September 4, 2013

Marilyn B. Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS–1601–P  
Mail Stop C4–26–05  
7500 Security Boulevard  
Baltimore, MD 21244–1850

Re: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals; Proposed Rule

Dear Administrator Tavenner:

The American College of Radiology (ACR), representing more than 35,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services’ (CMS) proposed rule on Hospital Outpatient Prospective Payment (HOPPS) and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs.

The ACR provides comment on the following important issues:

1) Proposal to use CT and MR Cost Centers Cost-to-Charge Ratio (CCR) Data

2) Establishing Comprehensive Ambulatory Payment Categories (APCs)

3) Solicitation for Comment on Increased Packaging for Imaging Services for 2015

4) Proposed New Packaging Policies for CY 2014

5) Comments on Category III Nuclear Medicine Code Assignment to a New Technology APC

6) Removing Transvenous Intrahepatic Portosystemic Shunt (TIPS) Services from the Inpatient Only List
7) Quality Measures for the 2016 Payment Determination and Subsequent Years

8) Possible Hospital Outpatient Quality Reporting (OQR) Program Measure Topics for Future Consideration

Refinement of the MS-DRG Relative Weight Calculation – Use of CT and MR CCRs Would Cause Inappropriate Payment Reductions for Many MS-DRGs

For 2014, CMS is proposing to use FY 2011 cost data to establish separate CCRs for CT and MR, distinctly separate from the general radiology CCR, for determining APC weights. The ACR strongly opposes this proposal. ACR concludes that the significantly lower CCRs for CT and MR (compared to the CCR for general radiology) lack face validity and should not be used for payment purposes.

The ACR has been following this issue and commenting on it since 2008. In 2008, ACR analysis and comments on separate CT and MR cost centers showed that the technical payment for CTs ($64) would fall below the payment of a chest x-ray ($99). A similar analysis done by the same consulting firm (as requested by a different stakeholder) analyzing the most recent 2011 data reaches similar conclusions: the cost data is under-representative and produces payment anomalies. For the past few years, CMS has asked hospitals to report separate costs for CT and MR studies on their cost reports using the new reporting methodology. Analysis of the 2011 data from these hospitals shows that a CT scan of the head/brain would be reimbursed at $84 (down from $206) and an x-ray of the skull would be reimbursed at $82 (up from $45). According to the American Medical Association’s (AMA) RVS Update Committee (RUC) database and related practice expense data posted on the CMS website, the cost of an x-ray machine is approximately $125,000 and the cost of a CT machine is over $1,200,000. The cost to hospitals to purchase this same equipment is similar to the amount an office would pay for similar technology. Generally CT equipment costs are tenfold of that of an X-ray machine. However, under the proposed calculations using the new CT and MR cost centers, the low cost item is increasing in payment (X-ray at $82) and the high-cost study is being undervalued (CT at $84). CMS defines “charge-compression” as a situation where the cost-based weights would undervalue high-cost items and overvalue low-cost items if a single CCR is applied to items of widely varying costs in the same cost center. In the case of the new CT and MR cost centers, just the opposite is occurring and the creation of individual CT and MR cost to charge ratios (CCRs) is only exacerbating the problem instead of solving it.

In 2007, the Research Triangle Institute’s (RTI) own analysis of the costs and charges of CT and MR scans pointed to some anomalous trends:

Many facilities had very low cost ratios on these nonstandard lines... This raises questions about the relative accuracy of their cost finding. ...[CT and MR] services are very capital-intensive, and accurate cost ratios will depend on providers’ being able to assign actual equipment depreciation and lease costs
directly to the cost centers, rather than the traditional method of allocating average capital costs based on square footage.¹

The ACR does not believe that more time and experience with the new cost centers will lead to improved data; it is our experience that hospitals vary widely on how they report their charges and costs. We believe it would be best to maintain a single diagnostic radiology cost-to-charge ratio, given the difficulties that hospitals have in accurately accounting for their radiology-related costs, especially on a more granular basis.

In 2011, CMS decided to add the new CT and MR cost centers and indicated that it would take 3 years before there would be adequate data for review and analysis. At that time, CMS further indicated the goal of analyzing the data to determine if the data is appropriate for use in creating distinct MR and CT CCRs for use in the relative weights for the IPPS and OPPS payment systems. The ACR expected the Agency to provide for adequate public review and comment before implementation. Now that actual data are available, it is clear to ACR that the separate CT and MR CCRs should not be used. The resulting changes in the CT and MR APCs do not follow logically from the data and raise serious questions about the quality of the underlying cost report data.

The ACR also wishes to take this opportunity to express our profound concern about the unintended consequences that the use of separate CT and MR CCRs would have on the technical component of these codes in the Physician Fee Schedule (PFS). If this policy were implemented, the resulting reductions in hospital payment would also affect the office practice setting. This is because the HOPPS technical payments would fall below the payment rates in the PFS causing further cuts as mandated by the Deficit Reduction Act of 2005 (DRA). The DRA mandates that the PFS technical payments be paid at the PFS rate or HOPPS rate, whichever is the lower.

The ripple effect of HOPPS payment rates on physician office services heightens the importance of ensuring that any changes made to the HOPPS methodology are fully justified. This is not simply a matter of ensuring that hospitals will be appropriately reimbursed. And since physician offices are unlikely to have the volume and mix of patients treated by a typical hospital, they do not have the same ability to offset underpayments of some services with increased payments for other services. In other words, the application of the new CCRs will decrease hospital payments in some cases but increase them in other cases to maintain budget neutrality within the HOPPS payment system. Thus hospitals may be somewhat less concerned about the overall effect of changes in CCRs. However, this is not the case in the typical physician office setting, where a narrower range of services is often provided and the cumulative effects of these reductions prove greater.

² AMA/Specialty Society RVS Update Committee Database, 2013
CT and MR services have endured 12 cuts since 2006, the majority of which have been applied to the technical component (TC). In addition, another impending 10% TC cut will take place with the implementation of the 90% equipment utilization rate as mandated by the Taxpayers Relief Act for CY 2014. Additional payment reductions would make these studies non-viable in the office setting since physician offices would be unable to cover the costs necessary to provide these services, under even the most cost-efficient scenario.

**ACR Recommendation**

In 2011, ACR recommended 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. CMS nonetheless chose to establish these separate cost centers. Now that we have actual CCRs for each of the radiology cost centers, we believe these values raise many questions about the appropriateness of applying these new CCRs. *We recommend for 2014 and future years that CMS continue to use only the single diagnostic radiology CCR and not use the proposed CT and MR CCRs for determining APC weights.*

**Establishing Comprehensive APCs**

**General Observations and Recommendation**

The ACR contracted with one of the local health care consulting firms to run analysis on the impacts of CMS’ proposal to establish device-dependent comprehensive APCs. From what we understand, the methodology allows for the comprehensive APC to be paid and every other service provided to the patient within a 30-day period that is either related or unrelated to the service to not be paid or captured. Initial estimates show that over $7 million in imaging studies that are done on separate days from the device-dependent base procedure will not be paid. This estimate does not include other non-imaging services provided that is unrelated to the device-dependent comprehensive APC which also will not be paid. This lack of payment and loss of data related to these services is a major concern. A further concern is that the methodology becomes more complex with a greater potential for loss of data, and thus loss of cost capture, when there are layers of packaging involved, including procedures that are affected by current conditional packaging methodology and those payment scenarios covered under the composite APC policy.

*The ACR recommends that CMS delay implementation of the proposed policy to develop comprehensive device-dependent packaged APCs until there is more time for sharing of information between CMS and the public so the methodology can be replicated with accurate data and more substantive comments can be submitted.*
System-Level Comments

The ACR is submitting the following system-level comments and concerns for CMS’ consideration. We feel that we cannot make detailed constructive comments until some of these concerns have been addressed.

1) There was an error in the evaluation and management (E&M) APC used to scale all APC weights. This error was not corrected until CMS posted a new file only 9 days before the close of the comment period. The original error obviously made it difficult for ACR or any other stakeholder to assess the implications of the proposed rule and develop substantive and constructive comments.

2) CMS should disclose as many of the steps as possible in order to allow stakeholders to replicate the methodology and data capture. This should include the order by which the steps take place.

3) CMS should disclose the order in which CMS applied various packaging policies. The order matters in terms of generating different numbers of single claims and different single claims across wide swaths of codes. Because so many of the packaging rules affect imaging codes, this problem affects imaging more than some other clinical areas.

4) Finally, the discrepancies in code lists and status indicators have an effect similar to the order of applying packaging policies: we can’t figure out which lists are correct or if they are all incorrect and applying different status indicators changes the number and geometric mean of single claims.

Conclusion

It is to CMS’ advantage to share this information if CMS wishes to continue to propose further packaging policies. The intent of ACR in replicating CMS methodology is to contribute analysis which stands to improve the accuracy of the OPPS and capture more costs for rate-setting. We feel that we have been doing this in good faith for many years and hope to continue to build on this relationship with CMS in the future. The comprehensive device-dependent APC proposal could set a precedent for future comprehensive packaging and ACR would like to ensure that the methodology accomplishes what CMS hopes to accomplish while insuring that hospitals receive accurate payments to cover their costs for the services provided.

Comment Solicitation on Increased Packaging for Imaging Services for 2015

The ACR would like to work with CMS to replicate the methodology that would be used for this increased packaging proposal for 2015. We would like to ensure that the highest level of costs are captured in any new packaging efforts and that those imaging studies that continue to be paid separately also have accurate APC weights.
In addition, the ACR has questions about how this increased packaging policy would affect single session “Q3” imaging codes. An understanding of CMS’ choice of methodology would be extremely important in determining the impact on costs captured and subsequent payment rates. We strongly suspect that the interaction of single session “Q3” imaging codes and this new policy may necessitate the creation of a new “Q4” status indicator and new conditional packaging rules.

**Proposed New Packaging Policies for CY 2014 - Drugs, Biologicals, and Radiopharmaceuticals That Function as Supplies When Used in a Diagnostic Test or Procedure**

The ACR is also concerned about our ability to replicate the methodology and the use of accurate data in the CMS proposal to package drugs functioning as supplies, add-on codes and ancillary codes. For example, when running preliminary analysis to the best of our ability, we found that the newly packaged add-on codes are captured in rate-setting only 44% of the time. The remaining 56%, or nearly $800M, of add-on code costs are unused in rate-setting. The ACR would like the opportunity to further explore the add-on codes and other packaging areas before CMS moves forward with implementing this proposal. Therefore, the ACR requests that these packaging proposals not be implemented in CY 2014.

**Comments on Myocardial Sympathetic Innervation, Imaging into new technology APC**

The ACR supports the nuclear medicine societies’ request to place the category III codes for myocardial sympathetic innervation, imaging, planar qualitative and quantitative assessment; and myocardial sympathetic innervation, imaging, planar qualitative and quantitative assessment; with tomographic SPECT into a new technology APC. The ACR also supports separate payment or appropriate cost capture of the drug N Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries, to insure that all costs are captured appropriately when these studies are then placed into a standard APC.

**Removing TIPS from the Inpatient Only List**

The ACR requests that CMS allow CPT codes 37182 and 37183 to be removed from the inpatient only list and allow for the insertion or revision of a transvenous intrahepatic portosystemic shunt(s) (TIPS) services to be provided in the outpatient setting. Clinical circumstances occur where a patient has a TIPS procedure done in the hospital, stays in the hospital overnight for observation and then is discharged in the morning, within 24 hours. Billing for these studies and scenarios would be considered an outpatient or observation visit rather than an inpatient stay. These procedures can be and are safely performed in the hospital inpatient or outpatient setting. The ACR believes that CMS should allow payment for TIPS procedures in the hospital outpatient setting in an effort to allow hospitals to move towards more efficient care and further cost savings.
Quality Measures for the 2016 Payment Determination and Subsequent Years

*OP-15 Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*

CMS notes that public reporting of the claims-based measure OP-15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache was deferred in previous rulemaking, and that deferral continues.

The ACR appreciates that CMS continues to postpone public reporting of the OP-15 measure, since we do not support this measure in its current form as stated in our comments during previous rule-making cycles. It would be helpful to have an update from CMS on the potential use or revision of this measure beyond its postponement.

Possible Hospital OQR Program Measure Topics for Future Consideration

CMS seeks comments on potentially using the following measure domains for future measures: clinical quality of care; care coordination; patient safety; patient and caregiver experience of care; population/community health; and efficiency. CMS believes use of these domains would promote better care and align with other quality reporting programs.

The ACR supports the use of the measure domains that CMS has suggested, as these domains align with measure domains in use in other hospital quality programs as well as with the Physician Quality Reporting System (PQRS) measures. Beyond aligning measure domains, we believe CMS should also work towards greater alignment of measures themselves across programs to better support improvement efforts. As an example, in CY 2014 CMS has finalized five measures in PQRS focusing on radiation dose optimization. These measures are being implemented as the Optimizing Patient Exposure to Ionizing Radiation (OPEIR) measures group. As a co-developer of the measure set, the ACR is pleased that these measures are slated for use in PQRS next year. However, since the OPEIR measures are structural in nature, and because the technology used or system modifications that may need to be implemented to meet the measures will likely be done at least at a group level and in many situations in conjunction with a facility, implementing the measures for hospitals would provide coordinating incentives for these important measures. The ACR urges CMS to continue to align quality programs for hospitals and physicians in such a way.

Additionally, CMS has stated that one intended goal for use of the Imaging Efficiency measures is to address the patient safety issue of unnecessary radiation exposure. While ACR certainly agrees that unnecessary or duplicative studies are inefficient and detrimental to the patient and we support measures that may improve patient safety and efficiency of imaging services, the OPEIR measures would affect larger numbers of people and larger critical organ doses in the hospital setting than the current Imaging
Efficiency measures. In particular, the measure, *Reporting to a Radiation Dose Index Registry*, has great potential for enabling substantial improvement for use of optimal imaging protocols and patient exposure to radiation across many imaging procedures.

The measure could be implemented similarly to the four structural measures included in the Hospital Inpatient Quality Reporting (IQR) program:

- Participation in a Systematic Database for Cardiac Surgery
- Participation in a Systematic Clinical Database Registry for Stroke Care
- Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
- Participation in a Systematic Clinical Database Registry for General Surgery

The ACR would be pleased to discuss with CMS use of the OPEIR set or the Dose Index Registry measure in the HOQR program.

**Conclusion**

Thank you for the opportunity to comment on the Proposed 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.

Respectfully Submitted,

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