

Philips Healthcare

September 2, 2008

BY ELECTRONIC DELIVERY

Kerry Weems, 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-1404-P (Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates)

Dear Acting Administrator Weems:

Philips Healthcare (Philips) is pleased to have this opportunity to comment on the proposed hospital outpatient prospective payment system for 2009 (the "Proposed Rule"). Philips operates in five main business areas: Diagnostic Imaging Systems, Clinical Solutions, Healthcare Information, Customer Services and Home Healthcare Solutions. Our product line includes best-in-class technologies in X-ray, ultrasound, magnetic resonance, computed tomography, nuclear medicine, PET, radiation oncology systems, patient monitoring, information management, personal emergency response systems, and resuscitation products.

To ensure that Medicare's reimbursement to hospital outpatient departments for imaging services is appropriate, we offer the following comments on the Proposed Rule:

- CMS should issue instructions to hospitals directing them to allocate all capital costs related to diagnostic imaging services directly to the cost centers involved, and should refrain from establishing separate reporting for CT and MRI services at this time.
- CMS should refrain from "packaging" new imaging services for at least two years.
- CMS should not implement the proposed imaging efficiency quality measures until the public has had an opportunity to learn about the measures and their specifications and can comment meaningfully on them.

- CMS should clarify how the establishment of the composite APCs for imaging services will impact the application of the Deficit Reduction Act “cap” on comparable services provided in non-hospital settings, verify that the payment rate for the “with contrast” APC is set using the costs of “with contrast” procedures as required by statute, and delay the implementation of composite APCs in trauma and cancer-staging cases
- CMS should reconsider the APC rates for fetal echocardiography and for myocardial PET.

I. Reporting of Capital Costs Associated with Diagnostic Imaging Services

In the Proposed Rule, CMS requests comments on whether it should create standard cost centers for CT scanning and MRI, as recommended by RTI International.¹ We do not believe that it would be appropriate for CMS to take this step at this time, since it appears that doing so would exacerbate the current undervaluation of CT and MRI which currently exists under the Hospital Outpatient Prospective Payment System (HOPPS).

Specifically, it appears that the current Ambulatory Payment Classification (APC) rates for MRI and CT are significantly understated because the substantial capital costs associated with these procedures are often allocated across all hospital departments, rather than being allocated directly to the radiology cost center. In fact, in a recent analysis, Direct Research found that a substantial portion of hospitals treat CT scanners and MRI equipment as fixtures, rather than equipment, and allocate their direct capital costs across the whole hospital, rather than to the radiology cost center. See attached Direct Research study. This results in the understatement of the costs associated with the provision of these services, and distortion of the applicable cost to charge ratio. This distortion would be aggravated if the cost to charge ratios for MRI and CT services were determined separately from other radiology services.

Because, under the Deficit Reduction Act (DRA), the APC rates for MRI and CT services function as a “cap” on payment rates for these services in the non-hospital setting, it is especially important that the APC rates for these services fully reflect all of the costs, including all of the capital costs, incurred in the provision of the services. In the hospital setting, the allocation of medical equipment costs across all hospital departments results in the undervaluation of some services (e.g., MRI and CT services) and the overvaluation of services in other departments (e.g., clinic services, which generally do not involve high capital costs). In the end, it might be argued that “it all balances out in the end.” However, because the APC rates for CT, MRI and other medical imaging services function as a “cap” on the amounts paid for these services in non-hospital settings, it is crucial that the APC rates for medical imaging services be accurate: Otherwise, the payment caps applicable to non-hospital medical imaging services will be inappropriately low. And many of the non-hospital providers impacted by the caps, unlike hospital providers, are not able to make up the difference through the provision of other services. For non-hospital providers, it clearly does not “all balance out in the end.”

¹ Id. at 41432.

For these reasons, we request that CMS not only refrain from establishing separate line items or cost to charge ratios for CT and MRI services, but that the agency take affirmative steps to ensure that the capital costs associated with CT, MRI and other medical imaging services impacted by the DRA are directly allocated to the appropriate departments (generally either radiology or cardiology). We would be delighted to work with CMS to draft appropriate instructions to hospitals to ensure that such costs are allocated appropriately and taken into account in establishing the APC rates for medical imaging services that are subject to the DRA cap.

II. Packaging Policies

Philips remains concerned about the “packaging” policies established last year, and especially the packaging policies for radiopharmaceuticals, contrast agents, and certain imaging services (for example, imaging guidance). We are also concerned about the decision of CMS to disregard the APC Panel’s recommendation to reinstate separate payment for intravascular ultrasound (IVUS) and intracardiac echocardiography (ICE). However, we recognize that CMS has considered the objections raised by Philips and others to these packaging policies, and that the agency is not prepared to revise or rescind these policies at this time. For that reason, we do not repeat our objections here; however, we do recommend that CMS monitor access to care and provide median costs for packaged services so that we can determine whether the proposed payment rates truly reflect their costs.

We fully support the recommendation of the Medical Imaging Technology Alliance (MITA) that any new imaging services be reimbursed separately under the HOPPS for at least two years to allow CMS to gather data on their costs. Without such an initial period of cost collection, it will be difficult, if not impossible, for CMS to determine the costs of these services with sufficient accuracy to ensure that these costs are accurately reimbursed under HOPPS.

III. Quality Measures

We find the section of the Proposed Rule relating to imaging quality measures to be extremely difficult to understand. These measures are not set forth in sufficient detail to permit meaningful comment from a clinical perspective. It is not clear from the preamble to the Proposed Rule what would be measured or why. In addition, the preamble suggests that these proposed measures are “claims-based” and since none of the other HOPPS quality measures are claims based it is unclear how this would work. We urge CMS to refrain from adopting any imaging quality measures without further amplification and elaboration. We urge CMS to work closely with all stakeholders, including relevant professional and hospital groups, to ensure that any quality measures applicable to medical imaging services are practical to implement.

IV. Composite APCs for Imaging Services

CMS is proposing to establish a number of composite APCs to facilitate the more efficient use of imaging services. We believe that this approach represents a significant improvement over the multiple procedure discount approach that applies to non-hospital providers. However, it is unclear to us how the establishment of these composite APCs will impact the application of the Deficit Reduction Act (DRA) “cap” that applies when the same procedures are performed by non-hospital providers.

We are concerned, however, about payment for combinations of services within the same imaging family with and without contrast. CMS establishes separate composite APCs for CT and CTA with and without contrast and MRI and MRA with and without contrast, but if a hospital performs a procedure without contrast during the same session as a procedure with contrast, both procedures are paid at the rate for the “with contrast” APC. We ask that CMS verify that the payment rate for the “with contrast” APC is set using the costs of “with contrast” procedures only.

Finally, we are concerned about the effect of the composite APCs on access to imaging services for trauma and cancer patients. Multiple procedures often are necessary for evaluation of trauma patients and for staging of cancer patients. Under the proposed rule, payment for three or more procedures would be significantly reduced. We urge CMS to exempt multiple imaging services for trauma and cancer patients from the composite APCs.

V. Comments on Specific APC Rates: Fetal Echocardiography and Myocardial PET

In addition to the general policy issues discussed above, Philips has a number of concerns about specific APC rates proposed by CMS for implementation in CY 2009.

First, we note that CMS is once again proposing a substantial change in the APC rate for myocardial PET (APC 0307), proposing to reduce the APC rate by 18%, from \$ 1400 to \$1,143. We believe that the proposed rate is substantially lower than the cost of providing the services involved, especially since the performance of the procedure requires the administration of a relatively costly radiopharmaceutical. We note that, over the past several years, the APC rate for this procedure has been extraordinarily unstable: CMS first categorized single and multiple studies into a single APC, then established separate APCs for single and multiple scans, then recategorized the two procedures into a single APC, then packaged the radiopharmaceutical involved, and now proposes to reduce the packaged rate by 18%. In light of this volatility, we request that CMS refrain from implementing the proposed reduction for myocardial PET.

Second, we note that CMS continues to categorize fetal echocardiography into a different (and lower paying) APC than similar studies performed on adults. Yet, fetal echocardiography is more resource intensive than similar studies performed on adults, since these studies require specialized equipment, specially trained cardiac sonographers, and longer examination time. We believe that it would be more appropriate to recategorize these procedures so that they are

Acting Administrator Weems
September 2, 2008
Page 5 of 5

reimbursed at rates that are least equal to those paid for the performance of similar studies on adults.

VI. Conclusion

We appreciate the opportunity to submit these comments. If you have any questions regarding these comments or related issues, please do not hesitate to contact me at laurel.sweeney@philips.com

Respectfully submitted,



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