September 11, 2017

BY ELECTRONIC DELIVERY

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Room 445-G
Washington, DC 20201

Re: Comments on Medicare Program 2018 Physician Fee Schedule Proposed Rule ("2018 PFS Proposed Rule" or "Proposed Rule")

Dear Administrator Verma:

On behalf of Philips Healthcare (Philips), I am pleased to have this opportunity to comment on the 2018 PFS Proposed Rule. Philips provides solutions that span the health continuum, including imaging, patient monitoring, and cardiac care systems; medical alert systems; sleep management and respiratory solutions; healthcare informatics solutions and services; and a complete range of comprehensive telehealth programs.

Our comments this year address the following issues:

- CMS' proposal to pay for services provided in new hospital outreach clinics at 25% of the otherwise applicable Hospital Outpatient Prospective Payment System (HOPPS) rates;
- CMS' solicitation of comments suggesting ways to modernize and expand coverage for telehealth services;
- CMS' solicitation of comments on ways to encourage remote patient monitoring;
- CMS' proposals related to implementation of a new Diabetes Prevention Program, and, specifically, CMS' continued reluctance to recognize a robust role for the remote provision of these services;
- Proposed payment changes impacting a number of diagnostic imaging services, including echocardiography, MR and CT and valuation of the professional PACS costs associated with vascular ultrasound; and
- Proposed changes to the Medicare Shared Savings Program (MSSP).

I. New Off-Campus Provider-Based Facilities

Philips strongly opposes CMS' proposal to pay for services provided in new off-campus hospital outpatient facilities[1] at 25% of the otherwise applicable HOPPS rates.

Section 603 of the Bipartisan Budget Act of 2015 states that certain "applicable items and services" furnished in certain off-campus provider-based departments (PBDs) will not be considered covered hospital outpatient department (HOPD) services for purposes of the HOPPS and will instead be paid under the "applicable payment system" under Medicare Part B. We understand that this legislation was motivated in large part by concerns that hospital acquisitions of physician practices were being fueled by the reimbursement differential between the amounts paid to PBDs under HOPPS and amounts paid to physicians' offices under the PFS. Congress presumably intended to "level the playing field" between hospitals and physicians' offices with respect to the provision of off-campus outpatient services while protecting those outpatient facilities that had been established under prior law.

The proposed implementation of these provisions by CMS, however, will go considerably further—strongly dissuading hospitals from establishing outreach clinics in medically underserved areas and making it financially impracticable for any outreach facilities that are established to provide needed diagnostic imaging services. In short, paying new off-campus hospital facilities at 25% of HOPPS rates will not result in a payment-neutral system, but rather will result in payment for many services at rates that are considerably lower than those paid for comparable services in non-hospital settings. This is especially true for diagnostic imaging procedures and many other procedures paid on the basis of separate technical component (TC) allowances under the PFS. We strongly believe that if this proposal is implemented without change, medically underserved areas—including many rural areas—will continue to be underserved, and that any new hospital outpatient outreach clinics that are established will need to run on a "bare bones" budget that will not facilitate access to diagnostic imaging or other needed diagnostic and therapeutic health care services.

By way of illustration, the following chart sets forth the amounts that would be paid for a number of common diagnostic imaging procedures in new hospital outreach clinics if the proposed payment reduction is adopted and if 2018 HOPPS rates are adopted without change.

CPT	**Procedure**	**2018 Proposed HOPPS Rate**	**25%*HOPPS Rate**	**2018 Proposed PFS TC**
74176	CT Abd+Pelv	$149.67	$37.41	$ 113.73
93971	Extremity Study	$149.67	$37.41	$ 98.97
93880	Extracranial Bilateral Study	$149.67	$37.41	$ 165.20
72148	MR Lumbar Spine w/o contrast	$264.07	$66.02	$ 151.16

[1] The proposal impacts off-site provider-based facilities that were not mid-build as of November 2, 2015.

70450	CT head, brain w/o dye	$96.54	$24.14	$ 73.42
72125	CT Neck, spine	$149.67	$37.41	$ 131.72

We do not believe that CMS' rationale for these major payment reductions is justified by the data cited in the Proposed Rule. This proposal is based solely on a comparison between the amounts paid for physicians' office visit practice expenses and hospital clinic services. However, as CMS has indicated in the past, hospital outpatient clinic services are not comparable to physicians' office services. In particular, hospital outpatient clinic services include a broad array of "packaged" items and services that are separately paid under the PFS and are generally more intensive and complex than physicians' office visits.

Moreover, CMS' own data suggests that the proposed cut would substantially underpay hospitals for the procedures and non-clinic visit services provided in new off-campus facilities. According to CMS' own analysis, the amounts paid for the TC or practice expenses associated with most common non-clinic services provided in off campus facilities approximates 40% of HOPPS rates—not 25%. If CMS finalizes the proposal without change, hospitals will be:

- Dis-incentivized to offer anything other than the simplest clinic visits in any new outreach clinics that they may establish.
- Incentivized to provide diagnostic imaging only on the main hospital campus, potentially resulting in increased waiting times in these settings and significant inconvenience for Medicare beneficiaries whose transportation options are often limited. We would anticipate that access problems may be especially severe in rural areas, which often include a disproportionate number of elderly residents.

***Recommendation**: We recommend that CMS refrain from adopting the proposed reduction in Medicare payment for new off-site clinics. If CMS decides to proceed with a cut of this magnitude, the agency should institute a reconciliation process at the end of each year, under which payments are adjusted to ensure that the amounts paid to hospitals for diagnostic imaging services provided in new hospital outpatient clinics are at least equal to the TC payment amounts that would have been paid if diagnostic imaging and other TC services had been provided in non-hospitals settings. Such a process will ensure a timely assessment of payment differentials between settings and will assure that the Medicare payment system achieves true site neutrality for TC services.*

II. Telehealth

A. Proposed Additions to the Telehealth List

The Proposed Rule announces CMS' intention to provide telehealth coverage for seven new services. Philips strongly supports this proposal. We are particularly supportive of CMS' proposal to provide telehealth coverage for HCPCS code G0296 (Counseling visit to discuss

need for lung cancer screening using low dose CT scan (LDCT), a service that is provided to determine a beneficiary's eligibility for screening and to assure shared decision making. We believe that telehealth coverage has the potential to make this screening service accessible for Medicare beneficiaries in geographically remote areas. We agree with the assessment in the Proposed Rule that this service is sufficiently similar to office visits to warrant telehealth coverage as a Category I service.

CMS is also proposing to add a number of behavioral health and add-on codes to the telehealth list, when the add-on services are provided in conjunction with a "base code" service that is also on the list. We agree with these proposals.

> ***Recommendation:*** *We recommend that CMS finalize its proposal to provide telehealth coverage for LDCT, as well as its proposal to add CPT codes 90839 and 90840 (psychotherapy for crisis; first 60 minutes) and (psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service) and four new add-on codes to the telehealth list.*

B. Ideas to Expand Coverage of Telehealth under Medicare For CY 2018

CMS is seeking information regarding ways that it might further expand access to telehealth services within the current statutory authority and pay appropriately for services that take full advantage of communication technologies. We very much appreciate CMS' solicitation of comments in this area.

First, while we believe that CMS could implement a number of policy revisions that would expand coverage of telehealth services within the scope of the current statutory framework, it is also true that the statutory limitations on telehealth coverage are woefully out of date. The current statutory language conceptualizes telehealth services as the remote provision of identifiable physician or practitioner services that are otherwise provided face-to-face. However, in recent rulemakings, CMS has made it clear that professional services need not be furnished face to face in order to be covered (e.g. transition care management and chronic care management coverage). Therefore, it is clear that the statutory language needs to be updated and telehealth should be re-conceptualized to reflect current policy.

> *<u>Recommendation</u>: We urge CMS to seek the enactment of legislation that eliminates the current limits on telehealth coverage and substitute a broader definition of "telehealth", which we believe better captures the role that telehealth may play in the delivery of health care services:*
>
> > *Telehealth is the use of remote sensors, communications and data processing technologies that focus on the patient/person and involves dynamic interaction with providers in real-time or near real-time resulting in improved clinical outcomes, lower costs and greater satisfaction. Telehealth technologies include bi-directional audio/video, physiologic and behavioral monitoring, engagement prompts and point-of-care testing. Telehealth programs utilize remote teams of*

physicians, nurses, pharmacists, social workers and health coaches supported by this enabling technology to provide the highest quality health care.

Second, we strongly believe that CMS should focus on providing appropriate coverage and payment for services provided by a tele-ICU. The recent application of broadband technologies to Intensive Care Units (ICUs) is permitting an increasing number of hospitals around the country to provide improved care to their ICU patients through remote monitoring and clinical intervention by critical care nurses and Intensivists. These Intensivists are able to monitor in real time all the vital signs of an ICU patient, see the patient, and dialogue with the patient from their remote location, and are able (under proper arrangements with the hospital in which the patient is located) to order a course of care for the patient. The cost of operating the e-ICU is not eligible for Medicare payment under any health benefit, and, while certain critical care professional services have been added to the telehealth list, these codes are more appropriate for billing for sporadic services provided by individual intensivists than for the kind of capital intensive infrastructure necessary to facilitate 24/7 intensivist coverage.

The clinical literature indicates that e-ICU coverage saves both lives and dollars.[2] In addition, a Health Care Innovation Award (HCIA demonstration award entitled "Rapid Development and Deployment of Non-Physician Providers in Critical Care" conducted by Emory University, in partnership with Philips and several regional medical centers) unequivocally demonstrates the potential cost savings and quality improvements achievable with proper deployment of the e-ICU. That demonstration resulted in estimated three year savings of approximately $18.4 million over 3 years.

***Recommendation**: We urge CMS to institute an expanded demonstration program based on the model e-ICU that was utilized successfully by Emory under its CMMI HCIA, for example:*

- *A shared savings program that would enable participating hospitals and Medicare to both share in savings achieved using e-ICU coverage. By, for example quantifying the hospital savings achieved during the course of the admission and reductions in post-discharge costs.*
- *A payment incentive for hospitals that provide 24/7 access to intensivist coverage.*
- *An upfront payment for rural hospital investment in technology to enable remote intensivist access and ongoing payment support, similar to the upfront support provided for Advance Payment ACOs.*

[2] **1.** Impact of an Intensive Care Unit Telemedicine Program on a Rural Health Care System. Zawada, et al. Postgraduate Medicine, 2009; 121(3):160-170.
2. Evaluation of Hospital-Setting HCIA Awards three-year independent financial and clinical outcomes audit conducted on behalf of Centers for
Medicare & Medicaid Services (CMS) by Abt Associates. **3.** 2015 ICU Physician Staffing Survey conducted by Leapfrog Group.

- *Provision of an add-on payment for admissions that involve the provision of e-ICU coverage, similar to the "new technology" add-on payments provided under the IPPS for certain new technologies.*

Third, we strongly urge CMS to utilize its demonstration project authority to waive the originating site and other telehealth coverage requirements for all Alternative Payment Models approved by the CMS Innovation Center (CMMI). In light of the growth of CMMI-approved APMs (and the further growth anticipated as the result of the payment incentives provided for Advanced APMs under MACRA), adoption of this change would have the potential to significantly expand the use of telehealth in all geographic areas and for services provided in different sites of care, including beneficiaries' homes.

> *Recommendation: We urge CMS to provide automatic waivers of originating site and other telehealth coverage requirements for all APMs approved by CMMI, including those APMs that were previously approved.*

Fourth, so long as the statutory provisions directly related to the telehealth benefit remain restrictive, it is appropriate for CMS to continue to use other coverage categories to expand coverage for the remote provision of medically necessary services whenever practicable. For example, we applaud the agency for expanding coverage of services furnished remotely by, for example, providing coverage for transitional care and chronic care management services as "physicians' services" payable under the PFS.

> *Recommendations: We recommend that CMS continue to expand coverage for services that are provided remotely through various coverage categories, including, but not limited to, the telehealth coverage category. Specifically*:
>
> - *We encourage the further expansion of coverage for remote monitoring under the PFS (see discussion below with regard to remote monitoring).*
> - *We encourage CMS to explore the use of new technology add-ons to provide incentives for hospitals to provide services via telehealth to hospital inpatients, including especially e-ICU services.*
> - *We encourage CMS to include services that are provided remotely in the new Diabetes Prevention Program and other new programs as they are developed.*

Fifth, we believe that coverage for specialty consultations that are provided remotely is authorized by the current law and that remote specialty consultations should be added to the telehealth list. The Medicare Act (SSA, Section 1834(m)(4)(F)(i))defines Telehealth Services as:

> (i) IN GENERAL.—The term "telehealth service" means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.

(Emphasis added). Yet, CMS only includes certain limited inpatient consultations on the telehealth list.

> ***Recommendation:*** *We urge CMS to include specialty consultations on the list of telehealth services, as mandated by the Medicare Act. We recognize that Medicare has eliminated coverage for "consultations" under the current E/M coding nomenclature, but believe that the agency has the authority to "crosswalk" the allowance for consultations provided remotely to the most comparable E/M code that is currently payable.*
>
> ***Recommendation****: The Proposed Rule indicates that CMS is currently considering revising the current E/M guidelines and codes, and, in effectuating this revision, CMS should reinstate payment for specialty consultations in a manner that facilitates remote provision of these services under the telehealth benefit.*

Finally, we note that CMS has broad authority to add services to the telehealth list, but historically has rejected the great majority of applications. Generally, the substantial clinical evidence required to add a new Category 2 service (a service that is not similar to an office visit, professional consultation, or other service currently on the list) is not available in the absence of reimbursement.

> ***Recommendation****: We urge CMS to reconsider its evidence requirements for inclusion of new services on the telehealth list. If current evidence requirements remain unchanged, CMS should establish a coverage pathway through the CED process for the needed evidence to be gathered.*

III. **Remote Patient Monitoring (RPM**)

A. Background: Philips' Remote Patient Monitoring Programs

Philips believes that coordinated remote patient monitoring programs are among the most cost-effective solutions to systematically manage patient populations with ongoing needs, particularly those with medically complex and/or chronic conditions. Philips' remote patient monitoring programs are designed to enable providers to coordinate care across the continuum for patients ranging from those who require chronic management to patients with complex, high-risk conditions requiring acute intervention. Philips remote patient monitoring programs focus on three key areas – complex care management, chronic disease management and readmission management. Technology, such as the clinical workflow of Philips' eCareCoordinator and the two-way audiovisual communication of eCareCompanion, the tablet-based interfaces for the patient, help improve the patient experience and give remote care a human touch. The eCareCoordinator platform connects patients with their caregivers, and caregivers with one another. Patients can log their daily health status with the home tablet-based eCareCompanion app, and clinicians in the hospital can track their populations of patients, identifying those most in need of immediate intervention to prevent a hospitalization.

Remote patient monitoring technologies have undergone a transformation that has created new capabilities that are not currently reflected in public policy. In fact, remote patient monitoring technologies are fundamentally altering the way care can be delivered to certain populations. These changes are permitting providers with new capabilities to address population health in ways that have not been possible in the past. These changes to and enhancements of remote patient monitoring technologies are creating opportunities for collaboration among providers at unprecedented levels, facilitating interaction with patients and enabling care teams to anticipate patient needs before they escalate beyond certain thresholds leading to more expensive levels. Furthermore, these technologies can and do optimize patient engagement and greater self-care.

Data released from a pilot program involving Philips' partnership with Banner Health (Phoenix, AZ) documents the effectiveness of a "high tech/high touch" system of managing patients with multiple chronic conditions. Results of the pilot program indicate that this approach has the potential to result in cost reductions in the range of 27%, reductions in acute and long-term care of 32%, and reductions in hospitalization in the range of 45%.

These findings are supported by the available clinical literature. The most recent and largest study of the potential impact of remote patient monitoring in the management of patients with chronic conditions, titled "The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management", was published in *TELEMEDICINE and e-HEALTH* in September, 2014. The study, authored by 23 experts in the area of Telemedicine, reviewed the use of telemedicine for the remote care of patients in the home for CHF, COPD, and stroke. The economic effects of telehealth interventions were measured or examined in two ways: (1) changes in rates or volumes of hospital admissions, re-admissions, length of stay, and/or emergency department visits and (2) cost-benefit analysis and cost-effectiveness analysis of remote patient monitoring in terms of specified outcomes. In both instances and with few exceptions, the evidence supported the economic benefits of telehealth compared with usual care among patients with CHF, stroke, and COPD. Based on the 71 studies that met applicable inclusion criteria, the experts concluded that:

> [T]he preponderance of the evidence produced by telemonitoring studies points to significant trends in reducing hospitalization and emergency department visits and preventing and/or limiting illness severity and episodes, resulting in improved health outcomes.

B. Current Status of Coding and Payment for Remote Patient Monitoring

CMS currently recognizes only a narrow set of remote patient monitoring services under the Physician Fee Schedule, including, for example, certain holter and remote cardiac event monitoring services and "remote monitoring" of heart rhythms through implantable cardiac devices (such as pacemakers). There is no widespread federal reimbursement remote patient monitoring of physiologic data from a patient experiencing a variety of other, non-cardiac diseases or conditions.

Historically, coverage and payment for remote patient monitoring has been complicated by an implicit assumption that, to be payable, professional services must be rendered on a face-to-face basis. With the recognition of the clinical utility of various care management services that

require minimial if any face-to-face interaction, this barrier to payment fortunately has eroded, leaving the path clear for increased covereage and payment for remote patient monitoring services.

Along these lines, we fully agree with CMS that remote patient monitoring services are not and should not be considered Medicare telehealth services as defined under section 1834(m) of the Act. Rather, remote patient monitoring services involve the technological infrastructure necessary to transmit medical information and the interpretation of that information without a direct interaction between the practitioner and beneficiary. While they are furnished remotely, these services—like other remote patient management services already recognized by CMS--should be covered without having to meet the restrictions imposed on telehealth services.

> ***Recommendation:*** *We support the distinction made by CMS in the Proposed Rule betweeb telehealth and remote patient monitoring and urge CMS to develop a payment mechanism for remote patient monitoring services under the PFS that is not subject to the originating site restrictions applicable to telehealth services.*

While there is a pressing need to develop an appropriate payment mechanism for remote patient monitoring services as quickly as practicable and while we recognize that use of existing CPT codes may facilitate the process, unfortunately we do not believe that the use of the existing CPT codes 99090 (reportable for the analysis of clinical data stored in computers)and 99091 (reportable for the collection and interpretation of physiological data) to report and value remote patient monitoring services would be appropriate, since it does not appear that either of these existing CPT codes fully reflect the resources involved or fully describe the broad range of clinical applications for remote patient monitoring. While we believe that these CPT codes should be "unbundled" and should be separately payable, we urge CMS to establish new Level 1 CPT codes (or, in the alternative, new "G" codes) to report remote patient monitoring services.

> ***Recommendation:*** *We urge CMS to "unbundle" CPT codes 99090 and 99091 and to pay for services reported using these codes separately; however, we believe that new CPT (or, in the alternative, new "G" codes) should be developed and implemented to report remote patient monitoring services.*

C. Our Recommendations

Philips is aware of the substantial efforts that the American Medical Association (AMA) has dedicated to issues related to the appropriate coding and payment of remote patient monitoring, as reflected in the AMA's comment letter on the Proposed Rule. Specifically, we understand that the AMA has formed a Digital Medicine Payment Advisory Group (DMPAG), comprised primarily of nationally recognized telehealth physicians and other practitioners at leading health systems around the country, subject matter expert physicians in coding and valuation, as well as industry experts with knowledge of expected technology advancements. We further understand

that the DMPAG's careful deliberations have resulted in (among other things) two code change applications that will be considered by the CPT Editorial Panel at its September 2017 meeting.[3]

> ***Recommendation****: In light of the care and attention that the AMA's DMPAG have dedicated to the formulation of appropriate codes for reporting remote patient monitoring services, Philips strongly recommends that CMS accept the DMPAG's recommendations with regard to new CPT codes for reporting these services, to be presented at the upcoming September 2017 CPT Editorial Panel meeting.*

In the event that the Editorial Panel decision is delayed or the DMPAG's recommendation rejected by the Editorial Panel or by CMS, we urge CMS to adopt an alternative set of "G" codes that physicians can use to report and receive Medicare payment for remote patient monitoring services.

> ***Recommendation****: In the event that CMS rejects the DPAG's recommended CPT codes for reporting remote patient monitoring services, we urge the agency to create at least two temporary G codes, one physiologic monitoring treatment management services, with 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month. Another code should focus on the technical component and set up of monitoring/management for chronic care patients with remote monitoring of physiologic parameters (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate); set-up and patient education on use of the devices with daily recordings or programmed alerts and transmission in a 30-day period.*

IV. Diabetes Prevention Program

Philips is extremely pleased that CMS is proceeding with its plan to implement Medicare coverage for services provided pursuant to a Medicare Diabetes Prevention Program (MDPP). We believe that implementation of this program has the potential to result in substantial

[3] Specifically, we understand that the DMPAG recommended the addition of a code to report the physician/provider services of chronic care monitoring/management of a patient using remote monitoring technology. It is for physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month. In addition, we understand that the DMPAG recommended The DMPAG also recommended the addition of codes to report the technical component of monitoring/management for chronic care patients with remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate); set-up and patient education on use device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.

Medicare savings and to improve the lives of Medicare beneficiaries who are at risk of developing this condition. However, we are concerned that excluding qualified virtual DPP providers from delivering the benefit will result in a critical lack of access for many beneficiaries who live in regions where in-person services are not available and will undermine the ability of these programs to achieve their full potential.

CDC has been recognizing digital programs for more than two years and has collected comprehensive data demonstrating these programs' effectiveness. Studies[4] demonstrating the effectiveness of digital programs were available to the CMS Actuary when the office certified the program in March 2016. We are confident a renewed analysis will demonstrate that virtual DPP providers, already recognized by CDC, demonstrate the same or better efficacy as in-person programs for Medicare beneficiaries.

> ***Recommendation****: Since the CMS Actuary must re-certify the program before the nationwide expansion next year, we strongly encourage CMS to include comprehensive coverage of remote provision of services under the MDPP in its analysis, and fully include qualified virtual DPP providers in the model expansion next year*.

V. Imaging-related issues

A. Echocardiography

We note that, under the proposed Rule, RVUs for echocardiography Technical Component (TC) services would be reduced by approximately 20%, due in large measure to re-pricing of echocardiography equipment. We urge CMS to make clear the basis for reductions of this magnitude, in order to facilitate public comment.

Medicare payment for echocardiography TC services has been reduced substantially since 2007, and we believe that payment reductions for this service and for nuclear cardiology services have triggered many cardiology practices to seek alignment with hospital systems. Caution is warranted in implementing a new round of payment reductions for this extremely useful cardiac test. At the very least, it is our understanding that where payment reductions are in the range of 20% as the result of revaluation of an existing code, Section 220(e) of the Protecting Access to Medicare Act of 2014 (PAMA) requires that the reduction be phased in over two years, and we urge CMS phase in any new payment reductions for this important service.

B. Vascular Ultrasound

CMS notes that in the 2017 PFS final rule, CMS finalized its proposal to add a professional PACS workstation (ED053) used for interpretation of digital images to a series of CPT codes and addressed costs related to the use of film that had previously been incorporated as direct PE inputs for these services. In total, CMS added the professional PACS workstation to 525 codes in its direct PE input database: 94 therapeutic codes and 431 diagnostic codes. In the Proposed

[4] See, e.g. http://drc.bmj.com/content/4/1/e000264

Rule, CMS seeks comments regarding whether or not the use of the professional PACS workstation would be typical in the following list of vascular ultrasound CPT and HCPCS codes: 93880, 93882, 93886, 93888, 93890, 93892, 93893, 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93965, 93970, 93971, 93975, 93976, 93978, 93979, 93980, 93981, 93990, and 76706, and HCPCS code G0365.

> *Recommendation: We urge CMS to incorporate direct cost inputs for a professional PACS workstation into the allowances for vascular ultrasound codes. It is our experience that such systems are routinely used by providers that provide these services.*

C. TC allowances for Other Imaging Procedures

We note that the Proposed Rule would further reduce Medicare payment for a number of diagnostic imaging TC services, such that TC allowances for key MRI and CT services would reach new lows, when these services are provided in non-hospital settings. We believe that the allowances for these services are substantially out of line with allowances for the practice expenses associated with other procedures paid under the PFS

CPT[1]/ HCPCS	Mod	Status	Description	PE RVUs	2018 Proposed PE Payment
70490	TC	A	Ct soft tissue neck w/o dye	3.61	$ 129.92
70491	TC	A	Ct soft tissue neck w/dye	4.66	$ 167.71
70492	TC	A	Ct sft tsue nck w/o & w/dye	5.76	$ 207.30
71260	TC	A	Ct thorax w/dye	4.69	$ 168.79
71270	TC	A	Ct thorax w/o & w/dye	5.78	$ 208.02
70544	TC	A	Mr angiography head w/o dye	9.33	$ 335.79
72195	TC	A	Mri pelvis w/o dye	8.48	$ 305.20
73719	TC	A	Mri lower extremity w/dye	9.09	$ 327.15
74181	TC	A	Mri abdomen w/o dye	7.29	$ 262.37
43123		A	Partial removal of esophagus	83.12	$ 2,991.49
43108		A	Removal of esophagus	82.87	$ 2,982.49
47142		A	Partial removal donor liver	79.44	$ 2,859.05
61698		A	Brain aneurysm repr complx	69.63	$ 2,505.98
32853		A	Lung transplant double	84.48	$ 3,040.44
61686		A	Intracranial vessel surgery	67.50	$ 2,429.33

This chart suggests that Medicare allowances for imaging TC services are undervalued under the PFS methodology, which is supposed to provide payment based on the relative resources required for each procedure. The non-imaging services listed above generally involve a physician's performance of surgical services in a hospital inpatient setting, where the hospital—not the physician—bears all equipment, non-physician personnel, supply and overhead costs; yet, the Medicare practice expense payment allowances far exceed the amounts proposed to be paid for relatively capital-intensive MRI and CT procedures. We urge CMS to carefully consider whether the proposed reductions result in payment that truly reflects the relative resources involved in providing these services, when the agency finalizes the Proposed Rule.

VI. Medicare Shared Saving Program

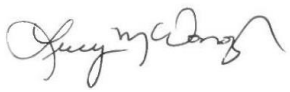
CMS is proposing several modifications to the rules for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program. These proposed modifications are designed to reduce burden and streamline program operations. The proposals include the following:

- Revisions to the assignment methodology to reflect the requirement under section 17007 of the 21st Century Cures Act (Pub. L. 114-255, December 13, 2016), that for performance years beginning on or after January 1, 2019, the Secretary determine an appropriate method to assign Medicare FFS beneficiaries to an ACO based on their utilization of services furnished by rural health clinics (RHCs) or federally qualified health centers (FQHCs);
- The addition of three new chronic care management codes (CCM) and behavioral health integration (BHI) codes to the definition of primary care services used in the ACO assignment methodology; and
- Reduction of burden for stakeholders submitting an initial Shared Savings Program application and the application for use of the skilled nursing facility (SNF) 3-Day Rule Waiver.

  <u>Recommendation</u>: Philips supports proposed revisions of the MSSP rules in the Proposed Rule.

We appreciate the opportunity to comment on the 2018 PFS Proposed Rule. If you have any questions or if we can provide any additional information, please do not hesitate to contact me at Lucy.Mcdonough@Philips.com.

Sincerely yours,



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