SOCIETY FOR VASCULAR ULTRASOUND

June 17, 2011

Donald M. Berwick, M.D., Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

By Electronic Submission

RE: CMS-1518-P; Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment System and CY 2012 Payment Rates

Dear Administrator Berwick:

The Society for Vascular Ultrasound ("SVU") thanks the Centers for Medicare and Medicaid Services ("CMS") for this opportunity to comment on the Proposed Changes to the Hospital Inpatient Prospective Payment System ("HIPPS") and CY 2012 Payment Rates (the "Proposed Rule").[1] SVU is a professional society comprised of over 4,500 vascular technologists, sonographers, nurses, and physicians who provide a variety of high-quality vascular ultrasound services to Medicare beneficiaries.

Hospital inpatient facilities often utilize ultrasound testing prior to surgical and other interventions, not only saving Medicare dollars, but also reducing the risks involved with other more expensive or invasive modalities, which may present more significant morbidity and mortality risks. Our experience is that the past cost reporting procedures resulted in dramatically undervaluing ultrasound services and dramatically overvaluing other services. Given the fact that the Deficit Reduction Act of 2005[2] effectively ties physician fee schedule reimbursement to hospital outpatient department ("HOPD") reimbursement, this problem has a broadly distortive impact, which biases the clinical pathway to more expensive procedures to the detriment of the Medicare program and its beneficiaries.

Accordingly, SVU continues to support CMS' decision to create standard cost centers for computed tomography ("CT"), magnetic resonance imaging ("MRI"), and cardiac catherizations, as well as requiring hospitals to report the costs and charges for

[1] 76 Fed. Reg. 25788 (May 5, 2011).
[2] Pub. L. No. 109-171 (Feb. 8, 2006).

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such services on the revised Medicare cost report. SVU believes that this is the first step in addressing the inaccuracies that were identified by CMS' independent expert RTI International ("RTI") in a July 2008 report[3] with respect to diagnostic radiology cost reporting and the cost-to-charge ratios ("CCRs") applied to ultrasound and other diagnostic radiology services.

As we stated in our comments to the 2009 and 2010 Hospital Outpatient Prospective Payment System ("HOPPS") proposed rules, as well as our comments to the 2011 HIPPS proposed rule, we believe the CT and MRI standard cost centers will help address the "aggregation bias" problem. As stated in RTI's July 2008 report, aggregation bias results in Medicare overpaying for procedures with high markups (i.e., CT and MRI) and Medicare underpaying for procedures with lower markups (i.e., ultrasound). Consequently, ultrasound services are currently not adequately reimbursed by Medicare. This conclusion is evidenced by the current struggle that SVU's members and the beneficiaries whom they serve face. Unfortunately, it is increasingly difficult to find access to quality ultrasound services.

While SVU commends CMS for beginning to address this very important issue by requiring hospitals to report information via the CT and MRI cost centers, SVU is concerned about CMS' proposal to reassess the availability of MRI and CT cost center data only in the 2013 HIPPS rulemaking cycle. Specifically, SVU is concerned that that delay in analyzing the MRI and CT cost data will further delay the necessary adjustments to the calculation of the MRI and CT relative weights, which inevitably forces Medicare to continue to overpay for MRI and CT services, while underpaying for ultrasound services. We believe more expedited treatment would be more consistent with the Congressional mandate that CMS engage in value-based purchasing. As a result, SVU strongly urges CMS to analyze and apply the MRI and CT cost center data as soon as it possibly can. This will, in turn, ensure that other diagnostic procedures are adequately and more accurately reimbursed by Medicare through fair reimbursement for all imaging services.

[3] RTI International, Refining Cost to Charge Ratios for Calculating APC and MS-DRG Relative Payment Weights (July 2008), *available at* http://www.rti.org/reports/cms/ (last visited June 3, 2011).

We thank you for your consideration of these comments to the Proposed Rule. We look forward to continuing to work with CMS to improve the health of Medicare beneficiaries.

Respectfully submitted,

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