June 12, 2013

The Honorable Marilyn Tavenner
Administrator
Center for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner:

We are writing to ask the Centers for Medicare and Medicaid Services' (CMS) to withdraw its proposal to use separate cost centers for computed tomography (CT) and magnetic resonance (MR) in the FY 2014 Inpatient Prospective Payment System (IPPS) rule and to avoid including an extension of such a proposal in the CY 2014 Outpatient Prospective Payment System (OPPS) rule. A full analysis of the practical impact of this policy demonstrates that it would result in incongruous and inaccurate Medicare reimbursements for CT and MR services in both the hospital and non-hospital settings—jeopardizing patient access to these services.

Background

CMS discussed separate cost centers for CT and MR in the FY 2009 IPPS and 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 MR scans. RTI's own analysis pointed to some anomalous trends:

> *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.*[1]

In fact, separate analyses conducted by other stakeholders raised similar issues which were expressed to CMS during public comment periods at that time. Despite these ongoing concerns about the potential for inaccurate separate cost reporting for these capital-intensive services, CMS finalized the cost center proposal for CT and MR in the FY 2011 IPPS final rule. CMS intended to use the new reporting to determine payments for CY 2013. However, due to challenges in adopting

[1] Research Triangle Institute. A Study of Charge Compression in Calculating DRG Relative Weights. Report to CMS, January 2007

the new cost report forms, CMS did not have sufficient data at the time and decided to defer implementation.

Inpatient Prospective Payment System

In the IPPS FY 2014 proposed rule, which was released on April 23, 2013, CMS announced its intent to use separate cost centers for CT and MR services. In the proposed rule, CMS highlights the fact that those MS-DRGs that include proportionally higher use of CT or MR relative to other codes (e.g. MS-DRGs associated with traumatic head injury and concussion) demonstrate the largest payment reductions. In fact, CMS states, "RTI's analyses were highly predictive for many of the MS-DRGs most sensitive to the effects of charge compression." This statement is troubling given the concerns RTI raised in its 2007 analysis. Due to the fact that MS-DRGs are bundled services, only a fraction of the negative impact can be observed in the IPPS proposed rule.

Outpatient Prospective Payment System

In addition to IPPS, CMS has indicated its intent to use separate cost centers for CT and MR to calculate payment in the OPPS beginning in CY 2014. Unlike the bundled MS-DRGs in IPPS, the APCs in OPPS more clearly demonstrate our concerns with using the new imaging cost centers. According to analysis using Medicare data and methodology, the new imaging cost centers would result in a 26 percent drop in the estimated costs used to determine CT payments, an 11 percent drop in the estimated costs used to determine MR payments, and a 28 percent increase in the estimated costs used to determine payments for other diagnostic imaging modalities.[2]

Additional analysis demonstrates how the new imaging cost centers can result in anomalous payments in the hospital setting for advanced imaging and traditional imaging modalities. This becomes apparent when one examines estimated costs using data for the group of hospitals that reported CT and MR costs separately. For these hospitals, the estimated cost of a CT scan of the head/brain was $84 and an x-ray of the skull was $82 (using 2011 OPPS claims). The resulting reimbursement based on estimated costs for imaging services with different equipment costs and dissimilar diagnostic power would be incongruous to hospital investment in these technologies and the clinical value of their outputs. Clearly, the new cost centers for imaging produce estimated costs that lack face validity.

Physician Fee Schedule

Due to the impact of the Deficit Reduction Act (DRA), these cuts in OPPS reimbursement for CT and MR will automatically trigger further reimbursement cuts in the Physician Fee Schedule (PFS). The DRA limits PFS technical component payments to the level of the corresponding OPPS payment for the same service. As a result, we estimate that the use of separate cost centers would

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[2] Direct Research LLC analysis of Medicare claims data

reduce technical component payments under the PFS by 6 percent for CT and 3 percent for MR. Neither CMS nor RTI has analyzed the impact of this policy on the non-hospital setting, despite this important indirect impact on the PFS.

Conclusion

Due to the negative impact of the new imaging CCRs on IPPS, OPPS, and PFS, we encourage you to halt CMS' use of these two CCRs for determining payment for FY 2014 (IPPS) and CY 2014 (OPPS). The new imaging CCRs result in estimated costs that significantly undervalue advanced imaging services. Finally, the impact of the new imaging CCRs used in the OPPS spills over into PFS payments with negative consequences for imaging services in the non-hospital setting.

Sincerely,

Access to Medical Imaging Coalition (AMIC)
Advanced Medical Technology Association (AdvaMed)
AHRA: The Association for Medical Imaging Management
American College of Radiology (ACR)
American Society of Radiologic Technologists (ASRT)
Association of Community Cancer Centers (ACCC)
Cardiology Advocacy Alliance (CAA)
Medical Group Management Association (MGMA)
Medical Imaging & Technology Alliance (MITA)
Radiology Business Management Association (RBMA)