RBMA™
Building the Business of Radiology

RADIOLOGY BUSINESS MANAGEMENT ASSOCIATION

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September 5, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1601-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8013

Subject: Medicare Program; 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 Radiology Business Management Association (RBMA) appreciates the opportunity to comment on the proposed rule for the CY 2014 Medicare Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgery Center (ASC) payment system as published in the July 19, 2013, *Federal Register*.

Founded in 1968, the RBMA represents over 2,300 radiology practice managers and other radiology business professionals. In the aggregate, RBMA's influence extends to over 24,000 radiologic technologists and 26,000 administrative staff. RBMA is the leading professional organization for radiology business management, offering quality education, resources and solutions for its members and the healthcare community, and helping shape the profession's future.

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General Comments

Since 2006, Medicare's payments to imaging have been cut 12 times, nine of which have directly targeted the technical component. Total cuts to computed tomography's (CT) technical component alone are in the range of 40 to 55 percent.[1] In the HOPPS/ASC rule, CMS proposes the use of new cost-to-charge ratios (CCRs) for CT and magnetic resonance imaging (MRI). If implemented, these new CCRs for CT and MRI would reduce Medicare payments for CT and MRI services performed in hospital outpatient departments by 18 to 38 percent depending on the service. Because of the Deficit Reduction Act (DRA) of 2005, which caps the Medicare Physician Fee Schedule (MPFS) technical component (TC) payments for advanced imaging services to the lesser of the MPFS or HOPPS rates, the proposed new CCRs for CT and MRI will result in further payment cuts to the TC of CT and MRI ranging from 12 to 35 percent. Physician practices and imaging centers are not going to understand why such a technical change in HOPPS results in additional payment cuts to

[1] Neiman Report, Brief 01, October 20, 2012, "Medical Imaging: Is the Growth Boom Over?", page 2, Harvey L. Neiman Health Policy Institute, American College of Radiology

non-hospital imaging centers. Therefore, it is crucial that hospital cost and cost-to-charge ratios (CCR) be as accurate as possible. Unfortunately, the proposed CCRs for CT and MRI contained in the CY 2014 HOPPS proposed rule do not inspire confidence that they accurately reflect hospital costs.

Comments on Specific Issues in the Proposed Rule

Proposed Calculation and the Use of Cost-to-Charge Ratios (*Federal Register,* page 43547)

RBMA opposes the proposed rule's cost-to-charge ratios for CT and MRI.

In its rule, CMS proposes new CCRs for CT and MRI for calculating Ambulatory Payment Classification (APC) weights, which are used for determining payment rates under HOPPS. Historically, there has been one CCR for radiology in the aggregate. The resulting CCRs for CT and MRI are much lower than those for all of radiology. The new lower ratios mean lower estimated costs and thus lower APC weights.

Estimated Costs and HOPPS Payments Lack Face Validity

The estimated costs for CT and MRI using the proposed CCR lack face validity. For example, according to CMS' APC cost file,[2] code 74020 (two-view x-ray of the abdomen) has cost estimates ranging from a low of $9.28 to a maximum of $1,237.65 while code 74150 (CT abdomen without contrast) has estimated costs ranging from $17.44 to $1,019.95. Moreover, under the proposed CCRs, HOPPS payment for CT will be on par with plain film. To illustrate, the proposed CY 2014 HOPPS payment rate for code 74150 is $113.21 (APC 0332) vs. $107.08 for code 74020 (APC 0261). This result is incongruous because the equipment and other operating expenses for CT and MRI are significantly higher than for plain film x-ray. For example:

- Room/Equipment Expenses:
  - CT and MRI machines and software are more expensive to buy and upgrade
  - CT and MRI rooms take up much more square footage (at least three times as much for CT and even more for MRI because of magnetic field lines, especially for 3T magnets)
  - Repair contracts and repair expenses for CT ad MRI are much higher than x-ray. Add this to the fact that CT and MRI are inherently more fragile because of the sheer number of parts and amount of computer processing that takes place.
  - CT and MRI use more electricity than x-ray
  - MRI uses liquid helium for cooling, which is expensive and needs to be replenished
- Study/Exam Expenses:
  - CT and MRI digital images take up more storage room
  - Throughput is much slower because the tables need to be changed for each patient. MRI is even slower because the coils need to be changed and earplugs need to be put in, etc.
  - MRI and CT are more sensitive to motion, which translates to more time spent making sure images are obtained perfectly: whereas x-ray techniques are much more straightforward
  - Processing of MRI and CT data into images takes much more time and computing power than x-ray
  - MRI and CT images take a much longer to acquire than X-ray

[2] CY 2014 HOPPS NPRM corrected files - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

- Personnel Expenses:
  - CT and MRI technologists require special training and demand higher pay. Studies are tailored to each patient which takes more technologist time than x-ray
  - Technologists spend time interviewing patients and obtaining informed consent for contrast agents for CT and MRI studies
  - CT and MRI technologists have to spend time placing intravenous lines for imaging studies involving contrast agents
- Quality Control/Assurance Expenses:
  - Accreditation takes machine time, hours of tech time, and has fees associated with it
  - Extra precautions are needed for MRI (magnetic fields) and for CT (increased radiation dose)

Finally, paying CT and plain film x-ray comparably under HOPPS is inconsistent in light of the fact that CT represents state of the art imaging care while plain film x-ray represents mature technology and less clinical specificity.

Hospital Cost Accounting Is Inaccurate

Hospital cost reports are widely viewed as inaccurate because, in part, most hospitals cannot accurately calculate direct costs by modality. This is particularly true for capital intensive modalities such as CT and MRI and hospitals continue to assign CT and MRI costs using the less accurate square footage methodology.

The inaccuracies inherent in these hospital cost accounting methods become significantly problematic when the resulting data are used in rate setting. The challenges posed by hospital cost reports are not new. CMS discussed separate cost centers for CT and MRI in the CY 2009 OPPS proposed and final rules. CMS based these discussions on a 2007 Research Triangle Institute (RTI) analysis of the costs and charges of CT and MRI scans. In its report, RTI warned that:[3]

> *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.*

CMS has had to defer previous attempts to use hospital CT and MRI cost data because of concerns over data quality and sufficiency. The lack of validity of the resulting data supports a continued deferral until hospitals implement improved cost accounting methods.

Minimum Data Quality Requirements

CMS should only use CT/MRI cost report data that meet minimum quality standards.

Because of persistent data concerns for CT and MRI and their negative implications on the Inpatient Prospective Payment System (IPPS), HOPPS, and MPFS, we recommend not

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[3] Research Triangle Institute. A Study of Charge Compression in Calculating DRG Relative Weights. Report to CMS, January 2007 (page 65)

utilizing the revised cost-to-charge methodology for CT and MRI in the CY 2014 HOPPS. We have previously commented that the proposed CCRs for CT and MRI should be withdrawn from the FY 2014 IPPS. Instead, CMS should adopt the following minimum quality measures for hospital claims data used in deriving the CCRs for CT and MRI:

1. Reporting of capital costs using <u>one</u> of the following methodologies:
   - Direct assignment of capital costs to cost centers 57 and 58, <u>or</u>
   - Allocation of movable equipment costs using the "dollar value" method
2. Establishment of a minimum threshold of total costs (e.g., $250,000) in cost centers 57 (CT) and 58 (MRI)
3. Presence of diagnostic-radiology-specific administrative costs in cost centers 57 and 58:
   - No negative reclassifications from cost center 54 (Diagnostic Radiology) <u>and</u>
   - No positive reclassifications to cost centers 57 and/or 58

RBMA believes that these aforementioned quality standards will better ensure that the CCRs for CT and MRI are based on accurate information. First, direct assignment and dollar value approaches surpass square footage in the hierarchy of cost allocation methodologies. Second, by establishing a minimum cost threshold that is sufficiently robust to reflect the costs of CT and MRI, CMS has some assurance that the cost centers contain reliable information. Finally, the total cost of CT and MRI should also include administrative expenses.

IPPS Final Rule

RBMA is aware that the CCR recommendations it made in the IPPS proposed rule were rejected by CMS in its IPPS final rule. However, we stand by those recommendations and believe that strong consideration should be given to them during the HOPPS comment period. In fact, the agency commented specifically that the decision to implement additional CCRs for the 2014 IPPS does not "predict what CMS may finalize for the CY 2014 [H]OPPS/ASC relative payment weights." The agency further states, "[w]e will separately evaluate the impacts of implementing any additional CCRs under the OPPS as part of the OPPS rulemaking process." We strongly encourage the agency to separately evaluate the impacts of implementing any additional CCRs under the HOPPS and the validity of the resulting fees rather than merely acting upon precedence established by the FY 2014 IPPS final rule.

<u>Proposed Changes to Packaged Items and Services</u> (*Federal Register,* page 43568)

RBMA recommends that CMS delay its proposed CY 2014 packaging changes until such time that the methodologies can be replicated and impact fully assessed.

The CY 2014 HOPPS/ASC rule proposes to expand the categories of related items and services packaged into a single payment for a primary service under HOPPS, specifically: (1) ancillary services, (2) add-on codes, (3) diagnostic tests on the bypass list, and (4) device removal procedures.

However, attempts to replicate CMS' methodology suggest that the proposed APC rates for the comprehensive service may not take into account the full costs of the packaged services. Also, it is not certain that these packaged services will be paid separately if performed on a different date from the comprehensive service. It is for these reasons that RBMA asks for a delay in the proposed packaging changes so that CMS' methodology can be verified and its impact assessed.

Collecting Data on Services Furnished in Off-Campus Provider-Based Departments *(Federal Register,* page 43626)

RBMA recommends that CMS issue better guidance on the definition of "off-campus provider-based" prior to any effort to collect information regarding those entities, such as the services they provide or the payments they receive.

In the proposed rule, CMS expresses interest in collecting information about off-campus provider-based outpatient departments to better understand hospitals' acquisition of physician offices and its impact on the Medicare program.

It is RBMA's understanding there is variability currently in how the Medicare Administrative Contractors (MACs) treat off-campus provider-based facilities. CMS' data collection efforts may result in inconsistent data without better and/or more consistent definitions or guidance.

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The RBMA appreciates the opportunity to comment on CMS' CY 2014 HOPPS/ASC proposed rule. We stand ready, as always, to assist CMS with data and other information regarding the practical aspects of the business of radiology. If questions arise or additional information is needed, please feel free to contact RBMA's Executive Director, Michael R. Mabry, at 703.621.3363 or mike.mabry@rbma.org.

Sincerely,

Wendy Lomers

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