

APPROPRIATE REIMBURSEMENT FOR RADIOPHARMACEUTICALS

Every year, millions of Americans are diagnosed and/or treated using nuclear medicine and molecular imaging in the diagnosis and treatment of cancer, heart disease and many other conditions. The Centers for Medicare and Medicaid Services (CMS) currently sets Medicare hospital payment rates for nuclear medicine procedures and radiopharmaceutical drugs that often do not cover the provider costs of all diagnostic radiopharmaceuticals. This lack of coverage threatens patient access to care, and Congress needs to make sure that CMS pays appropriately for all diagnostic radiopharmaceuticals.

The Problem:

- **Packaging diagnostic radiopharmaceutical drugs with nuclear medicine procedures:** CMS is packaging too wide a range of diagnostic radiopharmaceutical drugs, by cost and indication, into a single procedural payment (known as an ambulatory payment classification, or APC). In instances where higher-priced radiopharmaceutical drugs are packaged with lower-priced radiopharmaceutical drugs, payment for the APC falls well below the provider cost of the higher-priced radiopharmaceutical drug, not to mention the time, equipment and supplies for that service. This year CMS proposes to go even further by *significantly* reducing the number of APCs.
- **Arbitrary:** CMS has arbitrarily declared that diagnostic radiopharmaceutical drugs are considered “supplies” for Medicare hospital outpatient payment purposes—even though they are considered by the Food and Drug Administration as drugs with all of the costs included with developing new drugs. CMS packages these items into the imaging procedure payment (APC) without consideration that these products are not interchangeable: they are prescribed based on the patient’s symptoms or diagnosis. The packaging also does not take into account the difference between the highest-priced and lowest-priced radiopharmaceutical drug.
- **Hurts both the patient and the taxpayer:** This CMS administrative payment policy results in inaccurate Medicare payments to hospitals—both underpayments for procedures using more expensive diagnostic radiopharmaceutical drugs *and* overpayments when less-expensive radiopharmaceutical drugs are used. In particular, this policy results in an extremely skewed payment for high-cost, low-volume radiopharmaceutical drugs (such as certain cancer radiopharmaceuticals), since Medicare payment for the combined procedure and radiopharmaceutical drug may not cover even a fraction of the provider cost alone.
- **Patient care and innovation are directly impacted:** Some hospitals have *stopped performing services*, forcing patients to go elsewhere for their testing. This ultimately threatens Medicare patient access to the most medically appropriate diagnostic tests. Innovation of new diagnostic tests also is at risk.

The Solution:

There are currently 22 APCs for diagnostic nuclear medicine services, and all diagnostic radiopharmaceuticals are packaged into these procedure-based groupings. For 2016, CMS proposes to reduce the nuclear medicine

APCs to 4. After reviewing our different options, the Society of Nuclear Medicine and Molecular Imaging (SNMMI) offer the following recommendations:

1. Pay for diagnostic radiopharmaceuticals separately from the procedure payment, but packaged into new radiopharmaceutical APC groupings.
2. Reconfigure the procedures from 22 to 8 APCs for CY 2016, in combination with 10 packaged APC groups of diagnostic radiopharmaceuticals.

These configurations achieve CMS's goal of reducing APCs while identifying alternative APC groupings, which incorporate packaging as a principle to achieve appropriate payment in the Hospital Outpatient Prospective Payment System (OPPS) setting for all nuclear medicine services. This proposal is widely supported by nuclear medicine stakeholders, which include patients, manufacturers, and medical societies.

The Request:

We respectfully request you join Senators Portman (R-OH) and Donnelly (D-IN), Congresswoman Brooks (R-IN), and Congressman Moulton (D-MA) in signing the Congressional letter to CMS urging them to withdraw the current proposed language in the 2016 OPPS proposed rule and instead re-evaluate the proposal put forth by SNMMI.