

**Statement to the Advisory Panel on HOP on the Implementation of CT and MR Cost
Center Data
March 10-March 11, 2014**

The American College of Radiology (ACR) appreciates the opportunity to present testimony before the Advisory Panel on Hospital Outpatient Payment (HOP) implementation of CT and MR cost center data. The ACR represents more than 36,000 diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians and medical physicists. For over three quarters of a century, the ACR has devoted its resources to making imaging safe, effective and accessible to those who need it.

For 2014, CMS has implemented the use of the FY 2012 cost data to establish separate cost-to-charge ratios (CCRs) for CT and MR, distinctly separate from the general radiology CCR, for determining APC weights. CMS attempted to address concerns by many stakeholders that the data was inaccurate by removing claims data from hospitals that used the “square feet” cost allocation method. CMS is adopting this change for four years, 2014-2017, and believes that this is sufficient time to use one of the more accurate cost allocation methods. Beginning in 2018, CMS will estimate the CT and MRI APC relative payment weights using cost data from all providers, regardless of the cost allocation statistic used.

The ACR is concerned that CMS’ establishment of separate cost-to-charge ratios (CCRs) for CT and MR is based on inaccurate data and a methodology that cannot be replicated. This flawed policy change has significant impacts on CT and MR payments in the HOPPS.

ACR requests the Panel recommend that:

1. CMS does not implement separate CT and MRI cost centers pending further analysis and collection of data on the impact of this policy.
2. CMS report back to the Panel with an analysis of the impact of this policy, including beneficiary access to these services.

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Technical Comments

In the Final 2014 HOPPS Rule, CMS introduced an interim method to calculate rates while hospitals work to convert to more accurate cost allocation methods. The new methodology excludes single claims for hospitals that use “square foot allocation” methods in cost reporting for CT/MR cost centers. The final rule describes the expected impact of its proposed methods on rate setting, specifically in Tables 3, 4 and 5 in the final rule. However, the description of the methodology used for these calculations is insufficient. ACR’s consultants from The Moran Company found it impossible within the 60-day comment period, to replicate CMS’ results. Since they cannot replicate CMS’ results we cannot comment on either how CMS should remedy the level of cuts to the rates in 2014 or comment on details of methodology.

Moran’s attempts to replicate CMS’ policy, including the removal of claims from providers that used a cost allocation method of the square foot (SF) to calculated CCRs were not successful due to lack of detail in the rule. CMS does not indicate the year of the cost reports they used to

determine the providers to be removed. CMS may also make determinations based on the characteristics of the cost report (e.g., partial year), but does not explain the approach used for this analysis. CMS mentions two different worksheets to check, and lists four combinations of providers (SF Allocators, Direct Allocators, Dollar Value Allocators, and Direct + Dollar Value allocators) but the specific situation where providers who use square foot allocation in combination with direct allocation are not addressed. As a result, our consultants are uncertain how to treat the cost reports for these hospitals.

Moran's replication of the removal of SF allocators showed a volume of single claims comparable to what CMS reports for the CT and MR codes. However, their calculations were not close to the geometric mean costs.

Impact on Hospitals

The ACR supports the comments submitted by The Association for Imaging Management (AHRA) the professional organization representing 5,000 members of all management levels of hospital imaging departments, freestanding imaging centers, and radiology group practices. They maintain that creating a cost center for a particular technology is not an activity that is prudent from a hospital accounting perspective, if the hospital has not already organized in this manner. As a result, hospitals are not likely to respond in a consistent way. There is a lot of work involved in determining how to allocate many different types of expenses to a new cost center, and removing them from an old cost center. Until hospitals are truly consistent in how their data are gathered and reported there will be significant gaps and flaws that will ultimately result in inaccurate reimbursement.

CMS should pay particular attention to establishing the validity of data used in the CT and MRI cost centers because CT and MRI services are capital intensive, and allocation of capital costs within the cost reports is both complicated and subject to error. A full analysis of the practical impact of this policy demonstrates that the results are incongruous and inaccurate Medicare reimbursements for CT and MR services in both the hospital and non-hospital settings—jeopardizing patient access to these services.

Impacts to hospital outpatient departments and imaging centers are significant for 2014 as demonstrated in the table below:

Code	Short Descriptor	2013 SI	2013 APC	2013 Relative Weight	2013 Payment Rate	SI 2014	APC 2014	Relative Weight 2014	Payment Rate 2014	% diff 2013 and 2014
75571	Ct hrt w/o dye w/ca test	X	340	0.6961	\$49.64	X	35	0.3042	\$22.11	-55%
70450	Ct head/brain w/o dye	Q3	332	2.4340	\$173.58	Q3	332	1.7403	\$126.47	-27%
74176	Ct abd & pelvis	Q3	331	4.2917	\$306.05	Q3	331	3.3271	\$241.79	-21%
76497	Ct procedure	S	282	1.3864	\$98.87	S	282	1.0948	\$79.56	-20%
74174	Ct angio abd&pelv w/o&w/dye	S	334	6.7671	\$482.58	S	334	5.3683	\$390.13	-19%
75572	Ct hrt w/3d image	S	383	3.7468	\$267.20	S	383	3.0549	\$222.01	-17%
70460	Ct head/brain w/dye	Q3	283	4.1669	\$297.15	Q3	283	3.4263	\$249.00	-16%
70470	Ct head/brain w/o & w/dye	Q3	333	4.6182	\$329.34	Q3	333	3.8584	\$280.40	-15%
70496	Ct angiography head	Q3	662	4.7570	\$339.24	Q3	662	4.0175	\$291.96	-14%
70540	Mri orbit/face/neck w/o dye	Q3	336	4.7466	\$338.49	Q3	336	4.0563	\$294.78	-13%
70553	Mri brain stem w/o & w/dye	Q3	337	7.7051	\$549.47	Q3	337	6.7828	\$492.92	-10%
70542	Mri orbit/face/neck w/dye	Q3	284	6.3741	\$454.56	Q3	284	5.8687	\$426.49	-6%