

June 25, 2018

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1694-P
P.O. Box 8011
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

Dear Administrator Verma:

The American College of Radiology (ACR), representing more than 36,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians, and medical physicists, appreciates the opportunity to provide comments on the Calendar Year (CY) 2019 hospital Inpatient Prospective Payment System (IPPS) Proposed Rule. The ACR provides comment on the following important issues:

- 1) National cost center cost-to-charge ratios (CCRs) for radiology, CT scan, and MR.
- 2) Promoting Interoperability Program Future Direction
- 3) Requirements for Hospitals to Make Public a List of Their Standard Charges Via the Internet

National cost center CCRs for radiology, CT scan, and MRI

In the CY 2013 Outpatient Prospective Payment System (OPPS) final rule, CMS adopted a policy to calculate the cost-to-charge ratios (CCRs) for the CT and MR cost centers that did not include those hospitals that used the “square foot” allocation methodology for reporting costs. CMS indicated that it was adopting this policy for four years in order to provide hospitals with time “to transition to a more accurate cost allocation method and for the related data to be available for rate setting purposes.”¹ CMS has not adopted the same policy for the IPPS as the OPSS and includes all hospital cost reports to determine MR and CT CCRs irrespective of the cost allocation methodology used by the hospital, including the “square foot” allocation methodology.²

In the CY 2018 final rule of the hospital outpatient prospective payment system (HOPPS) CMS decided to continue its transitional policy for another year to exclude providers that use the square foot cost allocation methodology to allocate costs for CTs, MRI and cardiac cath. Full implementation would not take place until CY 2019.

¹ Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, Final Rule, December 10, 2013, page 74847.

² Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care; Hospital Prospective Payment System and Fiscal Year 2014 Rates, Final Rule, August 19, 2013, page, 50523.

ACR has two requests related to this issue:

1. For the FY 2019 IPPS final rule, ACR requests that CMS set weights based on a single diagnostic radiology CCR—the same policy that CMS applied before it created separate CT and MR standard cost centers in 2011; and
2. In the CY 2019 OPSS rule, CMS not move forward with the policy it finalized in CY 2013 to use all hospital cost reports including those hospitals that allocate CT and MR costs using the square foot methodology and that it follow the same policy ACR is suggesting for the FY 2019 IPPS.

The ACR makes this request based on evidence that the CCRs for CT and MR are incorrect and are causing payments for hospitals patients in need of CT and MR services to be too low.

The College recognizes that CMS' policy for CT and MR CCR has been in place for several years and CMS did not include a specific proposal in the IPPS related to this issue. As such, CMS may view ACR's request as out-of-scope. However, ACR believes the FY 2019 IPPS rule, by not following the same policy as the OPSS, illustrates the problem that ACR would like to avoid exacerbating in the CY 2019 OPSS where the impact is more significant.

Rationale for Separate Hospital Reporting of CT and MR Cost Centers

CMS' policy on this issue was raised in the FY 2009 IPPS rule where it discussed “a contract [awarded] to RTI to study the effects of charge compression in calculating the relative weights and to consider methods to reduce the variation in the CCRs across services within cost centers.”³ Charge compression describes higher percentage mark-ups on low cost items than high cost items. Using a single CCR that groups low and high cost items will result in underpayment of the high cost item and overpayment of the low-cost item. While RTI's study was largely undertaken because of concerns about high cost medical devices being reported in the same cost center as low-cost supplies, RTI's analysis went beyond that narrow issue.

For MR and CT, the charge-compression hypothesis would set out to determine if higher cost diagnostic tests like MR and CT have lower percentage mark-ups than lower cost X-ray tests. While MRI and CT scans are more expensive than traditional X-rays, the results of creating separate cost centers for them has produced the opposite result than would be expected—higher mark-ups for the more expensive services than the less expensive services. As this result is the opposite of the hypothesis, the hypothesis is false. However, it does not mean that the opposite is true—that MR and CT have lower percentage mark-ups than other diagnostic X-ray tests. As the results are counter-intuitive, it makes more sense to conclude that how costs are reported to these costs centers is problematic than it does to conclude that CT and MR are overvalued with a single radiology CCR.

Indeed, public comments acknowledged by CMS on this issue suggest the data is problematic:

The commenters believed that the CCRs for advanced imaging may reflect a misallocation of capital costs on the cost report. They further stated that this could indicate that many hospitals are reporting CT and MRI machines as fixed equipment and allocate the related capital costs as part of the facility's Building and Fixtures overhead cost center instead of reporting the capital costs directly in the Radiology cost center.⁴

³ Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates, Final Rule, August 19, 2008, page 48451.

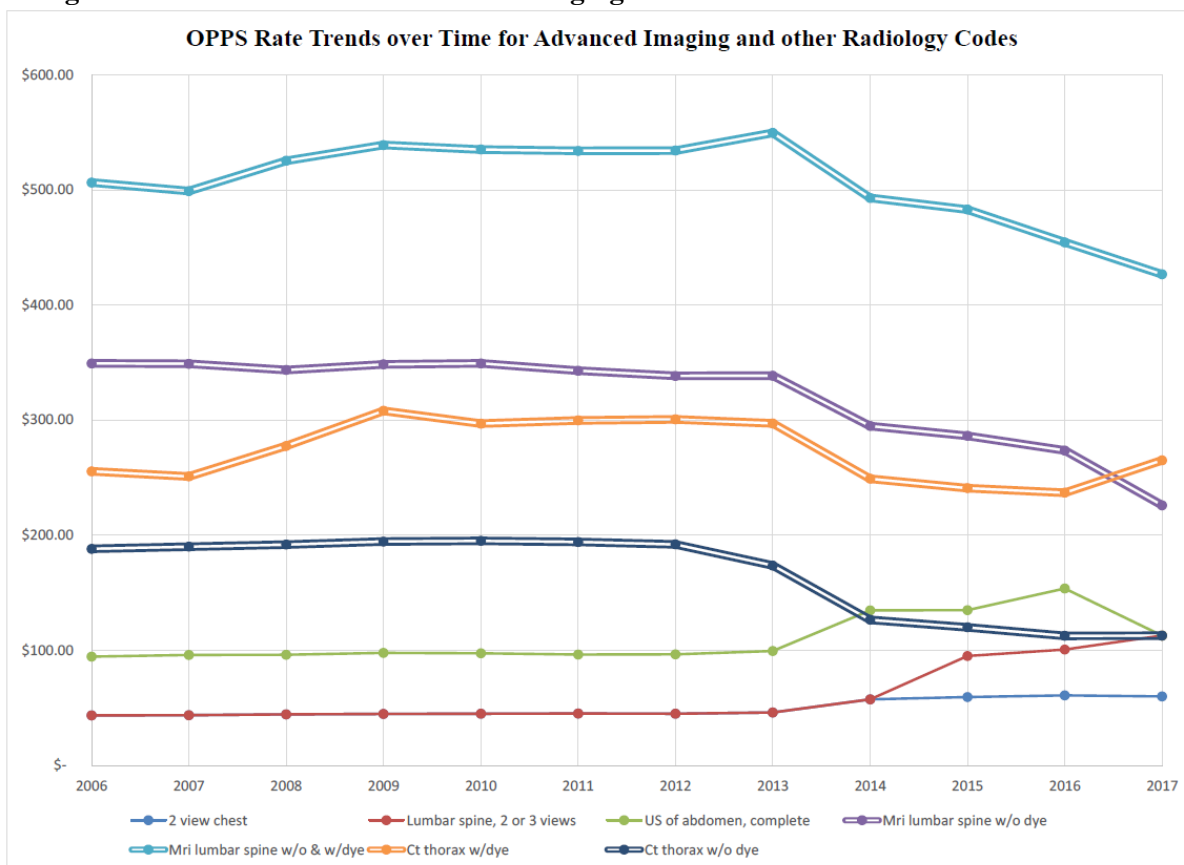
⁴ FY 2009 IPPS Final Rule, page 48456.

In responding to commenters’ statements that hospitals would have problems with accurate creation of these new standard cost centers, CMS acknowledged that the allocation of very high cost “moveable equipment” to the department using that equipment, may not be a standard practice in hospitals. CMS recognized that such practice would not produce accurate CCRs and, it is for this reason that CMS delayed use of some hospital CCRs to set OPPS rates until CY 2018, and now for CY 2019.

Policy Impact of Separating CT and MR Cost Centers

Figure 1 below illustrates the trajectory of selected single procedure OPPS rates for advanced and non-advanced imaging procedures. An OPPS example is being used because single IPPS rates cannot be identified as the IPPS payment groups include a much larger bundle of services. Nevertheless, the same point—that the CCRs for CT and MR cost centers are inaccurate and too low and are depressing the valuation of MS-DRGs that include CT and MR—remains applicable. The rate in CY 2017 under the OPPS for CT thorax w/o dye is now the same as that for an ultrasound of the abdomen complete and for an X-ray of the lumbar spine 2-3 views. These are all high-volume procedures, and advanced and non-advanced imaging are being paid at the same levels. Other high volume advanced imaging procedures have rates moving in the same direction. This pattern of payment does not fit the hypothesis of “aggregation bias” described by RTI based on 2007 data. On its face, it does not make sense to pay the same for a CT as an ultrasound or an x-ray when a CT scanner is far more expensive than the ultrasound or x-ray equipment.

Figure 1. Trends in Rates for Selected Imaging Procedures: Advanced and Non-Advanced



The Problem is Getting Worse, Not Better

In the chart below, we show the hospital level billing practices for selected CT and MR claims. These data show that only about half of all hospitals paid under the OPPS had CT and/or MR cost centers that were reporting CCRs using the preferred methods (“dollar value” or “direct assignment”). Hence current rates have declined based on using partial data. When all data are used for the CY 2019 (like is occurring now for the IPPS), it is unlikely that more hospitals will have changed their cost reporting to the method preferred by CMS.

These data show that hospitals have either been unable or unwilling to make the changes CMS regulations mandated.

HCPCS	Short Descriptor	Total Number of Hospitals	Number of Hospitals with MR or CT Cost Centers	Percent of Hospitals with MR or CT Cost Centers	Number of Hospitals with MR/CT Cost Centers Using Non-Square Footage Allocation Method	Percent of Hospitals with MR/CT Cost Center using Non-Square Foot Allocation Method	Geomean Cost of Total Hospitals	Geomean Cost of Hospitals with MR/CT Cost Centers Using Non-Square Footage Allocation Method	Percent Difference Between All Hospitals and Hospital Correctly Complying with CMS MR/CT Cost Center Billing
70553	Mri brain stem w/o & w/dye	2,926	2,020	69.0%	1,467	50.1%	\$ 360.51	\$ 335.76	-7.4%
71250	Ct thorax w/o dye	3,187	2,145	67.3%	1,541	48.4%	\$ 97.89	\$ 80.86	-21.1%
71260	Ct thorax w/dye	3,074	2,114	68.8%	1,519	49.4%	\$ 125.59	\$ 100.39	-25.1%
72148	Mri lumbar spine w/o dye	2,975	2,039	68.5%	1,472	49.5%	\$ 254.28	\$ 231.25	-10.0%

Notes

MRI Agents included in the analysis: A9575, A9576, A9577, A9578, A9579, A9581, A9583, A9585

CT Agents included in the analysis: Q9951, Q9953, Q9956, Q9957, Q9958, Q9961, Q9962, Q9963, Q9964, Q9965, Q9966, Q9967

Other allocation methods include dollar allocation and direct allocation.

The IPPS proposed rule shows the CCRs that will be in use under the OPPS if CMS uses all CCRs for the CT and MR cost centers irrespective of the cost allocation method that the hospital is using. CT Scans have a CCR of 0.037 and MRI is 0.076.⁵ A CCR of 0.037 suggests that hospitals are charging 27 times their costs for a CT exam. It is unreasonable to assume that this is correct. Further, ACR notes that this problem has become worse, not better since 2009. In the FY 2009 IPPS rule, CMS reported a CCR for CT of 0.054 which is higher than the CCR of 0.037 reported in the FY 2018 IPPS proposed rule.⁶

The change required to create standard cost centers for CT and MR is complex and hospitals are unable to respond. The CCRs for selected CT and MR procedures show a significant number of CCRs that are close to zero. These near zero CCRs indicate that even when hospitals create standard cost centers, they are likely unable to accurately re-allocate many costs that are already allocated across hospital departments to new CT and MR departmental cost centers. For these hospitals, the CCRs probably reflect allocations of staffing and dedicated departmental expenses, while the costs of equipment, some costs associated with space (e.g., lead in walls), other administrative costs have been spread across all hospital departments and have not been moved. The presence of these near zero CCRs will contribute to underestimated costs used in rate setting, pulling rates for CT and MR procedures down below their actual cost and further eroding payment accuracy. No other high cost technologies are treated in this manner. Hospitals have standard accounting practices for high cost moveable equipment and it is inconsistent and burdensome to expect hospitals to account CT and MR in a different manner than they deal with other types of equipment. As CMS moves away from granular procedure specific payment mechanisms across payment systems, it is inconsistent to focus on CT and MR treating them differently from all other technologies.

⁵ Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates, Proposed Rule, May 7, 2018, page 20275.

⁶ Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates, Final Rule, August 19, 2008, page 48456.

Do Not Continue with the Planned Policy

The ACR's concerns are farther reaching given the linkage of this policy in IPPS to the OPSS. The use of separate CT and MR CCRs created unintended consequences on the technical component of CT and MR codes in the Physician Fee Schedule (PFS). If this policy is finalized and fully implemented, the resulting reductions in hospital payments would also affect the office practice setting. This is because the OPSS technical payments would fall below the payment rates in the PFS causing further cuts as mandated by the Deficit Reduction Act of 2005 (DRA). The DRA mandates that the PFS technical payments be paid at the PFS rate or HOPSS rate, whichever is the lower. The ACR believes that these linked policies heighten the importance of ensuring that any changes made to the IPPS and thus the OPSS methodology are fully justified. The ACR is an advocate for payment stability in both the hospital and office settings where radiologists primarily work.

In February 2018, the ACR met with CMS officials and recommended the elimination of CT & MR standard cost centers from both IPPS and OPSS and return to diagnostic radiology for IPPS. ACR makes this request because of evidence that the CCRs for CT and MR are incorrect and are causing payments for hospitals patients in need of CT and MR services to be inappropriately low. ACR reiterates this request for the FY 2019 IPPS as well as the CY 2019 OPSS.

Promoting Interoperability Program Future Direction

The ACR supports CMS' goal of advancing health information exchange via the requirements for eligible hospitals in the Promoting Interoperability (PI) Program. To that end, we agree with CMS' suggestion that hospital participation in the Office of the National Coordinator for Health IT's (ONC) Trusted Exchange Framework and Common Agreement (TEFCA) could potentially be used in future years of the program for credit towards the PI score. This concept should be revisited in detail after TEFCA is launched and relatively established—perhaps as early as the 2020 IPPS rulemaking cycle.

More importantly, the ACR recommends that CMS leverage the PI Program to incentivize hospitals to facilitate appropriate health information exchange between their certified EHR technology (CEHRT) and the health IT systems used by external medical imaging providers. Referring clinicians who use hospital CEHRT should be empowered to order studies from imaging providers of their choice (including the hospital's competitors), and to seamlessly receive and incorporate the resultant radiology reports/data into the EHR.

We understand these activities are, in part, addressed by the interoperability requirements in the "EHR exception/safe harbor" from self-referral/anti-kickback rules, as well as the future "information blocking" prohibitions mandated by Sec. 4004 of the 21st Century Cures Act. However, given CMS' enhanced focus on interoperability, it would be appropriate for Office of the Inspector General-determined violations of either a) the EHR exception/safe harbor requirements; or, b) the Cures-mandated information blocking prohibitions to also result in a hospital's failure of the PI Program.

Requirements for Hospitals to Make Public a List of Their Standard Charges Via the Internet

The ACR applauds the overarching effort by the Centers for Medicare and Medicaid Services (CMS) to improve patient accessibility and usability of charge information hospitals are required to post on the Internet under Section 2718(e) of the Public Health Service Act. The College supports the new mandate to post this previously required hospital charge information in a machine-readable format, as well. Yet, the College questions any perceived connection between the need to increase hospital price transparency and alleviating so-called "surprise bills," or

patients receiving care from physicians, such as radiologists, who are out-of-network but located at in-network facilities. In short, ACR believes that:

- Issues surrounding surprise billing are not a Medicare problem but rather a concept involving private insurance and, as a result, is best regulated by state legislatures;
- It is improper to place exclusive or even majority blame on the providers as the payors must have accountability for the products they are selling (without proper disclosure) and the aggressive contracting they employ;
- The term “surprise gaps in insurance coverage” is a better summary of the issue; and
- Any discussion of “surprise bills” is largely inapplicable to Medicare and outside-the-scope-of the IPPS rulemaking process.

More specific comments regarding these topics can be found below:

ACR continues to favor steps to enhance transparency regarding the cost of health care, including advanced diagnostic imaging services, administered in the hospital and all other care settings. The ACR is supportive of provisions originally enacted via the CY 2015 IPPS Final Rule (79 FR 50146) requiring hospitals to make public either a list of charges (either the chargemaster itself or in another form of their choice) for provided items and services or their policies for allowing the public to view prices in response to a patient inquiry. The College also supports new provisions in the CY 2019 IPPS Proposed Rule mandating hospitals post the charges in a machine-readable format. ACR shares CMS’s view that patients are more inclined to choose the most efficient setting for care if they are more conscious of its underlying expense. Choice, however, must remain a two-way concept and patients, in consultation with their treating physician, should retain the ability to pursue the care they feel best suits their clinical and quality needs, even if it means selecting the more expensive setting.

Despite our support for greater price transparency, the College is perplexed why CMS included provisions in the 2019 IPPS Proposed Rule stating their concern that insufficient access to hospital cost information is contributing to patients being surprised by out-of-network bills for physicians, such as radiologists, at in-network hospitals. **First and foremost, ACR questions any true connection between the issue of surprise bills and Medicare.** Surprise bills typically arise when an individual receives planned care from an in-network provider but other providers brought in to participate in the patient’s care do not participate in the same network. The ramifications for patients seeing out-of-network physicians at an in-network facility are typically higher cost-sharing (e.g. copayments, coinsurance, and deductibles) and balance bills, or treating providers billing individuals directly for the remaining cost of the service rendered above the negotiated rate assessed by the insurance company to in-network providers.

The College, however, views surprise bills as an issue largely stemming from the actions of private insurers and not government payors. In fact, Medicare classifies practitioners into three categories: participating, nonparticipating, or opt out/private contracting providers. According to briefs published on the web sites of the AARP and Kaiser Family Foundation, as many as 95 percent of Medicare physicians are participating providers⁷⁸. This classification means they agree to accept Medicare’s approved payment as payment in-full (e.g. “accept assignment”) for the Medicare covered services they provide for *all* Medicare patients they see. In addition, they must also collect payment from services rendered directly from Medicare, rather than the patient. As a result,

⁷ AARP (2017) Fact Sheet: Medicare’s Financial Protections for Consumers: Limits on Balance Billing and Private Contracting by Physicians. Retrieved from <https://www.aarp.org/content/dam/aarp/ppi/2017-01/medicare-limits-on-balance-billing-and-private-contracting-ppi.pdf>

⁸ Kaiser Family Foundation (2016) Paying a Visit to the Doctor: Current Financial Protections for Medicare Patients When Receiving Physician Services. Retrieved from <https://www.kff.org/medicare/issue-brief/paying-a-visit-to-the-doctor-current-financial-protections-for-medicare-patients-when-receiving-physician-services/>

Medicare patients who see a “participating provider” are guaranteed to not be charged more than the published fee-schedule amount, nor will they face higher out-of-pocket cost-sharing above the standard 20 percent coinsurance for the service received. It’s important to note that the coinsurance is assessed based off the Medicare discounted rate, as well.

Only a small percentage of providers, approximately 4 percent, are classified as nonparticipating Medicare physicians⁹. Nonparticipating physicians only receive 95 percent of the Medicare payment reimbursed to participating providers. In addition, nonparticipating physicians can only balance bill patients based off of payment rates that are no more than 115 percent above Medicare’s established fee-for-service rates. While patients seen by nonparticipating providers are still assessed a 20 percent coinsurance, it is calculated based off of 95 percent of Medicare’s established fee-for-service amount for a participating physician. The stipulations placed on the amount nonparticipating providers can charge Medicare patients have successfully limited out-of-pocket expenses. In fact, total out-of-pocket liability from balance billing declined from \$2.5 billion in 1983 to \$40 million in 2011¹⁰. An even smaller percentage of providers, approximately less than 1 percent, are classified as opt-out or private contracting providers¹¹. In 2016, of this 1 percent, 42 percent of opt out physicians were psychiatrists¹². In fact, 2013 data indicates in the specialties of radiology/nuclear medicine, only 19 out of a possible 24,887 radiologists, were opt-out/private contracting providers within Medicare¹³. In other words, radiology and nuclear medicine only comprised 0.1% of the total opt-out/private contracting population in 2013. This category of provider is not bound by Medicare’s physician fee schedule in any way and is free to balance bill for the entire cost of the service. However, beneficiaries that choose to use these physicians are required to sign a contract before receiving any services that makes them aware that these physicians do not take Medicare and are not limited in how much they can be billed. Patients, therefore, are not being surprised by charges from these physicians as they contracted with them knowing that they would be free to charge amounts that are not limited by Medicare.

Since the vast majority of providers are classified as participating and non-participating physicians are subject to a ceiling for their charges, there is no concern about surprise billing from any physician, including radiologists, in fee-for-service Medicare. Plus, the strict limitations on balance billing placed on nonparticipating Medicare providers, as well as requirements for a private contract that makes beneficiaries aware that there are no limitations on how much they may be charged when using opt-out/private contracting physicians, further lessens the concerns pertaining to this issue.

Finally, the College views the term “surprise bills” as overly biased against physicians and mischaracterizes the role of the insurer. Private payors are quick to shift the blame for excessive out-of-network bills to physicians when, in reality, “surprise bills” are “surprise coverage gaps” typically associated with cheap insurance plans and inadequate provider networks. As a result, it’s more accurate to associate “surprise bills” with insurers preying upon consumers’ desire for low-cost insurance, as well as private payors failing to disclose potentially costly flaws in their plans.

⁹ Kaiser Family Foundations (2016) Surprise Medical Bills. Retrieved from <https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/>

¹⁰ Kaiser Family Foundations (2016) Surprise Medical Bills. Retrieved from <https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/>

¹¹ Kaiser Family Foundation (2016) Paying a Visit to the Doctor: Current Financial Protections for Medicare Patients When Receiving Physician Services.

¹² Kaiser Family Foundation (2016) Paying a Visit to the Doctor: Current Financial Protections for Medicare Patients When Receiving Physician Services.

¹³ Kaiser Family Foundation (2016) Paying a Visit to the Doctor: Current Financial Protections for Medicare Patients When Receiving Physician Services.

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In summary, ACR questions the exposure of patients to surprise out-of-network bills within Medicare. Issues pertaining to out-of-network bills are the result of private payors and, as a result, any policy proposals are best dealt with at the state level. Furthermore, the College believes this policy concept is outside-of-the-scope of the IPPS proposed rule and we question the validity of trying to address any perceived problems in this manner.

We appreciate the opportunity to submit comments. Should you have any questions, please do not hesitate to contact Pam Kassing, Senior Economic Advisor, American College of Radiology, either via phone (703-648-8900 x4544) or email (pkassing@acr.org).

Sincerely,

A handwritten signature in black ink, appearing to read "William T. Thorwarth Jr. MD", with a stylized flourish at the end.

William T. Thorwarth Jr., MD, FACR
Chief Executive Officer
American College of Radiology