CMS to Implement Two-Year Phase in of CT and MR Cost Center Policy

On November 1, 2019 Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2020 Hospital Outpatient Prospective Payment System (HOPPS) final rule. The changes finalized will take effect on January 1, 2020.

CMS will implement a conversion factor of 2.6 percent bringing it up to $80.784 for CY 2020. The reduced conversion factor for hospitals failing to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements is to be $79.770.

Beginning in CY 2020, CMS will begin a two-year phase in period of CT and MR cost center policy after receiving many public comments stating concerns of the implementation of this policy. In 2020, CMS will begin a two-year phase of the policy that will apply 50 percent of the payment impact. For CY 2020, CMS will calculate imaging payment rates using both the transition method (excluding providers using a square feet allocation method) and the standard methodology that includes all providers regardless of allocation method. In CY 2021, the transition will end and fully implement the CT and MR cost data regardless of the cost allocation method. The ACR has raised concerns many times in the past regarding the use of claims from hospitals that continue to report under the “square foot” cost allocation method noting that it would under-estimate the true costs of CT and MR studies. CMS has given the hospitals six years to adjust their cost allocation methods from “square foot” to either “direct” or the “dollar” method. These changes are the result of a study that was done by the Research Triangle Institute (RTI) back in 2007¹. Although ACR has argued that the RTI study, and data which back it up, are outdated CMS is adamant to continue with full implementation of the policy.

For CY 2020, CMS finalized the creation of two new comprehensive APCs (C-APCs). These new C-APCs include the following: C-APC 5182 (Level 2 Vascular Procedures) and proposed C–APC 5461 (Level 1 Neurostimulator and Related Procedures). This proposal would increase the total number of C-APCs to 67.

CMS will continue to paying for drugs and therapeutic radiopharmaceuticals at ASP + 6% as set forth in the CY 2010 OPPS/ASC Final Rule. CMS finalized policy to increased threshold payment for therapeutic radiopharmaceuticals of $130, where CMS will package those that are priced less or equal to $125 into the APC payments and pay separately for those that meet or exceed this threshold amount.

In the CY 2020 HOPPS proposed rule, CMS included a proposal to require hospitals make public their “standard charges.” CMS did not address these proposals in the final rule and intends to include this in a separate final rule. This final rule is currently for review at the Office of Management and Budget.

ACR staff is preparing a detailed analysis of the final rule and will provide additional information in the coming week.