

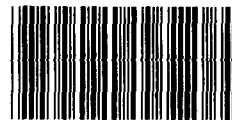
GAO

Report to the Chairman, Subcommittee  
on Health, Committee on Ways and  
Means, House of Representatives

May 1992

MEDICARE

Excessive Payments  
Support the  
Proliferation of Costly  
Technology



146973



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RELEASES

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United States  
General Accounting Office  
Washington, D.C. 20548

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Human Resources Division

B-247483

May 27, 1992

The Honorable Fortney H. (Pete) Stark  
Chairman, Subcommittee on Health  
Committee on Ways and Means  
House of Representatives

Dear Mr. Chairman:

This report responds to your request that we compare Medicare payment levels with providers' costs for high-technology radiology services to determine if payments have been adjusted to reflect declines in costs. Services such as Magnetic Resonance Imaging (MRI) and Computed Tomography (CT)<sup>1</sup> require large capital investments, making costs per scan sensitive to machine utilization. Greater utilization and lower costs per scan are being achieved because the machines now operate faster and are being used for more types of diagnostic procedures than before.

Our objective was to determine whether Medicare's technical component payments<sup>2</sup> reflect the lower costs per scan associated with technological improvements and greater machine utilization. Without periodic adjustments to payment levels as technologies evolve, Medicare payments can remain unnecessarily high. Moreover, MRI and CT are part of a \$19 billion diagnostic imaging services market in which Medicare payment policies have a strong influence on the pricing and spread of new technology. Unnecessarily high Medicare payments can support needless proliferation of these expensive machines.

As agreed with your staff, we focused our review on Medicare's technical component payments for MRI. We selected MRI because it is Medicare's most expensive diagnostic radiology service and because MRI services have grown rapidly since Medicare approved them for coverage in 1985. However, because the problems we found relate to Medicare's policies for technical component payments rather than the specific services, we believe that our conclusions and recommendations are also applicable to such payments for other high-technology radiology services, like CT scans. Our scope and methodology are described in appendix I.

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<sup>1</sup>MRI scans and CT scans (also called CAT scans) produce images of internal structures, such as the brain and spine.

<sup>2</sup>Technical component payments are for the radiology facility, equipment, technicians, and supplies that produce the images. In contrast, professional component payments are for the radiologists and other physicians that interpret the images.

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## Results in Brief

In some localities, Medicare's technical component payments for MRI do not reflect the lower costs per scan now being achieved through faster scanning and greater machine utilization. This is because current payment levels are based, in part, on the charges allowed by local Medicare contractors in the mid-1980s. The 1991 payment levels in some localities were more than twice as high as in others, reflecting wide geographic disparities in the historical allowed charges.

In localities with higher payment levels, such as in Florida, Medicare supports a proliferation of MRI machines by allowing even low-volume, high-cost providers to realize profits on Medicare scans. In localities with lower payment levels, such as in Michigan, MRI providers are also able to realize profits because there are fewer machines, machine utilization is high, and costs per scan are low.

In the past several years, the Congress mandated changes that had the effect of narrowing geographic variations in the Medicare rates and bringing the MRI payments more in line with costs. But the payments in some localities are still too high and continue to be based in part on historical allowed charges instead of costs. Medicare should base its payments on the costs incurred by high-volume, efficient facilities to reduce Medicare program expenditures and to discourage providers from adding expensive, excess capacity to the health care system.

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## Background

Medicare, a federal health insurance program for the elderly and disabled, is administered by the Health Care Financing Administration (HCFA), an agency within the Department of Health and Human Services (HHS). Medicare provides two basic forms of coverage—Part A provides hospital insurance, and Part B provides supplemental medical insurance. Part B payment includes a technical component allowance<sup>3</sup> for radiology services provided in ambulatory settings, such as hospital outpatient departments, freestanding facilities, and physicians' offices.<sup>4</sup> Medicare Part B payments are made by about 35 carriers<sup>5</sup> that process and pay claims under contract

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<sup>3</sup>Medicare pays 80 percent of the technical component allowance, and the patient is responsible for the remainder. In this report, the total payment allowed under Medicare is referred to as the Medicare payment or payment level.

<sup>4</sup>Hospitals do not receive technical component allowances for inpatients. Instead, Medicare Part A pays hospitals a flat fee covering all services the patient receives. When a hospital provides radiology services to outpatients, Medicare pays the lesser of that hospital's cost or customary charges, or a blend of the hospital's cost and the technical component allowance. Freestanding diagnostic imaging centers receive payments based on the full technical component allowance.

<sup>5</sup>Private insurance companies or Blue Shield plans.

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with HCFA. When MRI became eligible for Medicare reimbursement in 1985, carriers also set the technical component payment levels for their geographic areas.

MRI is one of the more advanced and expensive technologies used in diagnostic radiology. Like the X-ray, MRI scans produce "pictures" of the internal anatomy. However, MRI uses a magnetic field rather than an X-ray beam; thus, the patient is not exposed to potentially harmful X-ray radiation. MRI is particularly good at imaging tissues, rather than bone, and computer processing allows scans to show "slices" and three-dimensional images. As MRI technology has evolved, the time needed to scan a patient has been reduced, allowing more patients to be scanned on each machine and enabling new applications, such as magnetic resonance angiography, which produces images of blood vessels. Further reductions in scan times are anticipated through upgrades to current machines.

The primary characteristic of an MRI machine is its magnet strength, which is measured in tesla units. Machines with high magnet strengths (1.5 tesla or higher) are the fastest and the most expensive—costing as much as \$2.2 million. Mid-range (0.5 to 1.0 tesla) and low-end (under 0.5 tesla) MRI units cost from about \$1.8 million to \$300,000. Some MRI machines can be installed in mobile trailers as well as fixed facilities.

Even though MRI is an expensive technology, the number of machines in the United States grew quickly from about 200 in 1985 to an estimated 2,000 in 1991. Outside of hospitals, MRI growth was largely unconstrained by state regulation, which is one reason that more than half of all MRI machines are in freestanding diagnostic imaging centers or physicians' offices.

In the absence of more stringent state controls, a primary factor in the decision to open an MRI facility was the per-scan payment levels set by health insurance programs. As the nation's largest health care insurer, the federal government has a strong influence on MRI growth through its Medicare payment policies. Medicare Part B payments for MRI scans totaled almost \$237 million in 1990—a 21-percent increase from the previous year, and a \$200 million increase since 1986.<sup>6</sup>

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<sup>6</sup>These amounts are allowed charges for MRI technical and professional component services, as reported in HCFA's Part B Medicare Annual Data files. The amounts do not include technical component payments for MRI scans in hospital outpatient settings because those payments are made by the Medicare Part A contractors and are not included in the data base. Based on Part B Annual Data file information and the 1990 radiology fee schedule, we estimate that 65 percent of the amounts shown above were MRI technical component payments.

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## Medicare's Technical Component Payments Based in Part on Historical Charges, Not Current Costs

Medicare's technical component payments for MRI services are not based on current costs. Instead, they have evolved (1) from initial payment levels set in the mid-1980s by the Medicare carriers, (2) to charge-based payments, and (3) to fee schedule systems mandated by the Congress. The Medicare payments changed to a resource-based relative value fee schedule<sup>7</sup> in 1992, but radiology technical component payments are still based, in part, on the initial payment levels and historical charges, not current costs. Although the technology improved and providers' per-scan costs declined, HCFA did not adjust MRI payments to reflect the declining costs.

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## Initial Payment Rates and Charge-Based System

After MRI services were approved for Medicare coverage in November 1985, HCFA published broad guidance to help carriers set the initial payment rates. This guidance, based in part on a February 1985 study of MRI by the Blue Cross and Blue Shield Association, showed carriers how they could use information on MRI costs and utilization to assess the reasonableness of charge-based payment levels or to set a cost-based payment level if they had insufficient charge data. HCFA included an example of how to compute a reasonable payment level, showing a technical component payment of \$570 per scan, based on the cost to operate a mid-level MRI machine for a single shift and perform 8 scans per day, or 2,000 per year.

The Blue Cross and Blue Shield Association study showed that per-scan MRI costs were particularly sensitive to machine utilization—for example, that increasing scans from 6 to 12 per day nearly halves unit costs. Yet HCFA did not determine what machine utilization levels carriers should use in setting payment rates. HCFA's guidance allowed carriers to base payments on their judgment of what minimum utilization should be, even if actual utilization was lower.

Lacking a single, national policy for setting Medicare payments for this expensive, new technology, the carriers established a wide range of rates. Based on a HCFA survey, fee schedule allowances, and HCFA data bases, we estimate that the technical component payments ranged from \$300 to \$700 per scan under this payment system, depending on the locality of the provider and the charges allowed in that locality by the carrier.

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<sup>7</sup>Under this system, payments are based on the value of a service, relative to other services, as determined by estimates of physician time and effort, practice expense, and the costs of professional liability insurance.

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The 1985 study by the Blue Cross and Blue Shield Association cautioned that MRI payment levels would have to be adjusted frequently to reflect technological advances, reduced equipment costs, and faster scans, all of which could be expected to reduce costs and justify future reductions in reimbursement rates. But, between 1985 and April 1989, HCFA did not update its guidance to the carriers and did not attempt to adjust the payment levels they set.

We believe stronger initial guidance and frequent follow-up was warranted in view of the high capital cost of MRI equipment, the sensitivity of per-scan costs to machine utilization, and the expectation of declining per-scan costs, as forecast in the 1985 MRI study. HCFA should have urged the carriers to base initial payment levels on greater machine utilization, conducted periodic MRI utilization and cost surveys, issued updated guidance as the technology evolved, and challenged carrier payment levels that did not reflect the declining per-scan costs.

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## MRI Payments Under the Medicare Fee Schedules

In the past several years, the Congress has mandated changes to Medicare payment policies. As shown in table 1, these changes reduced technical component payments and the geographic variation in payment levels. In 1989, radiology payments were converted to a fee schedule system and cut by 3 percent overall. Additional cuts were made for 1990 and 1991.<sup>8</sup> The 1992 changes in payment levels occurred when the radiology fee schedule became part of a broader, resource-based relative value fee schedule covering other Part B services.<sup>9</sup>

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<sup>8</sup>The 1990 reductions were included in the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), Public Law 101-239, December 19, 1989. The 1991 reductions were included in OBRA 1990, Public Law 101-508, November 5, 1990.

<sup>9</sup>The broader fee schedule was mandated by OBRA 1989 and amended by OBRA 1990.

**Table 1: MRI Technical Component Payment Rates (1985-92)**

	Lowest locality	Highest locality	Geographic variation
1985-88 <sup>a</sup>	\$300	\$700	\$400
1989	293	679	386
1990	281	652	371
1991	253	531	278
1992	276 <sup>b</sup>	485	209

Note: The payments shown are for basic MRI scans; higher payments are allowed for special scans.

<sup>a</sup>Estimated.

<sup>b</sup>In 1992, the lowest payment level increased as a new fee schedule system began to phase in a national payment formula.

These changes reduced the geographic variation in MRI technical component payments, and there will be further reductions in the range of payments as the new fee schedule system is phased in over the next few years. However, these changes did not address an underlying problem—the technical component payments are still based on historical charges, not costs. Also, the 1992 fee schedule maintains MRI payments as high as \$485 in some localities, an amount that exceeds the costs incurred by high-volume providers, as discussed below.

HCFA plans to adjust the new fee schedule so the technical component allowances are based on actual costs rather than historical charges. However, HCFA has not completed the data gathering and analysis needed to make those adjustments. Since 1985, HCFA has not determined the actual costs to produce an MRI scan as a basis for setting technical component payments.

## MRI Per-Scan Costs Declined While Some Technical Component Payments Remained High

In 1990, MRI facilities generally had higher patient volumes and lower per-scan costs than in 1985. Upgrades to MRI machines have made them faster, and providers are doing more scans, at lower costs per scan, especially in states with limited MRI proliferation, such as Michigan and Massachusetts.

Some MRI machines are performing two to four times the 2,000 scans per year cited in HCFA's 1985 guidance to carriers. At 10 of the 14 MRI facilities we visited, machine utilization averaged over 4,000 scans in 1990, and one



machine performed over 8,200 scans.<sup>10</sup> MRI utilization overall in Michigan averaged over 4,900 scans per machine,<sup>11</sup> and in Massachusetts, most machines were doing over 3,500 scans per year, and some reported over 5,000 scans.

Where machine utilization is high, per-scan costs are relatively low, with some variation based on the magnet strength of the machine (low-end, mid-range, and high-end), as shown in table 2.

**Table 2: Per-Scan Costs for 17 MRI Machines (1990)**

<b>MRI facilities</b>	<b>Fewer than 4,000 scans</b>	<b>4,000 scans or more</b>
<b>Low-end machines</b>		
Number of machines	3	1
Average cost per scan	\$391	\$262
<b>Mid-range machines</b>		
Number of machines	1 <sup>a</sup>	4
Average cost per scan	\$361	\$367
<b>High-end machines</b>		
Number of machines	2 <sup>b</sup>	6
Average cost per scan	\$483	\$399

<sup>a</sup>This machine was acquired in 1984 and had been fully depreciated by 1990; therefore, per-scan costs were relatively low, even though utilization was under 4,000 scans.

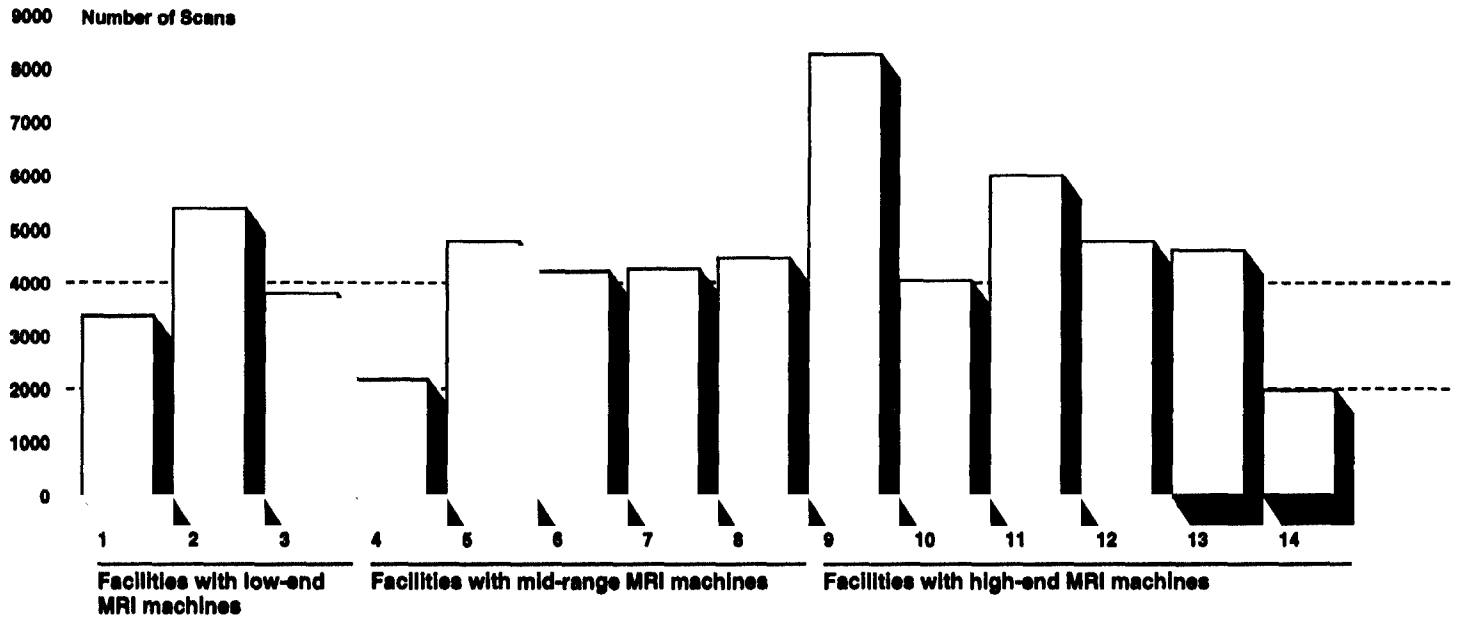
<sup>b</sup>This includes one mid-range and one high-end machine, both installed at the same facility, with each used for fewer than 4,000 scans. We could not separate costs between the two machines; therefore, the cost shown is the combined average for both machines.

Nearly all of these facilities, even those with low volumes, were able to realize profits on Medicare-reimbursed scans in 1990, as shown in figures 1 and 2. The 1990 Medicare technical component payments covered from 96 to 170 percent of the per-scan costs at the 14 facilities. Legislation reduced the MRI technical component payments in 1990 and 1991, as discussed on page 5, but lower initial rates or earlier reductions might have helped limit MRI proliferation as well as reduce Medicare program costs.

<sup>10</sup>Of the 14 facilities, 3 were each operating two MRI machines and 11 were each operating one machine.

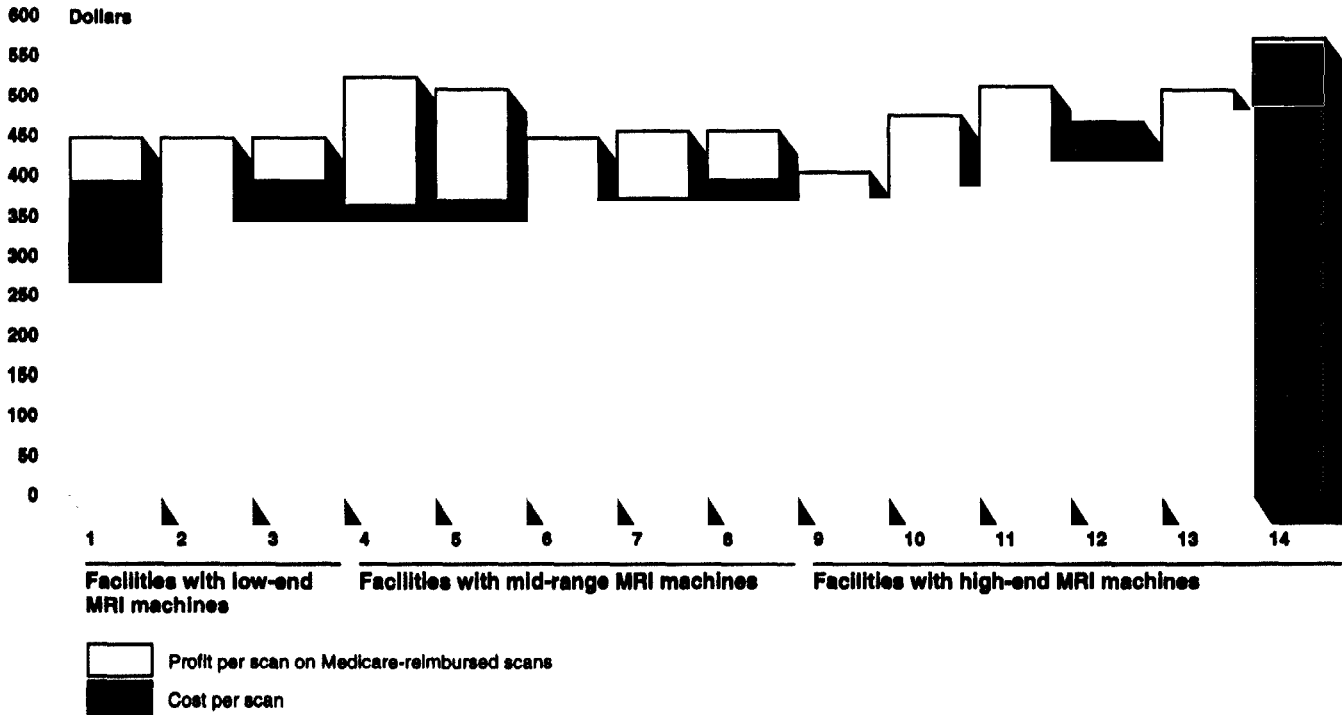
<sup>11</sup>This average is for the period from July 1, 1989, to June 30, 1990, and includes MRI facilities that had been in operation since at least July 1, 1988.

**Figure 1: Machine Utilization at MRI Facilities Visited by GAO (1990)**



Note: Facility 14 includes one high-end and one mid-range machine.

**Figure 2: Per-Scan Costs and Profits at MRI Facilities Visited by GAO (1990)**



Note: Facility 14 includes one high-end and one mid-range machine. At facility 12, which had a recently installed high-end machine, the Medicare allowance covered 96 percent of the per-scan costs.

## High Medicare Payments Support Excess Capacity

Some geographic areas of the United States have a large number of MRI providers and excess machine capacity.<sup>12</sup> High Medicare payment rates in those areas help pay for the excess capacity by allowing providers to realize profits at low operational volumes.

In Florida, for example, there are so many MRI machines that utilization averages only about 2,700 scans per machine. This low machine utilization makes per-scan costs relatively high, but Medicare's high technical component payments in Florida, up to \$569 per scan in 1990, fully covered costs at the Florida facilities we visited. In contrast, in Michigan, which

<sup>12</sup>Overall, the United States has about eight times as many MRI machines per capita as Canada, as noted in our recent report Canadian Health Insurance: Lessons for the United States (GAO/HRD-91-90, June 4, 1991).

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has about 48 percent fewer MRI machines per capita than Florida, utilization per machine is about 82 percent higher, and providers we visited are still able to realize profits at Medicare technical component rates that are up to 20 percent lower.

Because the Medicare technical component payments in areas such as Florida are linked to high historical charges, the payment system gives new providers an incentive to enter the market even when their anticipated patient volumes are low relative to machine capacity. If, instead, Medicare payments were based on the costs incurred by providers operating at high machine utilization levels, new providers would have less of an incentive to enter the market in a geographic area that already has sufficient machine capacity.

Low cost and high quality are associated with high-volume providers for other types of radiology services,<sup>13</sup> and we believe those relationships also hold true for high-technology services such as MRI, which require large capital investments and a highly skilled technical staff. Therefore, we believe Medicare payment levels should reflect the costs incurred by high-volume providers, except where adjustments are needed to provide access to care in rural areas.

HCFA agrees that the technical component payments for radiology services should reflect the actual costs incurred by efficient providers. However, HCFA has not developed the procedures to survey provider costs and adjust the rates to reflect the unit costs incurred by high-volume providers.

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## Conclusions

Medicare's technical component payments for radiology services generally are not based on providers' costs and do not promote efficient use of expensive new technology. Under this charge-based payment system, technical component payments were based on local determinations by carriers and the charges submitted by providers. HCFA did not establish payment rates that reflected providers' costs at high machine utilization rates.

Medicare maintained high technical component payment levels while MRI technology evolved and unit costs declined. Even with legislatively imposed payment reductions in recent years, MRI payments in some

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<sup>13</sup>This relationship was discussed in our report, *Screening Mammography: Low-Cost Services Do Not Compromise Quality* (GAO/HRD-90-32, Jan. 10, 1990).

localities are still too high relative to the costs incurred by high-volume providers.

High Medicare payment rates support needless MRI proliferation in some areas by reimbursing providers for excess capacity. We believe payment levels should be primarily based on the costs incurred by high-volume, efficient providers and should be updated periodically to reflect the economies achieved as technologies continue to evolve.

## Recommendations

We recommend that the Secretary of HHS require the Administrator of HCFA to

- survey the technical component costs incurred by facilities providing radiology services and revise the fee schedule to more accurately reflect the unit costs incurred by high-volume, efficient providers and
- periodically adjust technical component payments to reflect changing costs, with annual payment reviews for procedures that use high-cost, evolving technologies.

We also recommend that, when new radiology services are approved for Medicare coverage, the Secretary require the Administrator to set technical component payment rates that reflect the costs incurred by high-volume, efficient providers.

## HHS Comments and Our Evaluation

HHS commented on a draft of our report in a letter dated April 14, 1992 (see app. II). HHS agreed that it is generally true that Medicare's technical component payments are not based on provider costs and may not promote efficient use of expensive new technology. HHS also agreed that Medicare payment levels may remain unnecessarily high without periodic adjustments as technologies evolve. Although HHS reiterated its intention to adjust technical component payment levels, as we recognize on page 6, it does not appear that HHS plans to give this issue much priority. It plans to gather the needed cost data "over the next several years," with subsequent revisions to the fee schedule "over time."

In an overall comment, HHS suggested that we rephrase our recommendations as goals and that the past legislative practices of reducing radiologic prices be continued until HCFA completes its studies. We believe HCFA should commit to a plan and timetable for adjusting the technical component levels if it is to avoid continued excessive payments

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that support the proliferation of expensive medical technology. The Congress has given HCFA the responsibility and authority to make such adjustments.

HHS agreed with the direction of our first recommendation, stating that more analytical work needs to be done before adjusting technical components. HHS cited the recent completion of a survey that included MRI and CT equipment and its plans to collect additional relevant data. Also, HHS suggested that research focus on efficient providers as contrasted to high-volume providers because high volume may not always be consistent with efficiency.

As we have noted, MRI and CT services require large capital investments, making unit costs very sensitive to volume. Our data clearly show that high volume is associated with the efficient use of equipment capacity and low unit costs. We do not mean to imply, however, that high volume is the only indicator of efficiency or the only criterion that should be used to set payment levels. To clarify this point, we have revised our draft recommendation to state that HCFA should revise the fee schedule to reflect unit costs incurred by high-volume, efficient providers. Also, while we agree with the need for more analytical work before adjusting technical components, we believe specific procedures, such as MRI and CT, should be targeted for priority analysis due to their high cost and evolving technologies.

Concerning our second recommendation, HHS commented that it may not be worth the effort and cost of making annual adjustments for procedures that use high-cost, evolving technologies. HHS would prefer the flexibility to make payment adjustments when appropriate. However, HHS will not know when adjustments are appropriate unless it closely tracks high-cost, evolving technologies that are more likely to require frequent adjustment. There is a high cost associated with the failure to make timely adjustments, as illustrated by the excessive payments for MRI and the proliferation of MRI machines. We have modified our draft recommendation to clarify that HCFA has the flexibility to make payment adjustments when appropriate but that payment reviews should be made annually.

Concerning our final recommendation, as with our first recommendation, HHS pointed out that high-volume providers are not necessarily the most efficient or low-cost providers. Consequently, to clarify that high volume is not the only indicator of efficiency, we have revised our draft

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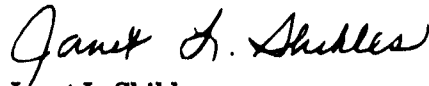
recommendation to state that HCFA, when approving new radiology services for Medicare coverage, should set technical component payment rates that reflect the costs incurred by high-volume, efficient providers.

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As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties.

Please call me on (202) 512-7119 if you or your staff have any questions about this report. Major contributors are listed in appendix III.

Sincerely yours,



Janet L. Shikles  
Director, Health Financing  
and Policy Issues

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## Abbreviations

CT	Computed Tomography
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
MRI	Magnetic Resonance Imaging
OBRA	Omnibus Budget Reconciliation Act





# Scope and Methodology

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We obtained information on how Medicare technical component payments are set by reviewing legislation and HCFA regulations and guidance, and meeting with officials from HCFA's Office of Payment Policy and Office of Coverage and Eligibility Policy. We obtained information on Medicare payments from HCFA's statistical data bases.

We also obtained information on MRI technology, costs, utilization, and payments through discussions with the American College of Radiology, the Physician Payment Review Commission, equipment manufacturers, and industry analysts.

We gathered detailed MRI cost and utilization data from state regulatory agencies and selected MRI facilities in Florida, Maryland, Massachusetts, and Michigan. These states were selected on the basis of their policies for regulating the establishment of MRI facilities—from highly regulated in Michigan, to less regulated in Maryland and Massachusetts, to largely unregulated in Florida. We wanted to obtain per-scan cost information at a variety of machine utilization levels. We expected that utilization would be higher in more regulated states, where there are fewer machines, and lower in less regulated states, where there are more machines.

In each state we visited MRI providers that included a cross-section of types of facilities (hospital-based and freestanding) and types of equipment (low-end, mid-range, and high-end). We obtained information on 25 MRI facilities, some of which had more than one machine. For 14 of these facilities, which were operating 17 MRI machines, we were able to obtain sufficiently detailed cost and utilization information to estimate MRI per-scan costs. We did not verify these costs to supporting accounting records or review the accounting controls, but we otherwise conducted our work in accordance with generally accepted government auditing standards.

# Comments From the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 14 1992

Ms. Janet L. Shikles  
Director, Health Financing  
and Policy Issues  
United States General  
Accounting Office  
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Medicare: Excessive Payments Support the Proliferation of Costly Technology." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

A handwritten signature in cursive script that reads "Richard P. Kusserow".

Richard P. Kusserow  
Inspector General

Enclosure

**Comments of the Department of Health and Human Services  
on the General Accounting Office Draft Report,  
"Medicare: Excessive Payments Support the Proliferation  
of Costly Technology"**

**Overview**

According to GAO, in some localities, Medicare's technical component payments for Magnetic Resonance Imaging (MRI) do not reflect the lower costs per scan now being achieved through faster scanning and greater machine utilization. This is because current payment levels are based, in part, on the charges allowed by local Medicare contractors in the mid-1980s. GAO reports that the 1991 payment levels in some localities were more than twice as high as in others, reflecting wide geographic disparities in the historical allowed charges.

Despite congressionally-mandated changes that narrowed geographic variations in the Medicare rates, GAO believes payments are still too high in some localities and continue to be based in part on historically allowed charges instead of costs. As a result, GAO concludes that Medicare should base its payments on the costs incurred by high-volume facilities to reduce Medicare program expenditures and to discourage providers from adding expensive, excess capacity to the health care system.

It is generally true that Medicare's technical component payments are not based on provider's costs and may not promote efficient use of expensive new technology. We agree in principle with the premise that Medicare payment levels may remain unnecessarily high without periodic (downward) price adjustments as technologies evolve.

We would note that we have established our future plans for determining technical component payments in the June 5, 1991 proposed rule on the physicians' fee schedule (56 FR 25850). We believe this discussion, quoted below, reflects our general agreement with GAO's findings.

"We do not consider the methods outlined above for determining the technical component fee schedule amount to be satisfactory for long term use. Rather than basing the fee schedule payment on historic average allowed charges, we believe the technical component payment should be derived based on analysis of the actual cost of producing the service by an efficient physician or supplier. Given the absence of this data now, we have no choice but to use historic charges. However, over the next several years, we plan to gather needed cost data to revise the fee schedule over time. Priority will be given to services involving the highest expenditure level or when we question the appropriateness of payment amounts or both."

**Appendix II  
Comments From the Department of Health  
and Human Services**

We believe, however, that the Congress and the Health Care Financing Administration (HCFA) would be better served if GAO would rephrase its recommendations as goals instead of directives and suggest that the past legislative practices of reducing radiologic prices be continued until HCFA studies are complete.

GAO Recommendation

We recommend that the Secretary of HHS require the Administrator of HCFA to:

- survey the technical component costs incurred by facilities providing radiology services and revise the fee schedule to reflect the unit costs incurred by high-volume providers; and

Department Comment

While we would generally agree with the direction of this recommendation, we believe that more analytical work needs to be done before adjustments can be made to technical component costs.

HCFA has recently completed the 1988 Physician Practice Costs and Income Survey which has an equipment costs section which can be analyzed. MRIs and Computerized Tomography (CT) were among the types of equipment for which data were collected. HCFA expects to obtain additional relevant information from a study of overhead costs of hospital outpatient departments, ambulatory surgical centers and physician group practices that will cover up to 400 procedures.

Upon completion and review of relevant research, decisions may be made to alter payments. We suggest that research focus on efficient providers as contrasted with high-volume providers because high-volume may not always be consistent with efficiency.

GAO Recommendation

- periodically adjust technical component payments to reflect changing costs, with annual adjustments for procedures that use high-cost, evolving technologies.

**Appendix II  
Comments From the Department of Health  
and Human Services**

Department Comment

It is not clear that the effort and cost of making annual adjustments would be justified. We would prefer more flexibility to adjust payments when appropriate.

GAO Recommendation

We also recommend that, when new radiology services are approved for Medicare coverage, the Secretary require the Administrator to set technical component payment rates that reflect the costs incurred by high-volume providers.

Department Comment

We believe we should not be constrained to set Medicare technical component allowances for new radiology services based on costs incurred by high-volume providers. High-volume providers are not necessarily the most efficient providers nor are they necessarily low-cost providers. We must have the discretion to determine what methodology would be used. However, we do agree that volume may well be one criterion in establishing technical allowances.

Technical Comments

Now on p. 2.

(1) At the bottom of page 4 of the report there is a sentence which reads: "Part B coverage includes a technical component payment for radiology services provided in ambulatory settings, such as hospital outpatient departments, freestanding facilities, and physicians' offices." It is not correct to say that "Part B coverage includes a technical component payment . . . ." Instead, the sentence should be revised to read "Part B payment includes a technical component allowance for radiology services . . . ."

Now on pp. 5 and 6.

(2) We believe that the discussion of congressionally-mandated payment cuts on page 11 should have specifically cited the 10 percent reduction in radiologist fee schedule amounts for the technical components of both MRI and CT procedures furnished after December 31, 1990, set forth in section 1834(b)(4)(E) of the Social Security Act. This reduction was carried over into the relative value units assigned to the technical components of MRI and CT procedures under the Medicare physicians' fee schedule. Similarly, we believe GAO should specify the OBRA '89 reduction in payment, as well as the OBRA '90 reduction in payment.

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# Major Contributors to This Report

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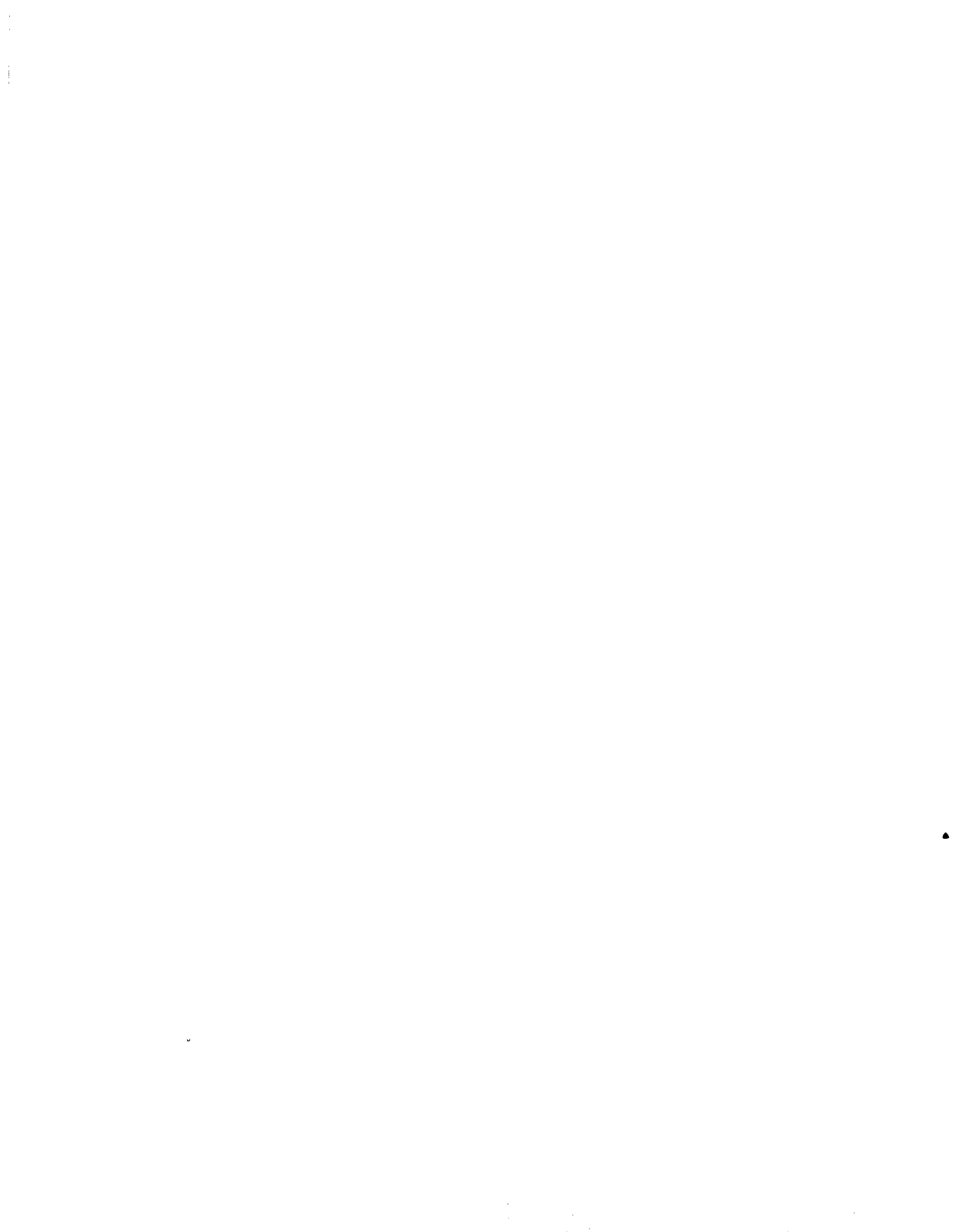
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