Medicare’s new CT and MRI cost centers demand accurate cost reporting

Payment models are rapidly changing in all areas of the healthcare industry, but one could argue that the impact on imaging has been far greater than on other clinical areas.

Historically, because imaging has been such a strong revenue producer for hospitals and health systems, finance personnel have tended not to focus as much on payment for imaging services as they have on payment for other areas. This approach is no longer viable. Changes in how the Centers for Medicare & Medicaid Services (CMS) determines payment for imaging services make it incumbent on each hospital to do all it can to ensure its cost reports appropriately reflect the true costs of such services. This effort will require renewed evaluations of a hospital’s chargemaster and cost reports.

Simply put, cost reporting for hospital-based imaging services—and for computed tomography (CT) and magnetic resonance imaging (MRI), in particular—must be accurate if a hospital is to receive appropriate payment for such services. To meet CMS requirements for accurate reporting of capital-related costs in this area, healthcare finance professionals must effectively transition from the “square foot” method to either the direct- or dollar-allocation methods of cost reporting for imaging services. Finance staff also must have a clear understanding of which costs should be reported in the new CT and MRI cost centers to help stabilize payments for these services.

CMS Actions
Currently, CMS uses CT- or MRI-specific cost-to-charge ratios (CCRs) for about a third of the hospitals in the outpatient prospective payment system (OPPS) rate calculations. In 2014, CMS is mandating that all hospitals begin using the CT and MRI cost centers to report their costs. Also, CMS is now using the FY13 cost data to calculate the CCRs for CT and MRI—as distinctly separate from the general radiology CCR—for determining ambulatory payment classification (APC) weights and, thus, payment rates. This change has resulted in significant cuts in the hospital outpatient payment rates for CT and MRI, as shown in the exhibit on page 2.

CMS has attempted to address concerns raised by many stakeholders that the data utilized for the calculations are flawed, resulting in inappropriate payment cuts, by removing from its calculations claims data from hospitals that used the square-foot cost-allocation method. CMS is adopting this change through 2017 to give hospitals sufficient time to transition to a more accurate cost-allocation method. 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 statistical methods.
Why Hospitals Have Used the Square-Foot Method

Prior to 2014, hospitals were not required to split out or establish unique cost centers for CT or MRI procedures, nor were they required to use a specific capital cost-allocation method. In preparation for the inpatient capital PPS, hospitals began evaluating the best method to allocate capital costs. Square-foot-based calculations often resulted in more costs being allocated to the inpatient services and, therefore, were preferred by the hospitals. Consider that during the transition to the inpatient capital PPS, outpatient services were still cost-reimbursed, while the hospital community gave little thought to the idea of an OPPS. Then, with implementation of the OPPS, there was no provision included to provide separate payments for operating and capital costs, as there was in the inpatient PPS.

Moreover, in using the square-foot method for allocating costs, hospitals often did not take the time to fully analyze and report both the operating and capital costs of these imaging services. Although hospitals generally could identify the gross charges associated with each discipline (based on uniform billing codes), determining the cost-report cost was challenging, particularly with respect to the labor component.

To manage cost, hospitals might share staff to deliver necessary patient care services, resulting in proxies to develop the costs. For example, combined costs might be allocated on the basis of revenue, the number of procedures, or the number of patients for each discipline. None of these allocations would be as accurate as specifically identifying all of the personnel costs, supplies specific to each service, and other costs. Once the personnel costs were accurately identified, it would be possible to properly allocate fringe benefits and other people-related costs (e.g., cafeteria and patient care administrative costs). A significant aspect of using these proxies is that they are also applied to allocating capital-related costs for CT and MRI. This method of averaging contributes to the distortion of the cost-finding process.

Other Options for Allocating Capital-Related Costs

Capital-related costs associated with CT and MRI include depreciation, interest (related to the capital asset), property insurance, and operating lease payments. Hospitals have a choice of three methods for allocating these costs and avoiding the distortions created by the square-foot approach.

Aggregate all capital-related costs into an overhead cost center and then allocate the costs to all departments within the hospital’s cost report based on the square footage of each cost center. Although this method is the simplest, it also may be the least accurate in that all the costs are averaged and the method infers that all departments “consume” depreciation and other capital-related expenses equally. Even when a hospital splits the building capital-related costs and the movable-equipment

PERCENTAGE CHANGE IN ESTIMATED COST FOR THOSE AMBULATORY PAYMENT CLASSIFICATIONS (APCs) SIGNIFICANTLY AFFECTED BY USE OF THE NEW STANDARD COST CENTER CCRs IN THE CMS FORM 2552-10 COST REPORTS

<table>
<thead>
<tr>
<th>APC</th>
<th>APC Descriptor</th>
<th>Percentage change in estimated cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>0282</td>
<td>Miscellaneous Computed Axial Tomography</td>
<td>-38.1</td>
</tr>
<tr>
<td>0332</td>
<td>Computed Tomography (CT) Without Contrast</td>
<td>-34.0</td>
</tr>
<tr>
<td>8005</td>
<td>CT and CT Angiography (CTA) Without Contrast Composite</td>
<td>-33.9</td>
</tr>
<tr>
<td>0331</td>
<td>Combined Abdomen and Pelvis CT Without Contrast</td>
<td>-32.9</td>
</tr>
<tr>
<td>8006</td>
<td>CT and CTA with Contrast Composite</td>
<td>-29.0</td>
</tr>
<tr>
<td>0334</td>
<td>Combined Abdomen and Pelvis CT with Contrast</td>
<td>-28.8</td>
</tr>
<tr>
<td>0662</td>
<td>CTA</td>
<td>-27.0</td>
</tr>
<tr>
<td>0283</td>
<td>CT with Contrast</td>
<td>-27.0</td>
</tr>
<tr>
<td>0333</td>
<td>CT Without Contrast Followed by Contrast</td>
<td>-26.3</td>
</tr>
<tr>
<td>0383</td>
<td>Cardiac CT Imaging</td>
<td>-24.8</td>
</tr>
<tr>
<td>0336</td>
<td>Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) Without Contrast</td>
<td>-19.3</td>
</tr>
<tr>
<td>8008</td>
<td>MRI and MRA with Contrast Composite</td>
<td>-18.9</td>
</tr>
<tr>
<td>8007</td>
<td>MRI and MRA Without Contrast Composite</td>
<td>-18.5</td>
</tr>
<tr>
<td>0337</td>
<td>MRI and MRA Without Contrast Followed by Contrast</td>
<td>-18.2</td>
</tr>
</tbody>
</table>

depreciation into two separate cost centers, the result is essentially the same.

Allocate building capital-related costs on square footage and movable-equipment capital-related costs on dollar value. The dollar value can be based on either the historical cost of the departmental equipment (which is less common) or the annual depreciation expense related to that department. This method represents a significant improvement compared with using square footage, but also presents limitations. For example, a disproportionate amount of depreciation expense may be allocated to departments that at one time had significant capital asset acquisitions, but not currently. As newer equipment may have shorter lives, the allocations may not be accurate in the year of either acquisition or disposition. This method does not accurately capture any capital-related expenses associated with leased equipment.

Allocate building capital-related costs based on departmental square footage, and then directly assign all the movable-equipment capital-related costs to the actual cost center to which they relate. Under this method the equipment-related capital-related costs are left in each cost center. The directly assigned capital-related costs are entered on Worksheet B Part II, Column o. This is the most accurate method and addresses the inconsistencies noted above. For inpatient reimbursement purposes, the capital-related costs are properly segregated to influence the capital PPS payment amounts. For outpatient purposes, because the expense is left in the cost center, the full cost can be used to determine payment rates. This method requires a review of the cost-report expense groupings to make sure that none of the equipment-related capital costs are double counted. Also, the hospital would need to elect this direct assignment for all cost centers. There may be situations where a hospital would use both Worksheet B Part II Column o and also have costs allocated on dollar value. This scenario would arise due to related-party transactions or residual capital-related costs that cannot be specifically linked to a department. A hospital using one of the other methods would likely need to seek approval from their Medicare audit contractor for the change in allocation methodology. Because this is a more sophisticated cost-finding method, obtaining approval should be a fairly routine matter.

An Obligation for Accuracy
CMS has always relied on cost-report information as the basis of Medicare payment for covered hospital services. Prior to the inception of the various PPSs, the cost-report data was used to determine Medicare’s liability at the individual hospital level. Today, as PPSs continue to evolve, CMS has moved to a system of calculating CCRs down to the most granular level, whether at the state, hospital, or department level, and then matching the data with corresponding charge and other utilization data to develop standardized amounts and episodic payments that it believes are appropriate based on the resources used to provide covered services to beneficiaries. As a result, the relevance of each individual hospital’s data has increased.

Moreover, the hospital community has a continuing obligation to prepare accurate cost reports that will enable CMS to identify appropriate payment amounts based on current industry practices and the realities of today’s high-tech and high-impact services. Our focus here has been on CT and MRI services, but this premise applies equally to all necessary patient care procedures.

Melody W. Mulaik is chair, regulatory affairs committee, The Association for Medical Imaging Management, Sudbury, Mass., and a member of HFMA’s Georgia Chapter (melody.mulaik@codingstrategies.com).

Pam Kassing, MPA, RCC, is senior economic advisor, economics and health policy, American College of Radiology, Reston, Va., and a member of HFMA’s Virginia-Washington, D.C., Chapter (pkassing@acr.org).

K. Michael Nichols, FHFMA, CPA, is a partner, McGladrey LLP, Chicago, and a member of HFMA’s First Illinois Chapter (mike.nichols@mcgladrey.com).
Changes in Payment and Cost Accounting for CT and MRI: The Genesis and the Impact

The Centers for Medicare & Medicaid Services (CMS) has established new requirements for how hospitals and health systems should report capital-related costs for computed tomography (CT) and magnetic resonance imaging (MRI) services. To fully grasp the impact of the cost-accounting changes, it is helpful to understand the background to the changes and factors CMS considered in adopting them.

Cost compression with respect to CT and MRI services was evaluated in a 2007 report by RTI International. RTI found that the costs and charges of CT scans, MRIs, and cardiac catheterization differ significantly from the costs and charges of other services included in the standard associated cost center. RTI concluded that both the inpatient prospective payment system and the outpatient prospective payment system (OPPS) relative payment weights would better estimate the costs of those services if CMS were to add standard cost centers for CT scans, MRIs, and cardiac catheterization. Such a step would allow hospitals to report the costs and charges for those services separately and CMS to calculate unique cost-to-charge ratios (CCRs) with which to estimate the cost from charges on claims data.

CMS adopted RTI’s recommended approach, and the new standard cost centers for CT and MRI scans and for cardiac catheterization became effective for cost-report periods beginning on or after May 1, 2010. Using the December 2012 Healthcare Cost Report Information System update, which it had used in its OPPS rate-setting process to estimate costs for CY14, CMS was able to calculate a valid implantable device CCR for 2,936 hospitals, a valid MRI CCR for 1,853 hospitals, a valid CT scan CCR for 1,956 hospitals, and a valid cardiac catheterization CCR for 1,367 hospitals.

CMS believes there is sufficient data in the Form CMS 2552-10 cost reports to provide a basis for a meaningful analysis of CCRs for 2014. CMS proposes to calculate the OPPS relative payment weights using distinct CCRs for cardiac catheterization, CT scan, and MRI and to continue using a distinct CCR for implantable medical devices.

The American College of Radiology (ACR) contracted with a well-known healthcare consultant to determine the effect on cost compression as a result of CMS’s decision to move forward with RTI’s recommendations. The conclusion was that the measured CCRs for advanced imaging may reflect a misallocation of capital costs on the cost report. That is, a significant number of hospitals report little or no capital cost for MRI and CT. These hospitals may be treating CT and MRI machines as hospital fixtures (allocated to hospital overhead) instead of equipment.
allocated to radiology cost). If this is true, RTI’s estimates of the costs and CCRs for CT and MRI are substantially too low.

The ACR has been following this issue and commenting on it since 2008. That year, the ACR released an analysis with comments on separate CT and MRI cost centers showing that the technical payment for CTs ($64) would fall below the payment for a chest X-ray ($99). A similar analysis, performed by the same consulting firm (as requested by a different stakeholder) and analyzing 2011 data, reached similar conclusions: the cost data are not sufficiently representative and produce payment anomalies.

For the past few years, CMS has asked hospitals to report separate costs for CT and MRI services using the new reporting methodology. Analysis of the 2011 data from these hospitals shows that a CT scan of the head/brain would be reimbursed at $84 (down from $206) and an X-ray of the skull would be reimbursed at $82 (up from $45). The RVS Update Committee database administered by the American Medical Association and related practice-expense data posted on the CMS website both indicate the cost of an X-ray machine as being approximately $125,000, whereas the cost of a CT machine is more than $1.2 million. The cost to hospitals to purchase this same equipment is similar to the amount an office would pay for comparable technology. Generally, CT equipment costs are tenfold those of an X-ray machine.

Nonetheless, under the proposed calculations using the new CT and MRI cost centers, payment for the low-cost item is increasing (X-ray at $82), and the high-cost service is being undervalued (CT at $84). CMS defines charge compression as a situation in which the cost-based weights would undervalue high-cost items and overvalue low-cost items if a single CCR is applied to items of widely varying costs in the same cost center. In the case of the new CT and MRI cost centers, a single CCR is not being applied, yet the result of creating separate CT and MRI CCRs has been to exacerbate the problem instead of solving it.

RTI’s 2007 analysis of the costs and charges of CT and MRI scans pointed to anomalous trends:

Many facilities had very low cost ratios on these nonstandard lines. This raises questions about the relative accuracy of their cost finding. …[CT and MRI] services are very capital-intensive, and accurate cost ratios will depend on providers’ being able to assign actual equipment depreciation and lease costs directly to the cost centers, rather than the traditional method of allocating average capital costs based on square footage.

The basic findings were that, even when all hospitals move away from the square-foot cost-allocation method to direct or dollar-allocation methods, the data for the cost centers will not improve much. A larger concern is what happens when all of the hospitals start using the CT and MRI cost centers. It is projected that if they continue to allocate costs as they have but direct them to these specific cost centers, they could face additional cuts of 7 to 26 percent.

Melody W. Mulaik is chair, Regulatory Affairs Committee, AHRA: The Association for Medical Imaging Management, Sudbury, Mass. (melody.mulaik@codingstrategies.com).

Pam Kassing, MPA, RCC, is senior economic advisor, economics and health policy, American College of Radiology, Reston, Va. (pkassing@acr.org).

K. Michael Nichols, FHFMA, CPA, is a partner, McGladrey LLP, Chicago, and a member of HFMA’s First Illinois Chapter (mike.nichols@mcgladrey.com).