the costs of residents' salaries and fringe benefits;
2. to add a provision to allow hospitals to count resident time spent in certain non-patient care activities while training in certain nonhospital settings for direct GME purposes;
3. to redistribute medical residency positions that have been unfilled during a prior cost reporting period to other hospitals; and,
4. to add a provision to allow for the redistribution to other hospitals in the same or contiguous areas of FTE resident positions from a hospital that closes.

Hospital Outpatient Quality Data Reporting Program

In this section our comments will address the hospital outpatient quality data reporting program’s proposed expansion of quality measures for 2012, 2013 and 2014 payment determination, considerations in expanding HOP QDRP measures, validation of claims-based HOP QDRP data, and publication of HOP QDRP data.

Publication of HOP QDRP Data

- Under the MIEA-TRHCA statute CMS is required to publicly report data under the HOP QDRP after hospitals have had the opportunity to review data prior to its publication. CMS states this will typically be done on the interactive Hospital Compare website but proposes to post information that may not be easily understood by the public or with pending display issues on other non-interactive CMS websites such as http://www.cms.hhs.gov/QualityInsits/.
ACR Comments: The ACR encourages CMS to allow for public comment period on the form and format of public reporting of data for any new HOP QDRP measures prior to implementation.

Regarding reporting of the HOP QDRP Imaging Efficiency measures -- CMS should be very careful about basing statements of “quality” against benchmark rates which have not been substantiated. Keeping the “within range” rates broad during early reporting is less likely to unfairly represent the performance or quality of facilities and reduce the potential for negatively affecting access to imaging services.

Additionally, terminology used to explain quality data to the public may be misleading or have unnecessarily negative connotations, which could have unintended consequences, potentially alarming patients and the public unreasonably. For example, the term “double” used to explain to the public that CT (Abdomen and Thorax) may create a false impression that these exams are always unnecessarily duplicative. While the ACR believes and supports these measures for having potential to reduce unnecessary imaging, there are instances when combination with and without contrast exams provide necessary and valuable information about abnormalities, many of which are cancers, and many of which could not be adequately diagnosed without pre- and post-contrast scanning.


ACR Comments: The ACR agrees with CMS that proposing new measures over a 3 year period, e.g. 2012 - 2014, will enable hospitals to plan ahead and potentially adjust processes of care or implement quality improvement goals.

Quality Measures for 2012 Payment Determination

CMS proposes for the CY 2012 payment determination to retain the current 11 HOP QDRP measures. Four additional claims-based imaging efficiency measures have been proposed:

- Preoperative evaluation for low risk non-cardiac surgery risk assessment
- Use of stress echocardiography, SPECT MPI, and cardiac stress MRI post-CABG
- Simultaneous use of CT brain and CT sinus
- Use of brain CT in emergency departments (ED) for atraumatic headache
• **ACR Comments**: The ACR submits the comments shown below on these new measures.

**Use of Stress Echocardiography or SPECT MPI Post-Revascularization Coronary Artery Bypass Graft**

*Importance/Relevance:*
If the measure is to apply to patients undergoing a "screening" assessment post-CABG, it does address the appropriate use of SPECT in such patients, although graft occlusions and progressive disease in native arteries can certainly occur within five years of surgery and is accurately evaluated by SPECT.

*Scientific Acceptability:*
The measure is reasonable if the denominator population is asymptomatic patients who are free of both signs and symptoms. It is important to exclude patients with signs, since in certain patients with diabetes or women, symptoms of ischemia may not be present. Signs would include new left ventricular enlargement or other indications of heart failure. This is in agreement with currently published guidelines. Other exclusions such as chest pain, dyspnea on exertion, or development of congestive heart failure should be considered.

**Use of Computed Tomography in Emergency Department for Headache**

*Importance/Relevance:*
The ACR supports the substance of the measure because it targets an area of known overuse, it is concordant with the ACR Appropriateness criteria, it is actionable by the emergency department, and it serves an independent public health need. Headache continues to account for large numbers of ED visits in the United States annually – estimated at approximately 3.1 million per year according to the National Center for Health Statistics (see reference below). There is little doubt that headache imaging in the ED on patients with non-focal neurologic exams yields a low percentage of positive studies and cumulative population radiation dose is a valid concern.³

*Scientific Acceptability:*
The statement of red flags is appropriate and the exclusion criteria are well thought out. Admission and/or transfer and lumbar puncture are operational indicators of pathology or high likelihood thereof, and the clinical findings of dizziness, paresthesia, lack of coordination, subarachnoid hemorrhage, thunderclap headache should be sensitive,

---

though not specific, indicators of pathology. However, historical features that predict structural pathology such as HIV/AIDS, cancer, visual disturbance, protracted nausea and vomiting should be added to the exclusions, as well as all codes for neurological signs of cerebral origin. To restate, the target population is patients with headache absent neurological signs or other symptoms.

Usability:
Much of the ED role has evolved to triage serious disease. As such, many studies are performed that are negative, e.g. c-spine x-rays as well as CT for neck pain or discomfort. The imaging findings of occult intracranial hemorrhage or tumors are non-specific and may present as headache. The issue is that imaging is often performed to exclude these unusual but potentially treatable causes. This is further exacerbated by tort systems that seem systematically structured to reach irrational conclusions in individual cases causing ED physicians' fear of missing 'high stakes' abnormalities. The same applies to headache imaging and the fear of missing the brain tumor in the 8 year old, for example.

Serious pathology can present with isolated headache and no focal findings. ED physicians are often overwhelmed by the number of patients presenting to the ED and may not be in a position to carefully and systematically exclude all causes of headache. Moreover, if a patient is not imaged, many simply return to the ED because of anxiety, perceived disability, loss of productivity, etc. This is especially true for the underserved or uninsured/underinsured. Also, patients who are well insured are probably more likely to use the ED when their symptoms are more severe or atypical. It is often more cost-effective to image and exclude serious disease (once and for all) from a societal point of view.

Moreover, a recent study showed that there can be economic value when patients with headache are imaged even when the study is negative. A symptom of headache is often quite ominous and burdensome to the patient, greatly affecting lifestyle, productivity, and sense of well being. If the value of negative studies does not incorporate the value of improved patient function and productivity (that often follows from knowing that the head CT is negative), from a societal point of view, the true value of the imaging, even when negative, will be understated.

Simultaneous Use of Brain and Sinus Computed Tomography
Importance/Relevance:
The measure is focused on headache with the intent to exclude patients with signs of serious infection. If imaging is indicated at all, it is probably enough to answer the question of whether or not there is substantial sinus disease that may be causing the headache with a small number of patients going on to a formal sinus CT if needed for surgical planning. However, little of the maxillary sinus should be included in a standard head CT, and adding that area would increase radiation dose to the lens of the eye, which means that a head CT is limited in excluding all sinus disease. The head CT reveals only
partial sinus information on imaging, with clinical information valuable, and significant, especially in the patient where sinus disease is more likely. Furthermore, many facilities have multi-slice scanners that are capable of reconstructing the data to better evaluate the sinuses without requiring rescanning and without additional radiation. This will ultimately become the norm.

**Scientific Acceptability:**
In many cases, sinus CT and brain CT are indicated because of the suspicion of infections or neoplastic pathology invading or extending intracranially. In addition, the symptoms of sinus obstruction and/or inflammation may coexist with indications of high likelihood of intracranial pathology. Thus, explicit exclusion criteria based upon these concepts should be added. The codes relevant to the clinical correlates of sinus infection, inflammation, obstruction and neoplasm need to be added to exclusions, along with neurological codes. One must distinguish between indications that require intravenous contrast. These include patients in whom studies are performed because of the possibility of intracranial complications from acute bacterial sinusitis. In this instance, a simultaneous sinus CT and brain CT are indicated. One can argue that in patients who undergo non-contrast imaging for routine "sinusitis" do not require a concurrent brain CT. "Sinusitis" requires clarification.

**Usability:**
Although we support the concept that the radiologist is the preferred imaging consultant, and we welcome CMS support for tools that will empower the radiologist to promote rational utilization of imaging, we do not support this measure as written. Actionability is a serious problem with this measure if the measured site is the radiology department rather than the referring department. It is disruptive to the doctor-patient relationship for the radiologist to intervene after the study has been ordered to comply with this measure. The numerator and denominator statement should be modified to reflect that the true nexus is the referring physician. Despite numerous attempts at physician education some patterns of referral die hard. Such ordering patterns are more often seen in situations of self-referral.

Other measure constructs can more specifically focus on patient safety issues of unnecessary radiation exposure and would affect larger numbers of people and larger critical organ doses. Several existing measures would be more beneficial in reducing population dose and imaging overuse i.e., the CT dose reduction measure developed by the AMA Consortium and the ACR. Such a measure would have affected larger numbers of people and larger critical organ doses.

---

Feasibility:
There are too many similarities with the Use of Computed Tomography in Emergency Department for Headache measure, increasing burden of analysis with little additional information or gain.

Quality Measures for 2013 Payment Determination

- ED– Head CT scan results for acute ischemic stroke or hemorrhagic stroke who received CT scan interpretation within 45 minutes of arrival

- **ACR Comments:** The ACR Neuroradiology Commission supports this measure with the modifications recommended by the National Quality Forum Imaging Efficiency Steering Committee in August 2010.

Quality Measures for 2014 Payment Determination

- Exposure time reported for procedures using fluoroscopy. This measure is currently specified for the physician quality reporting initiative (PQRI).

- **ACR Comments:** The ACR supports this measure as it was developed by the ACR/AMA PCPI Radiology workgroup. However, we recommend CMS wait to finalize inclusion of the measure until testing of the measure (currently underway) has been completed and any potential modifications as a result of the testing have been made. Additionally, ACR is concerned about the level of effort that may be required for chart abstraction of the measure in hospital outpatient imaging centers or departments. Measure testing will inform the feasibility of this.

Possible Quality Measures under Consideration for Future Inclusion in HOPQDRP

- CMS provided a list of 38 measures or measure topics under consideration for future years. Measures potentially relevant to radiology are shown below. Included in this list as a topic for future development is Breast Cancer Detection Rate.

- **ACR Comments:** The ACR continues to be concerned that the Mammography Recall Rate measure that CMS currently includes in HOP QDRP is the sole metric used for assessing mammography performance. We have expressed our concerns to CMS on numerous occasions, and do so here again. Although the ACR is encouraged that CMS is considering development and inclusion of a Breast Cancer Detection Rate measure in the HOP QDRP program, we are concerned about how that measure will be specified, collected and reported.

Because the purpose of breast cancer screening is cancer detection at early stages where intervention is more likely to be beneficial, accurate collection of true positive cases is essential and challenging. To provide consistent and meaningful feedback that can be used for performance improvement, with a greater likelihood of
improving patient care and outcomes, a combination of four measures should be used. These are: Positive Predictive Value 2 (PPV2) on Screening Exams, PPV2 – Diagnostic Exams, Cancer Detection Rate and Abnormal Interpretation (Recall) Rate. These metrics combined can provide robust audit data measuring both sensitivity and specificity and balancing them.

This group of measures provides the minimum data needed for a clinically meaningful basic-level audit, as recommended by the Institute of Medicine. Calculating the rates of cancer detection and abnormal interpretation facilitate appropriate interpretation of PPV2, which is influenced by the prevalence of cancer in the screening population. At minimum, Cancer Detection Rate should be calculated in concert with Recall Rate.

And even though cancer detection rates may be the best single measure of success, this rate analyzed alone may also be misleading. As well, it is problematic for sites that only do screening exams (do not perform diagnostic exams) to obtain pathology reports in order to determine their cancer detection rate.

The four measures mentioned above evaluated in concert ensure the best markers that women are efficiently and effectively screened. Thus, the ACR strongly recommends that CMS use in the HOP QDRP the four measures described below. These measures are recommended by the ACR Breast Imaging Reporting and Data System (BIRADS®); in publications by the Breast Cancer Surveillance Consortium (BCSC), which is funded by the National Cancer Institute; and by the Institute of Medicine in their 2005 report “Improving Breast Imaging Quality Standards”. The measures are currently under consideration for endorsement by the National Quality Forum (NQF).

1. Diagnostic Mammography Positive Predictive Value 2 (PPV2 - Biopsy Recommended) – proportion of women recommended for biopsy who are subsequently diagnosed with breast cancer.
2. Screening Mammography Positive Predictive Value 2 (PPV2 – Biopsy Recommended) – proportion of women who are recalled (BIRADS category 0, 4 or 5 from a screen) who are subsequently diagnosed with breast cancer.
3. Cancer Detection Rate (CDR) – cancers correctly detected at mammography per 1,000 patients screened.
4. Abnormal Interpretation Rate (Recall Rate) – proportion of screening mammogram interpreted as positive (BIRADS Category 0, 4 or 5).

To reiterate, inclusion of these measures in the HOP QDRP will go much further in assessing efficient, effective, quality mammography services at a site level. The ACR also encourages CMS to expect sites to conduct a complete tracking of individual rates for each mammographer in the practice. The ACR measure set was designed to be reported at the practice level or at the individual level for those whose volumes are sufficient for reliable interpretation. Participation in a national mammography
database, such as the ACR’s National Mammography Database (NMD) Registry, could simplify such HOP QDRP mammography measure requirements. A single metric could be that the site participates in a national mammography database that includes, at a minimum, these measures. CMS has set a precedent for such a structural measure in the IPPS quality reporting program, Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) with the cardiac surgery measure, “Participation in a Systematic Database for Cardiac Surgery”. Public reporting of participation in such a registry serves as an indicator that the site strives to provide the best care possible, is straightforward and easy to understand.

Proposed Data Validation Requirements

- CMS is proposing, beginning with CY 2012 payment determination, to validate data each year from a random sample of 800 hospitals (20% of participants)

- **ACR Comments**: The ACR assumes that validation of the Imaging Efficiency measures will not be required as part of the proposed validation process since the analysis of the measures is done by CMS through claims data. However, it would be helpful for CMS to clearly describe how these measures are calculated. It is not entirely clear how it is determined that data insufficient for measuring a hospital’s performance. Upon review of the Hospital Compare data, it appears that hospitals with fewer than 30 or so patients are always marked as lacking sufficient data. Hospitals with more than 70 or so patients are never marked as having insufficient data. But in the 30-70 patient range, there is some variability. Most of the facilities are marked as not having adequate data, but some are not. Other than this issue of not specifying the criterion on minimum number of patients, the stated methods for arriving at the measures is fairly clear.

Conclusion

Thank you for the opportunity to comment on the important issues discussed in this proposed rule. We are gravely concerned about the far reaching impacts some of these proposals will have not only to hospital outpatient departments but other payment systems that are linked to the HOPPS which could lead to negative effects on access to
quality affordable care for patients especially in rural communities. If you have any questions about our general comments please feel free to contact Pam Kassing at 800-227-5463 ext. 4544 or via email at pkassing@acr.org. If you have any questions about our comments on quality issues please feel free to contact Judy Burleson at 800-227-5463 ext. 4787 or via email at jburleson@acr-arrs.org.

Respectfully Submitted,

Harvey L. Neiman, MD, FACP
Executive Director

cc: Edith Hambrick, MD, CMS
    Chris Ritter, CMS
    Alberta Dwivedi, CMS
    James Poyer, CMS
    James Rawson, MD, FACP, Chair, APC Committee
    Bibb Allen, Jr., MD, FACP, Chair, ACR Commission on Economics
    Rich Duszak, Jr., MD, FACP, Vice-Chair, ACR Commission on Economics
    Paul Larson, MD, FACP, Chair, Quality and Safety Commission
    Pamela J. Kassing, ACR
    Maurine Dennis, ACR
    Judy Burleson, ACR
    Angela J. Kim, ACR
    Sneha Soni, ACR