RBMA | Radiology Business Management Association

9990 Fairfax Blvd.
Suite 430
Fairfax, VA 22030

Direct 703-621-3355
Toll Free 888-224-7262
Fax 703-621-3356

October 3, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Attention: CMS - 1734-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Submitted electronically via http://www.regulations/gov

Medicare Program; CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Updates to the Quality Payment Program; Medicare Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Proposal to Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy Proposed Rule

Dear Administrator Verma:

About RBMA

The Radiology Business Management Association (RBMA) appreciates the opportunity to submit these comments to the Centers for Medicare & Medicaid Services (CMS) on the calendar year 2021 Medicare Physician Fee Schedule (MPFS) Proposed Rule. Established in 1968, the RBMA is the leading professional organization for radiology business management that represents over 2,300 radiology practice managers, over 24,000 radiologic technologists, and 26,000 administrative staff. The mission of the organization is to educate and support radiology practices maintaining the successful, viable business model and availability of radiology services for all patient populations.

Evaluation and Management Codes Increased Valuations

The RBMA expresses our extreme concern over CMS proposed revaluation of the Evaluation and Management coding that will greatly hinder the ability of radiology physician groups throughout the country to deliver high quality and timely diagnostic testing to Medicare participants. We see increased issues with access and a potential reduction in the timely

diagnosis and treatment of major illnesses. Coupled with the reduction in revenues due to the COVID-19 pandemic these cuts may become catastrophic. .

RBMA asks CMS to delay implementation of the proposed EM coding and RVU conversion factor revaluation. In addition, RBMA asks that the Department of Health and Human Services (HHS) use the powers granted to them under section 319 of the Public Health Service Act, specifically the ability to waive budget neutrality requirements as necessary to ensure that sufficient health care items and services are available to meet the needs of individuals in the Medicare program.

The 2021 proposed rule moves to adopt the proposed coding structure for the Evaluation/Management (EM) codes as recommended by the American Medical Association (AMA) effective 1/1/2021. Due to budget neutrality requirements, many medical specialties, including radiology will face a 10.6% reduction in RVU conversion factor, decreasing from $36.09 in 2020 to $32.26 in 2021. It is estimated by RBMA members that these cuts may exceed 13% in 2021. In addition, the American College of Radiology estimates that the cumulative effect of these cuts to diagnostic radiology is $452 million in one year. Substantial losses in radiology remuneration are compounded by the drastic decline in hospital and clinic visits amidst the current COVID-19 pandemic, potentially jeopardizing radiology practices and patient care.

As physicians and their practices have moved through 2020, we have seen continued pressure both clinically and economically to provide high quality radiology services within the environment of a pandemic. It is estimated that radiology groups have seen a reduction of nearly 20% in revenues due to the pause in non-essential health care services during the April-June 2020 period. While radiology volumes have returned to baseline, this lost revenue will not return.

As the COVID pandemic continues within the United States, radiology remains at the forefront of care to these patients. The essential services provided by our specialty include interpretation of the chest radiographs, chest CTs, and numerous angiographic studies in every body system that evaluate for thrombotic complications of the COVID-19 disease. In addition, interventional radiology provides multiple services of minimally invasive procedures for the critically ill patients in ICU including central lines placement, gastrostomy placements, thoracenthesis, biliary and nephrostomy tube placements, and many others. Furthermore, IR-operated procedures directed to treat covid-induced thrombotic complications in the cerebral, pulmonary, and peripheral circulations significantly reduce hospital stays and overall healthcare costs. . While radiology and interventional radiology, amidst a global pandemic, continue to provide high quality services to diagnose and treat large patient populations, it is anticipated that the industry is faced with the financial instability of our practices.

RBMA recently completed an extensive survey (See Addendum A) of members to gauge the effects the EM revaluation on practices throughout the country. With 155 responses it is clear that these cuts will drive very difficult decisions regarding access and jobs within radiology practices.

Some highlights include:

- 70.32% plan to reduce operating overhead reducing ancillary staff and benefits.
- Over 50% are preparing for possible furloughs to staff.
- 63.8% anticipate a delay in equipment purchases and upgrades.
- Over 34% are afraid they may need to close imaging centers or reduce hours of operation.
- 34% are considering restricting imaging services for Medicare beneficiaries

There is also a great potential for negative impacts to non-Medicare patients if the conversion factor reduction goes into effect. RBMA members report that 81.88% of those surveyed have commercial payor contracts tied to Medicare reimbursements. In addition, the Veterans Administration, Tricare and many Medicaid plans maintain reimbursement

tied to Medicare rates. Quite simply, as Medicare reimbursement drops so do private commercial and other government and private payor reimbursements. These negative changes will most significantly affect general, small, emergency, and rural centers, further widening the clinical care disparity gap for underserved populations.

Supervision of Diagnostic Tests by Certain Nonphysician Practitioners (NPPs)

We note CMS's proposals with respect to supervision of diagnostic imaging, including virtual presence and allowing non-Physician Practitioners to provide direct supervision. The appropriate level of training and licensure for clinicians supervising diagnostic imaging is a clinical issue outside the scope of RBMA's expertise. However, we strongly encourage CMS to clearly define who should provide supervision for each level of diagnostic tests, and to be consistent in the application of these requirements across all settings, including IDTFs Independent Diagnostic Testing Facilities (IDTFs). This may involve drawing a distinction between requirements for direct and personal supervision of individual patient imaging studies, and overall direction and control of an IDTF's testing services in physician offices, hospital outpatient departments and IDTFs. Regional variations and lack of clarity in these requirements leads to significant confusion for those working in IDTF settings.

Merit Based Incentive Payment System MIPS

With respect to the MIPS program, CMS proposes to increase weighting of the cost category in the 2023 and 2024 payment years. However, we are concerned to see no meaningful update to address the major problems with the current cost measure system as it applies to radiologists.

Currently, many diagnostic radiologists see significant numbers of inpatient stays attributed under the Medicare Spending per Beneficiary (MSPB) cost measure. Diagnostic radiologists almost never have an opportunity to manage inpatient stay or pre- and post-admission care, or even be aware of related costs. Currently, attribution of cases to diagnostic radiologists under the MSPB measure is a matter of chance. If a diagnostic radiologist happens to read diagnostic imaging studies for patients who have low cost under the MSPB measure, they are rewarded. If they happen to read diagnostic imaging studies for patients who have high cost under the MSPB measure, they are penalized. Most inpatient diagnostic imaging studies are ordered by other clinicians, not the interpreting radiologist.

In order to address this problem, RBMA strongly recommends that diagnostic imaging services (7xxxx and 93xxxx) be excluded from expenses used for MSPB attribution. Alternatively, physicians with specialty of Diagnostic Radiology could be excluded from MSPB attribution. In either event, we would expect that for most diagnostic radiologists, the cost category would be reweighted.

We also have significant concerns about application of the Revascularization for Lower Extremity Chronic Critical Limb Ischemia Episode Based Cost Measure for interventional radiologists. Interventional Radiologists frequently perform procedures with trigger codes for this measure (including 37224-37229). However, patients with chronic limb ischemia are some of the sickest and most complex patients who nearly always suffer numerous concomitant conditions including end-stage renal disease, diabetes, coronary artery disease, hypertension, and many others managed by the multispecialty team of cardiologists, nephrologists, wound care specialists, etc. Interventional Radiology involvement in these cases is typically limited to the trigger procedure itself and rarely involves the treatment of other comorbidities.

It is unrealistic to expect interventional radiologists to be responsible for the costs related to patients' entire care (not the procedure itself) 30 days before and 90 days after the trigger procedure. RBMA strongly recommends that the trigger codes for this measure be reviewed with clinical experts including interventional radiologists to select more appropriate trigger codes typically billed by all physicians who manage these cases, and that application of this measure be suspended until that process is completed.

In summary, RBMA stands as a partner in supporting CMS initiatives to advance the high-quality healthcare delivered to our Medicare population. We urge CMS leadership to find funding solutions, including the waiving of budget neutrality, to advance this goal and secure access to all medical specialty services in 2021 and beyond.

If there are questions regarding these comments please feel free to contact RBMA Executive Director Robert Still at bob.still@rbma.org.

Sincerely,

Linda A. Wilgus
President
Northwest Radiology
Indianapolis, Indiana

Robert T. Still,
RBMA Executive Director

SurveyMethods
ASK. ANALYZE. IMPROVE.

Survey: Radiology Hot Topic 08/26/2020-09/09/2020

Report: Default Report

Survey Status		Respondent Statistics		Points Summary
Status:	Closed	Total Responses:	155	No Points Questions used in this survey.
Deploy Date:	08/26/2020	Completes:	155	
Closed Date:	09/09/2020	Partials:	0	

1. Do you believe that a 10.6% reduction in the Medicare formula will ultimately lead to decreased access to care for your patients?

	Responses	Percent
Yes:	126	82.35%
No:	27	17.65%
Total Responded to this question:	153	98.71%
Total who skipped this question:	2	1.29%
Total:	155	100%

2.

If the fee reductions go into effect as proposed, what measures do you anticipate your group will have to consider to mitigate the loss of income? Please select all that apply.

	Responses	Percent
Furlough/terminate existing staff:	78	50.32%
Offer early retirement options for existing physicians:	47	30.32%
Delay hiring new physicians:	105	67.74%
Restructure salaries and bonuses for physicians:	103	66.45%
Reduce/restructure operating overhead (benefits, ancillary staff, outsourcing business services):	109	70.32%
Delay equipment purchases, equipment replacement:	99	63.87%
Closing/reducing hours of imaging centers:	53	34.19%
Restrict imaging services to Medicare beneficiaries in an outpatient setting:	53	34.19%
Other expense reductions:	79	50.97%
No changes planned at this time.:	12	7.74%
If other, please specify:	11	7%
Total Responded to this question:	155	100%
Total who skipped this question:	0	0%
Total:	155	100%

2.

If the fee reductions go into effect as proposed, what measures do you anticipate your group will have to consider to mitigate the loss of income? Please select all that apply.

Response	Comments
1	commercial payers to follow suit
2	We will be required by our hospital partners to staff and maintain the same level of coverage, quality and TAT. However, we will internally reduce shifts as much as possible and cut expenses - could ultimately affect TAT etc.
3	Terminate commercial insurance plan participation that are tied to current year Medicare Reimbursement. Terminate Medicare Advantage participation.
4	This is a nearly catastrophic change in one year, especially coming off of Covid. We know physician suicide rates are increasing, and burn out is huge issue. Piling on these impacts is very difficult to keep staff employed, and safe operations. Simply running too tight.
5	Less sub-specialized coverage of hospitals
6	Reduce staffing which will result in longer patient wait times, diminished overall access, and scheduling exams out further. Older equipment with fewer upgrades and diminished technological capabilities.
7	Opt out of Medicare
8	Eliminate services at rural hospitals with high government populations
9	hospital based and cannot control the number of Medicare patients that come to the hospital for x-rays
10	Medical Imaging is essential to Healthcare. If you continue to make cuts we will not be able have adequate equipment or qualified physicians willing to take on the enormous responsibility for diagnosing illness. Having minimal equipment and staff available would make any urgent medical situation (or pandemic) less able to address the communities needs. Healthcare can not be a "revenue neutral" budget item. Everyone working deserves to be paid appropriately, and you can't decide to pay some people less so others can make more.
11	We CANNOT CUT EXPENSES TO PROFITABILITY. How can we continue our imaging businesses with such a heavy burden of equipment cost, maintenance, utilities and regulation? What the hell?

3.
In which state do you practice?

	Responses	Percent
Alabama:	8	5.23%
Alaska:	3	1.96%
Arizona:	1	0.65%
Arkansas:	3	1.96%
California:	9	5.88%
Colorado:	3	1.96%
Connecticut:	3	1.96%
Delaware:	1	0.65%
District of Columbia:	0	0%
Florida:	11	7.19%
Georgia:	1	0.65%
Hawaii:	1	0.65%
Idaho:	1	0.65%
Illinois:	4	2.61%
Indiana:	3	1.96%
Iowa:	1	0.65%
Kansas:	6	3.92%
Kentucky:	2	1.31%
Louisiana:	3	1.96%
Maine:	0	0%
Maryland:	3	1.96%
Massachusetts:	5	3.27%
Michigan:	7	4.58%
Minnesota:	0	0%
Mississippi:	1	0.65%
Missouri:	4	2.61%
Montana:	2	1.31%
Nebraska:	0	0%
Nevada:	1	0.65%
New Hampshire:	1	0.65%
New Jersey:	3	1.96%
New Mexico:	1	0.65%
New York:	5	3.27%
North Carolina:	6	3.92%
North Dakota:	0	0%
Ohio:	7	4.58%
Oklahoma:	1	0.65%
Oregon:	4	2.61%
Pennsylvania:	4	2.61%

Rhode Island:		0	0%
South Carolina:		1	0.65%
South Dakota:		0	0%
Tennessee:		3	1.96%
Texas:		11	7.19%
Utah:		0	0%
Vermont:		0	0%
Virginia:		6	3.92%
Washington:		5	3.27%
West Virginia:		8	5.23%
Wisconsin:		0	0%
Wyoming:		0	0%
	Total Responded to this question:	153	98.71%
	Total who skipped this question:	2	1.29%
	Total:	155	100%

4.
What is the primary zip code for your practice? (optional)

	Responses	Percent
Zip Code:	110	100%
Total Responded to this question:	110	70.97%
Total who skipped this question:	45	29.03%
Total:	155	100%

4.
What is the primary zip code for your practice? (optional)

Response	Zip Code
1	60435
2	37066
3	29401
4	59101
5	93003
6	14221
7	44304
8	99507
9	66044
10	14620
11	97062
12	70006
13	98402
14	66202
15	92270
16	03038
17	63141
18	46250
19	96818
20	32210
21	98501
22	48124
23	90025
24	48061
25	34285
26	23235
27	10065
28	33901
29	48103
30	45459
31	83712
32	48507
33	35801
34	35801
35	49440
36	48502
37	74135
38	89706
39	35801
40	61265
41	35801

42	63301
43	35801
44	35406
45	35801
46	70809
47	15601
48	28401
49	70809
50	15220
51	14075
52	44053
53	77002
54	28801
55	46278
56	99501
57	32901
58	78216
59	32159
60	71913
61	98055
62	23235
63	52403
64	26554
65	87401
66	97086
67	08043
68	98371
69	26554
70	32216
71	78045
72	07661
73	43215
74	22603
75	59715
76	39210
77	40207
78	93401
79	85258
80	45342
81	06708
82	66604
83	75231
84	34990
85	33756
86	30604
87	97401
88	80920
89	78229
90	93105
91	72903
92	19958

93	43026
94	32156
95	79912
96	80045
97	60137
98	92270
99	38138
100	01915
101	01915
102	26505
103	75093
104	01915
105	01984
106	27710
107	93721
108	20850
109	63141
110	66044

5. Number of FTE radiologists represented by your practice?

	Responses	Percent
0-20:	68	43.87%
21-40:	44	28.39%
41-60:	22	14.19%
61-80:	6	3.87%
81-100:	4	2.58%
100>:	11	7.1%
Total Responded to this question:	155	100%
Total who skipped this question:	0	0%
Total:	155	100%

6.
Practice Structure:

	Responses	Percent
Hospital based:	81	52.26%
Not hospital based:	3	1.94%
Mix:	55	35.48%
Imaging Center:	53	34.19%
Breast Centers:	22	14.19%
Other (Please specify):	2	1.29%
If other, please specify:	3	1%
Total Responded to this question:	155	100%
Total who skipped this question:	0	0%
Total:	155	100%

6.
Practice Structure:

Response	Comments
1	Teleradiology - over night
2	Vascular Center
3	IDTF

7. What percentage of the patient population are Medicare beneficiaries (including Medicare Advantage)?

	Responses	Percent
0 – 20%:	10	6.58%
20 – 40%:	85	55.92%
40 – 60%:	42	27.63%
> than 60%:	15	9.87%
Total Responded to this question:	152	98.06%
Total who skipped this question:	3	1.94%
Total:	155	100%

8.

Do you have Commercial Payor Contracts that are tied to current year Medicare reimbursement? If yes, what percent of the group's overall revenues (both Medicare and non-Medicare) would be impacted by this reduction.

	Responses	Percent
Yes:	122	81.88%
No:	27	18.12%
Additional Comments:	50	33.56%
Total Responded to this question:	149	96.13%
Total who skipped this question:	6	3.87%
Total:	155	100%

8.

Do you have Commercial Payor Contracts that are tied to current year Medicare reimbursement? If yes, what percent of the group's overall revenues (both Medicare and non-Medicare) would be impacted by this reduction.

Response	Comments
1	60%
2	WE CAN NOT AFFORD ANY ADDITIONAL CUTS THIS WILL PUT RADIOLOGY INTO BANKRUPTCY
3	55
4	Researching
5	5%
6	55% Medicare and contracts tied into current Medicare
7	20%
8	48%
9	100%
10	55%
11	45%
12	over 25%
13	35%
14	20%
15	50%
16	2%
17	75%
18	50%
19	Additional 10% at least
20	80%
21	50% Most are tied to the medicare RVU schedule and are a % of Medicare i.e. 180-230% of Medicare.
22	60
23	70%
24	20%
25	potentially 20-30%
26	At least 50%
27	all of them.
28	35%
29	over 1 million
30	Blue Cross and Blue Shield of Arkansas ties any reductions in Medicare payments to the BCBS payments. This reduction will carry through to BCBS and reduce payments to over 80% of our business.
31	approximately 40%
32	THIS would be devastating. WE have a pop base of almost 80% Medicare and Medicaid. Radiology has taken the HITS every time and this has got to STOP!
33	>50%
34	Estimated 65%
35	90%
36	50+%

37	A minimum 70% of our payments would be negatively impacted if this legislation were to be enacted. it would be devastating to the practice.
38	50%
39	The value of imaging services continues to be undervalued when we are the primary, and most accurate, diagnostic tool available(e.g. appendicitis, etc.). Also, the most cost-effective use of health care dollars. They should be increasing our reimbursement and decreasing other less effective physicians.
40	10% additional.....
41	30 to 40%
42	This will be ugly.
43	80%
44	15-20%
45	75%
46	100
47	About 50% overall
48	5
49	As Medicare becomes USUAL AND CUSTOMARY then private insurance reimbursement will decline. How the hell can we continue to provide quality care to our patients? Why not reimburse us on individual QUALITY OF SERVICE instead of using this bludgeon on us with no recourse?
50	50%