June 23, 2021

Mr. Lane Burgette
RAND Corporation
1200 South Hayes Street
Arlington, Virginia 22202-5050

Re: ACR, ASNR, and SNMMI Feedback to June 16th CMS Practice Expense Town Hall Meeting - *Improving Data and Methods Related to the Indirect Practice Expense in the Medicare Physician Payment Schedule*

Dear Mr. Burgette:

The American College of Radiology (ACR), the American Society of Neuroradiology (ASNR), and the Society of Nuclear Medicine and Molecular Imaging (SNMMI) appreciate the opportunity to comment and assist the current effort to update indirect practice expense (PE). We agree that improving methodology and updating data is needed. Our aim is to both provide clarifying information for radiology and share our overall experience from prior updates.

Topic I: A System of Ongoing Data Collection

We believe the most important component of producing accurate results relevant to the Medicare Physician Fee Schedule is gathering data that is diverse and representative. One of the major shortcomings of the Physician Practice Information Survey (PPIS) was that it was not as representative of radiology and nuclear medicine and under-represented office-based practices. For instance, the majority of the data, 67 percent, was contributed by individual radiologists who practice solely in the hospital and academic settings with no direct and modest indirect practice costs as compared to an office-based practice. This led to too many practices in the PPIS failing to cover all of the expense categories that are used to set the PE/HR rates. 60 percent of radiology practices in PPIS reported zero in at least one or more of the three direct expense categories. This caused a dramatic undercalculation of PE/HR for radiology despite attempts to correct this at both the vendor and Centers for Medicare and Medicaid Services (CMS) level. Instead, recommendations from the ACR and associated organizations were not accepted, and a substantial amount of objectively inaccurate data was used to lower indirect reimbursement. Regardless of the mechanism chosen to update indirect expenses, there needs to be an understanding that poor quality data will be excluded, preferably with pre-approved statistical guard-rails, and that stakeholder input will be valued and considered if irregularities arise.

A second consideration to gathering sufficient data is the survey contact point. The PPIS was a physician-level rather than practice-level survey. The survey requested complex information from individual physicians and a very high percentage of them found the requested information too complex to develop responses and declined to participate in the survey. This resulted in several anomalies, including radiology PPIS data needing to be cross walked to nuclear medicine physicians. Like many specialties, radiology has seen consolidation of small group-practices into large corporate, academic, and privately held groups. The

day-to-day cost management has shifted further from the individual radiologist to the radiology business managers. This shift may improve the accuracy of data as organizations have the scale to develop more sophisticated cost accounting, assuming the correct stakeholders are surveyed. In addition, all practice patterns must be represented, including small and rural practices, larger private practices and academic practices. The survey contact point may be different for each of these practice types. As such, we believe it is important to work with specialty societies to ensure that surveys are flexible and broadly distributed across different practice types. Simply directing a vendor to send surveys to a list of physicians without context or support from medical societies would lead to inadequate response rates and inaccurate data. Specialty-led surveys with a vendor or CMS as a partner would greatly improve the veracity of data collection.

Topic II: Collecting PE Data by Specialty

We support the idea of pooling similar specialties based on commonly billed procedures to improve the quality of survey analysis. However, radiology and nuclear medicine have little overlap with other specialties. It is not uncommon for high-volume radiology CPT codes to be performed solely by radiologists or interventional radiologists 90 percent or more of the time. For this reason, pooling data outside of radiology or nuclear medicine will decrease accuracy.

Similarly, we do not believe the quality of data or analysis would be improved by splitting radiology services into modality or service-line procedures (e.g. advanced imaging, standard imaging, ultrasound, etc.). This would require practices to assign shared administrative and other indirect expenses among service-lines without a clear way of proportioning cost. We believe this would result in error, confuse practices and lower survey participation.

Topic III: Improving Indirect PE Allocation

We are interested in the idea of moving some indirect practice expense line-items to direct practice expense which accurately reflect the true overall cost structure. We agree with the observation that there is a large range in the PE/HR across specialties for items such as "clerical payroll" without a clear explanation. However, direct inputs would need to be flexible enough to capture appropriate variances in the same way that an aggregate cost would. For example, radiology and other surgical specialties are required to perform complex preauthorization and coding for a large range of procedures that require more resources on an administrative level than specialties who perform only a handful of procedures. Providing some mechanism to allow for variance should be considered. Similarly, if real estate costs were done formulaically, there should be a mechanism that allows capture of cost above and beyond the typical office setting. For example, radiology incurs larger than typical real estate costs due to building safety and equipment requirements such as specialized radiation shielding in rooms and MR-compatible room fixtures. In addition, due to the extreme cost of relocating radiology equipment, practices may have little leverage with rental agreements and subsequently pay higher than average rent.

The ACR, SNMMI and ASNR acknowledge the challenges in allocating PE for new services like Artificial Intelligence (AI) tools which may have overlapping features of direct and indirect inputs. At this time, the market for these types of products is extremely diverse, with multiple variations in product structure and use cases. It would be difficult at this point to make a universal paradigm for how PE for future AI codes should be treated, but we would appreciate the opportunity to collaborate with CMS as the field progresses.

In summary, the ACR, SNMMI and ASNR strongly believe that stakeholder input and participation is necessary in the effort to collect representative data that will capture the different practice patterns within radiology and nuclear medicine, as well as acknowledge the circumstances that set radiology and nuclear medicine apart from other specialties, such as higher administrative and real estate costs.

We thank RAND for their interest and willingness to receive comments. We would like to emphasize that any single one of these proposals could result in a large erroneous shift in reimbursement if survey data and analysis is not done methodically, patiently, and in close collaboration with medical societies. The ACR, SNMMI and ASNR look forward to continued dialogues with RAND on this issue affecting radiology. If you have any questions or comments on this letter, please contact Stephanie Le at sle@acr.org or (703) 648-8900 ext. 4584.

Sincerely,

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