

Philips Healthcare

BY ELECTRONIC DELIVERY

August 31, 2009

Charlene Frizzera, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: [CMS-1414-P] Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates

Dear Acting Administrator Frizzera:

Philips Healthcare (Philips) appreciates the opportunity to comment on the proposed CY 2010 Hospital Outpatient Prospective Payment System policies and rates (the HOPPS Proposed Rule). Philips' current activities are organized across five businesses: Imaging Systems (x-ray, computed tomography (CT), magnetic resonance (MR) imaging, and nuclear medicine imaging equipment); Clinical Care Systems (ultrasound imaging, hospital respiratory systems, cardiac care systems and children's medical ventures); Home Healthcare Solutions (sleep management and respiratory care, medical alert services, remote cardiac services, remote patient management); Healthcare Informatics and Patient Monitoring (patient monitoring systems, healthcare informatics and image management services); and Customer Services (consultancy, clinical services, education, equipment financing, asset management and equipment maintenance and repair).

Our comments focus on the following areas of concern:

- Proposed imaging efficiency measures under consideration for 2012 and subsequent years in the HOP QDRP measures set.
- Multiple imaging composite APCs and other packaging policies
- CMS' proposal for payment for brachytherapy services
- Payment for radiation therapy guidance services

Proposed Imaging Efficiency Measures

Philips is extremely concerned with the four imaging efficiency measures under consideration for CY 2012, as well as CMS's decision to move forward with implementation of four imaging efficiency quality measures in CY 2010, despite widespread opposition. We echo the comments of the American Hospital Association (AHA) and other industry and provider groups that all imaging





PHILIPS

efficiency measures, as well as any other quality measures, should gain NQF endorsement and be adopted by HQA BEFORE they are used by CMS.

The process that CMS used in deciding to propose these measures for approval is insufficient: It was established and implemented with input by companies that have a clear stake in the outcome; allowed only 30 days for comment; and did not provide a fair and open process for endorsement. Such a process is not at all comparable to the far more rigorous procedures followed by the NQF.

It is our understanding that these measures initially would be applied based on claims submitted prior to the measures' adoption, or even the proposal to adopt them. We believe this is inappropriate and inadequate for several reasons. First, the benchmark between quantity (number of procedures) alone and quality is not clearly established in the published literature or in nationally recognized clinical practice guidelines for the measures. Therefore, it is not at all clear how these measures will improve quality of care. If the primary goal of the measures is simply to reduce procedure volumes, it raises additional questions about the impact on care this could have for Medicare patients.

Secondly, it is critical that CMS refrain from evaluating providers through the use of 'quality' or 'efficiency measurement' tools until after providers have had an opportunity to modify their practices to come into compliance with the new standards. Providers should have the opportunity to modify their practices BEFORE they are measured and before their compliance is publicly disclosed. If the new measures are implemented as proposed, we anticipate that hospital compliance will be based on a review of claims submitted several years ago, significantly before the new measures were designed, let alone approved. Additionally, because these measures are not necessarily linked to accepted standards of care, public reports evaluating provider "quality" will be confusing and potentially misleading to patients. Based on these concerns, we ask that CMS not implement the proposed measures for 2012 and retire in 2011 the four imaging efficiency measures that were adopted for use beginning in 2010.

Multiple Imaging Composite APCs and Other Packaging Policies

A number of provisions in the HOPPS Proposed Rule reflect continuation or expansion of existing HOPPS policies, such as multiple imaging composite Ambulatory Payment Classifications (APCs) and packaging of imaging guidance services into the underlying procedures. The five multiple imaging composite APCs: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA Composite with Contrast Composite); APC 007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite) were finalized in 2009. We remain concerned that payment is inadequate when more than two procedures are performed. This echoes similar concerns raised by the American Hospital Association and other industry and provider groups, as well as members of the APC panel during its February 2009 meeting. The APC panel recommended that CMS continue to work with stakeholders to examine different options for APCs for multiple imaging sessions and multiple imaging procedures. We appreciate CMS' indication in the Proposed Rule that it is willing to follow this recommendation.

We are especially concerned that hospitals that treat multiple trauma and/or cancer patients are particularly impacted since multiple images (more than two) are routinely required for trauma patients and for staging of cancer patients. In addition to the fact that the payment for the



PHILIPS

Composite rate drops significantly after two images (as compared to individual APC payments), we are concerned about the potential application of the Composite APCs to multiple imaging sessions. Efficiencies often erode when more than one imaging session is required within 24 hours. Given the nature of trauma, for example, not all symptoms are evident at one time nor can the treating physician necessarily order all of the appropriate imaging tests at once since trauma symptoms may appear several hours later.

We appreciate CMS' willingness to continue to evaluate and refine the policies surrounding the Composite APCs. As a first step, we would like to support Advamed's recommendation that CMS apply the multiple imaging composite APC payment rule only to those procedures performed on the same patient on the same day of service during the same session. CMS could designate the use of a modifier to identify cases when such procedures are performed on the same date of service, but not during the same session. Further, we support Advamed's recommendation that CMS continue to evaluate whether the methodology used to establish existing composite APCs has resulted in payments that accurately reflect the resources needed to provide these services.

Regarding other packaged services, Philips, along with other industry and provider groups, urges CMS to adopt the APC Panel's recommendations to pay separately for radiation therapy guidance services for two years and then reevaluate packaging on the basis of claims data. CMS' statement that the decline in aggregate payment for these services is "attributable to many factors" suggests that further evaluation is needed in order to understand those causes and that packaging is premature at this time. We also agree with MITA that guidance services are different from the treatment itself, and should be paid accordingly.

Payment for Brachytherapy Services

Philips is concerned that CMS's proposal to pay for brachytherapy services under the prospective payment system may undermine access to this important cancer treatment. It is our understanding that Medicare payment for brachytherapy services in non-hospital settings has been reduced substantially. At a time when access to these important cancer treatment services may be jeopardized in non-hospital settings, we do not believe that it would be prudent to implement a new and untested prospective payment methodology for these services in hospital settings. To do so may well jeopardize the continued availability of these services in either setting.

In conclusion, we ask that CMS:

- Not implement the proposed imaging efficiency measures for 2012 and retire in 2011 the four imaging efficiency measures that were adopted for use beginning in 2010.
- Apply the multiple imaging composite APC payment rule only to those procedures performed on the same patient on the same day of service during the same session.
- Continue to evaluate whether the methodology used to establish existing composite APCs has resulted in payments that accurately reflect the resources needed to provide these services.
- Delay implementation of a new and untested prospective payment methodology for these services in hospital settings.
- Further evaluate the impact of packaging on payment for radiation therapy services.



PHILIPS

- Pay separately for radiation guidance services.

Again, we appreciate the opportunity to comment on the HOPPS Proposed Rule for 2010. Please contact me at (978) 659-2972 or by email at laurel.sweeney@philips.com if we can provide more information or answer any questions.

Regards,

Laurel Sweeney
Sr. Director, Reimbursement & Legislative Affairs



PHILIPS