MEDICARE PAYMENTS FOR CT AND MR ADVANCED IMAGING

October 30, 2013

Executive Summary

- Accurate cost reporting is a prerequisite for achieving accurate CT/MR payments
- CT/MR cost reporting is significantly more difficult and complicated than implantable device reporting because CT/MR are capital intensive
- **CMS should only use data from CT/MR cost centers that meets minimum data quality standards**

New Diagnostic Radiology Cost Centers

- Before 2010

ID	Description
41	Radiology-Diagnostic
42	Radiology-Therapeutic
43	Radioisotope

- After 2010

ID	Description
54	Radiology-Diagnostic
55	Radiology-Therapeutic
56	Radioisotope
57	**CT**
58	**MRI**

Implantable vs. CT/MR Cost Reporting

Implantable

- Device itself accounts for substantially all costs
  - Device costs and revenues are easily transferred from general ledger
- Hospitals had adequate time to adjust to new implantable cost reporting

CT/MR

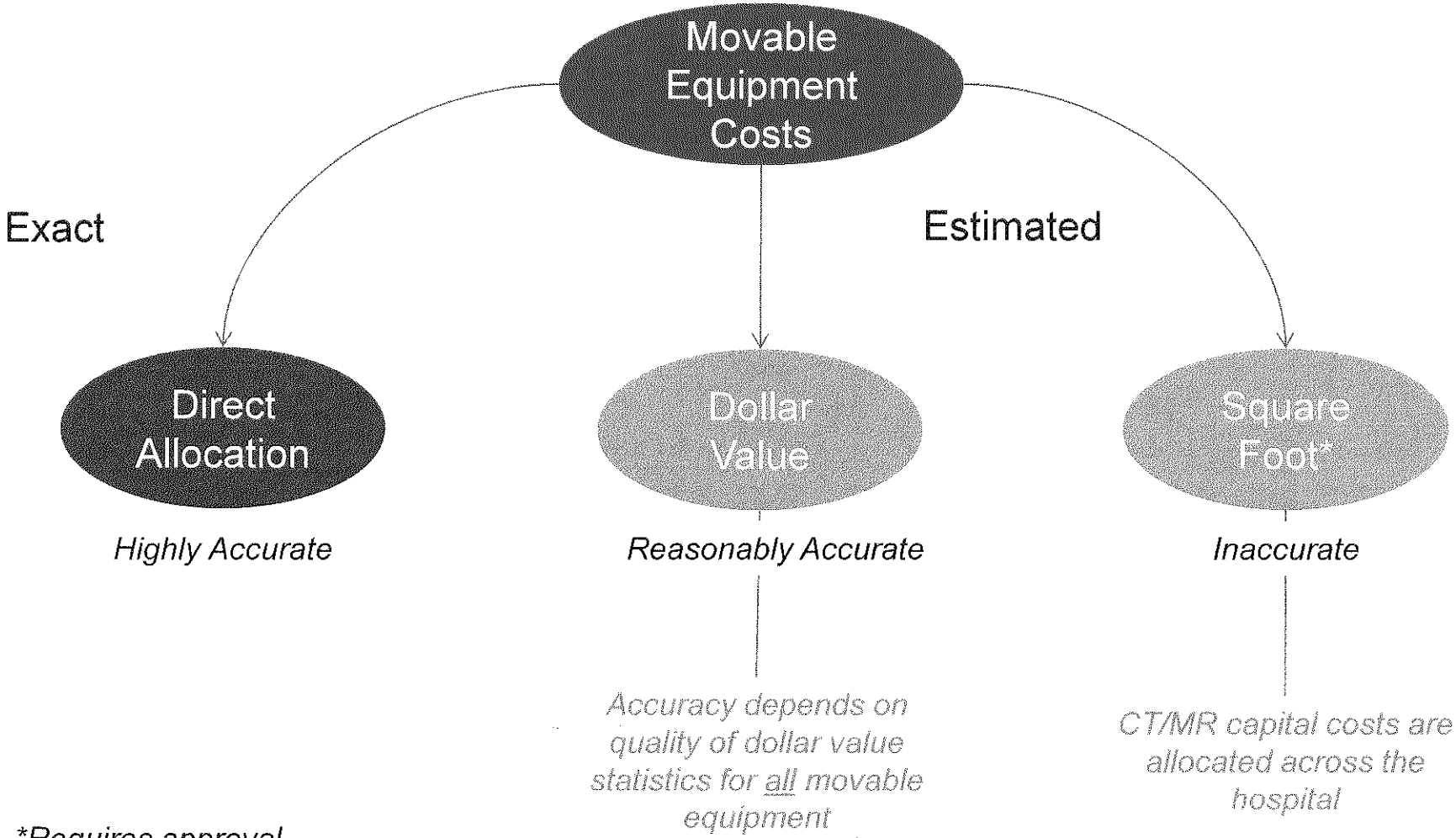
- Equipment costs, labor, & overhead all contribute significantly to total costs
  - Difficult to appropriately capture all overhead costs
- Hospitals had inadequate time to adjust to new CT/MR cost reporting
- **Significant capital cost allocations required**
- **Allocation of department overhead costs through reclassification required (eg, IT systems, director, etc.)**

RTI Recognized That Accuracy Depends on Correct Capital Cost Reporting

- "[CT and MR] 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."
- "Many facilities had very low cost ratios on these nonstandard lines…This raises questions about the relative accuracy of their cost finding."

Source: A Study of Charge Compression in Calculating DRG Relative Weights. Report to CMS, January 2007

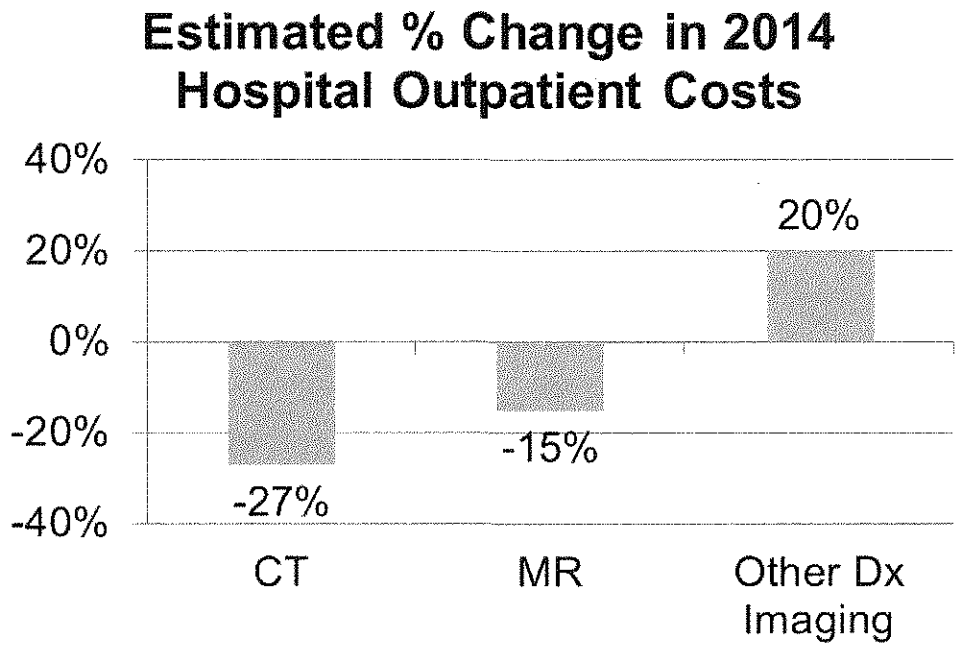
Capital Cost Allocation Methods



*Requires approval

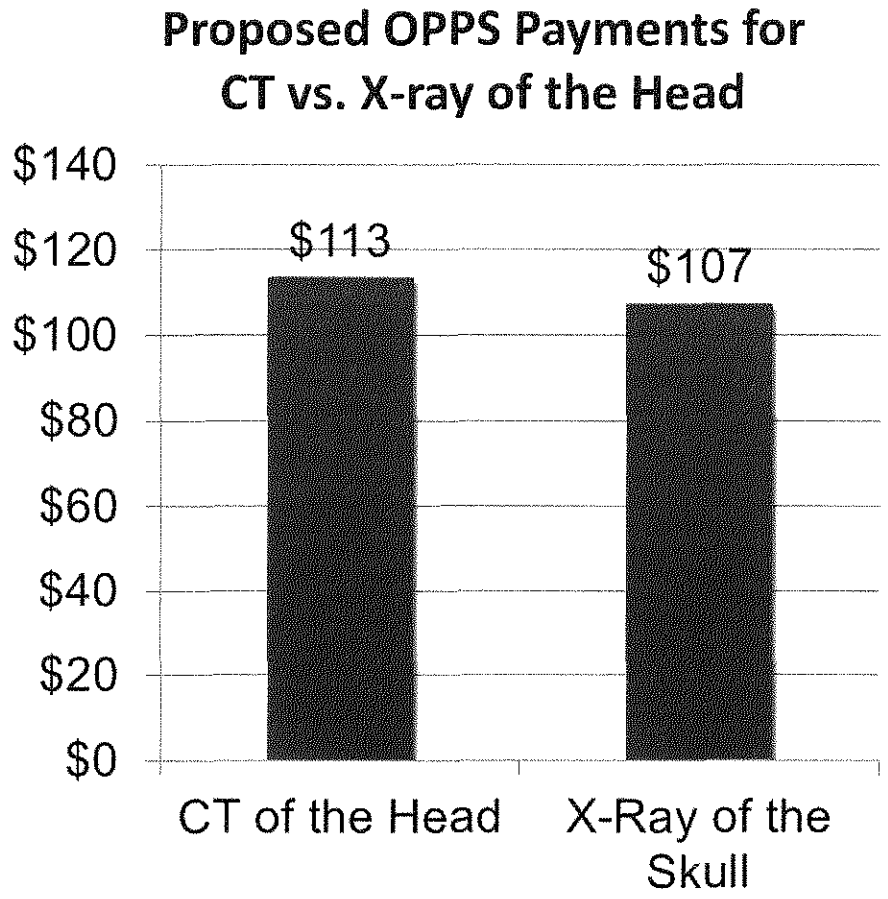
Overall Impact

- Budget neutral shift in hospital outpatient settings
- CT & MR cost reductions offset by increases in x-ray, ultrasound, and other diagnostic radiology services
- Also impacts:
  - DRG payments for CT/MR intensive admissions
  - Physician office and imaging center payments through the Deficit Reduction Act (DRA)caps



Source: Direct Research LLC analysis of Medicare claims data

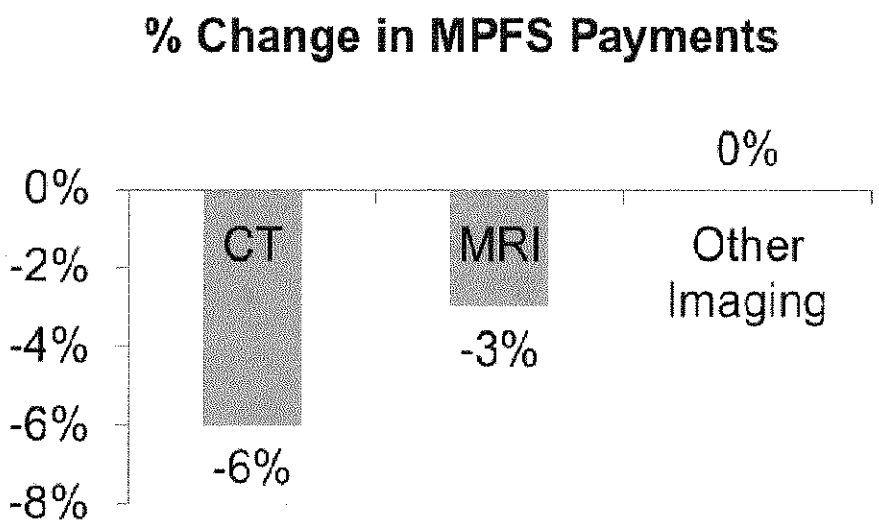
Without Quality Checks, Separate Reporting Leads to Costs that Lack Face Validity



Source: Analysis of CMS OPPS Proposed Rule for CY2014

Spillover Impact on MPFS via DRA Cap

- Deficit Reduction Act caps MPFS technical component (TC) payment at HOPPS payment, when HOPPS is less
- Overall cuts are estimated to be 6% for CT and 3% for MRI
  - No offsetting increase in other diagnostic imaging
- These cuts would be in addition to cuts of 40-55% implemented since DRA



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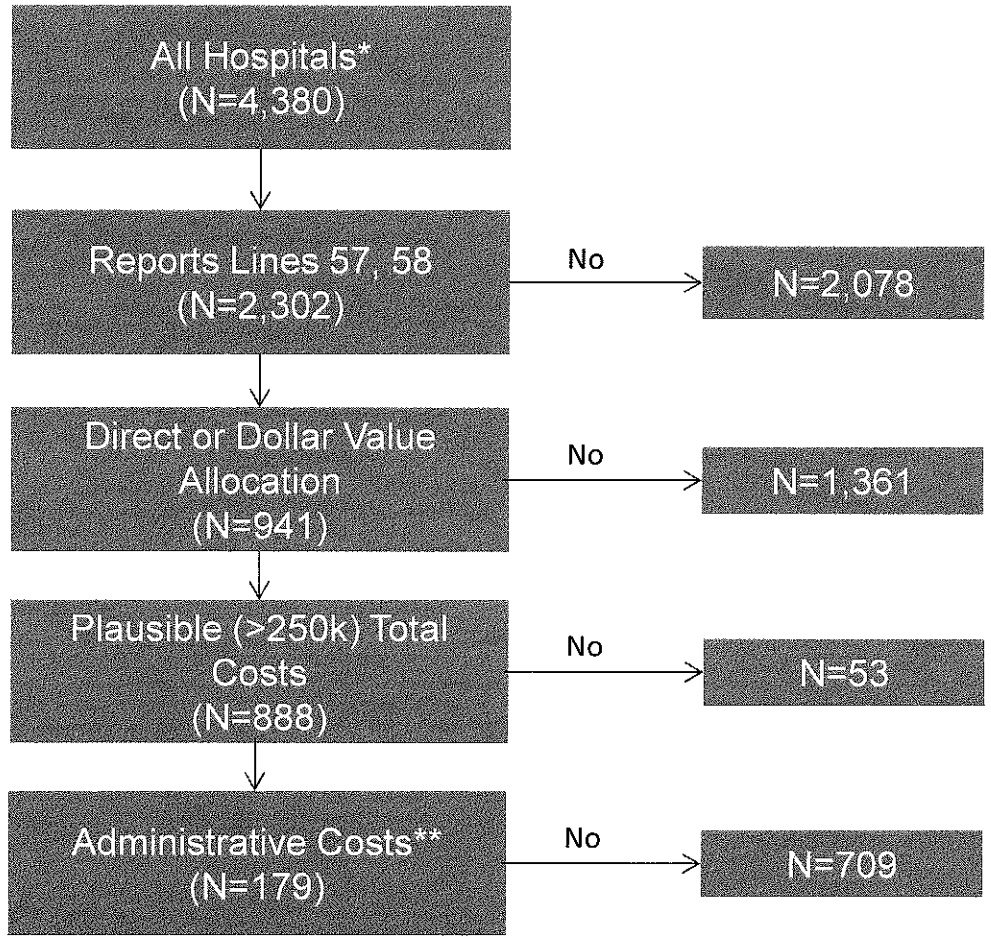
Proposed Minimum Data Quality Requirements for CT/MRI Cost Centers

- Accurate reporting of capital costs
  - Direct assignment of capital costs in cost centers 57 and 58[1], or
  - Allocation of movable equipment costs using the "dollar value" method
- Plausible (>$250,000) total costs for cost centers 57 and 58[2]
- Evidence of diagnostic-radiology-specific administrative costs in cost centers 57 and 58
  - No negative reclassifications from cost center 54 and no positive reclassifications to cost centers 57 and/or 58[3]

1. Worksheet B, Part II, Column 0. 2. Worksheet A, Column 7. 3. Worksheet A-6.

Hospitals Meeting Data Quality Requirements

We estimate that 179 hospitals meet minimum data reporting requirements



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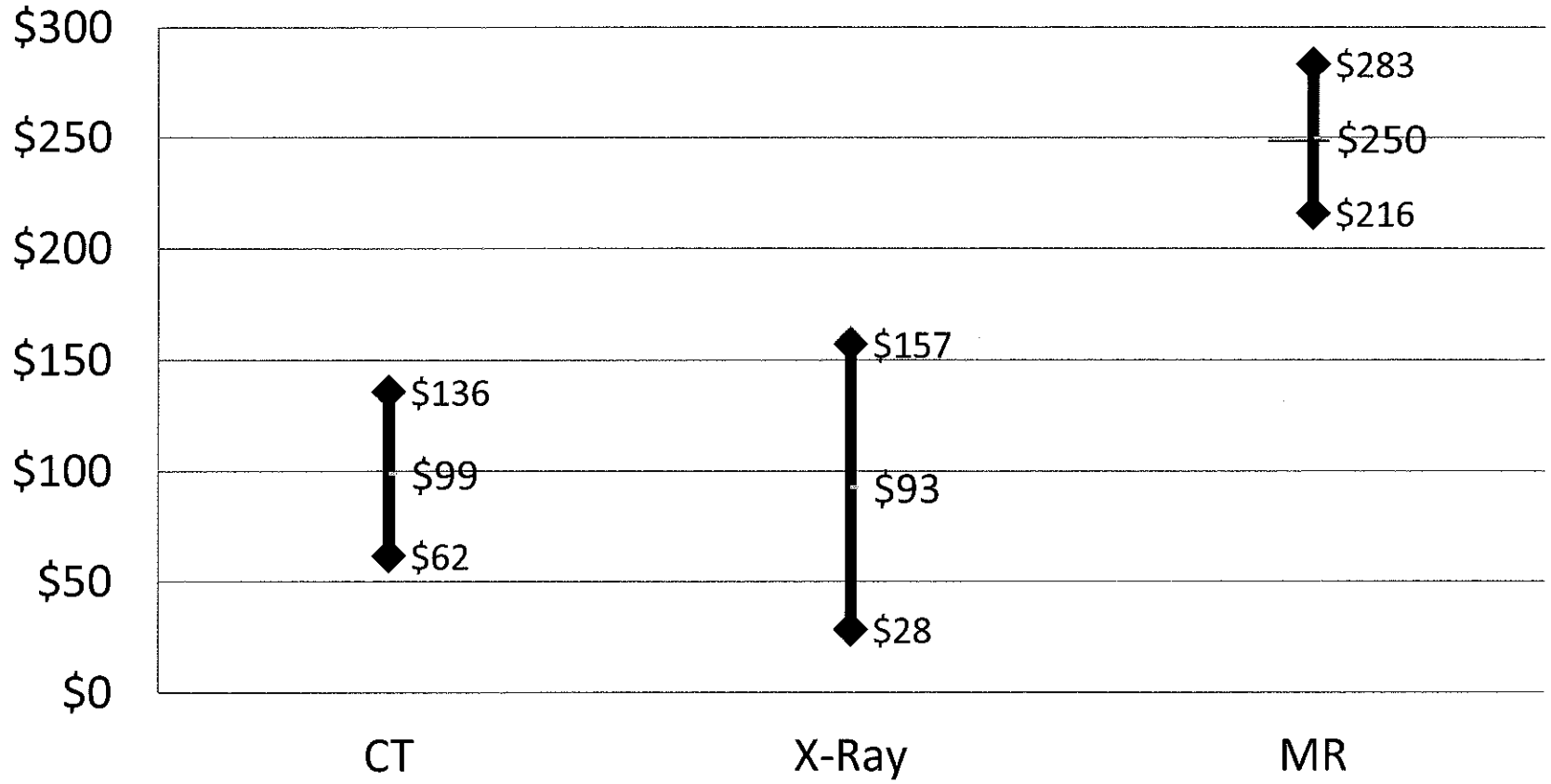
Hospital Outpatient Cost Distribution for Hospitals Reporting Separate Cost Centers
(Mean, +/- 2 St. Dev.)



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Geometric mean of single-service claims

Requested Policy Change

- To achieve accurate payment for CT and MR, CMS should establish simple, minimum data quality standards for using separately reported CT and MR costs.
- Specifically, CMS should implement minimum data quality requirements for lines 57, 58*
  - For cost reports that do meet minimum data quality requirements
    - Use costs information in lines 57, 58*
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    - Roll up costs from lines 57, 58* to line 54 (consistent with CMS policy)
  - For inpatient, CMS should establish a minimum number of hospitals reporting data that meets quality requirements before using these cost centers for inpatient payment determination
- Number of hospitals reporting data that meets these quality standards should increase over time
  - Hospitals had insufficient time to adjust to new cost report forms

* Includes any self-designated cost centers for CT or MR hospitals may be using in lieu of 57, 58

FAQ: Won't hospitals improve their cost report systems to avoid inaccurate payments caused by the CMS policy to use separate CT and MR cost centers to determine payments?

- No, the CT & MR separate cost centers policy does not contain sufficient incentive for hospitals to make changes that will incur substantial new costs for no direct benefit to individual hospitals. To achieve the goal of improved accounting, CMS should not rely on one or more separate cost center payment changes to promote hospital accounting improvements.

- No, inaccurate payments will be unavoidable, without a data validity screen. Even if every hospital decided today to switch to the "direct assignment" or "dollar value" allocation methods, it would be several years before cost reports using these new methods become available. Once submitted by the hospital, there is a 3-year lag before that report is used by CMS to calculate payments.

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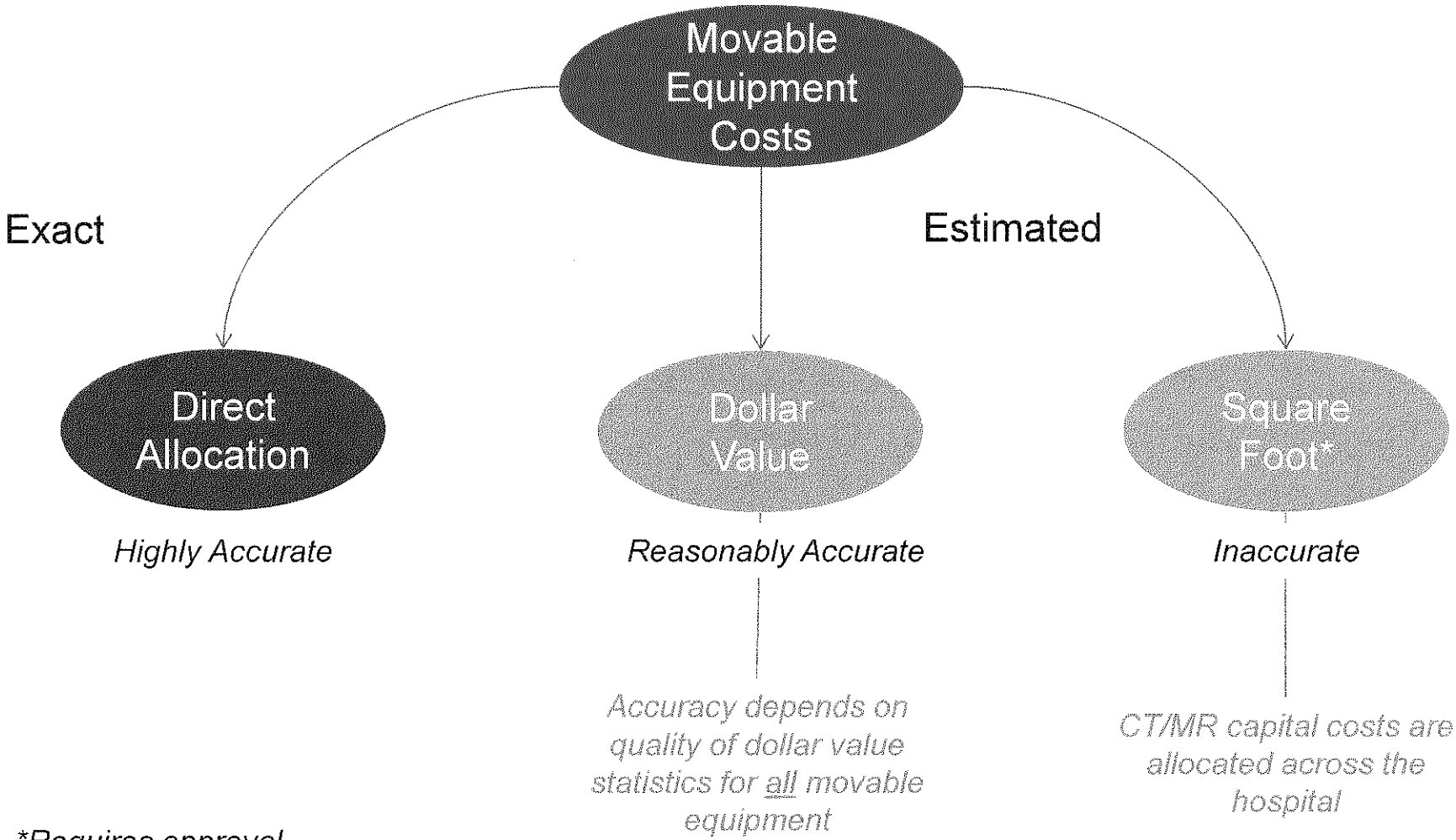

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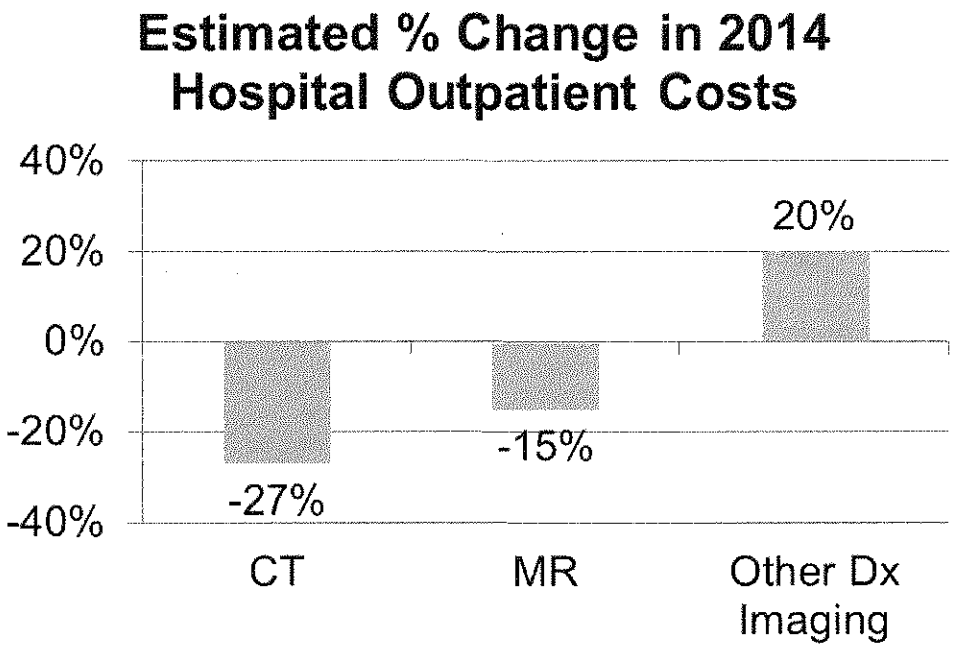

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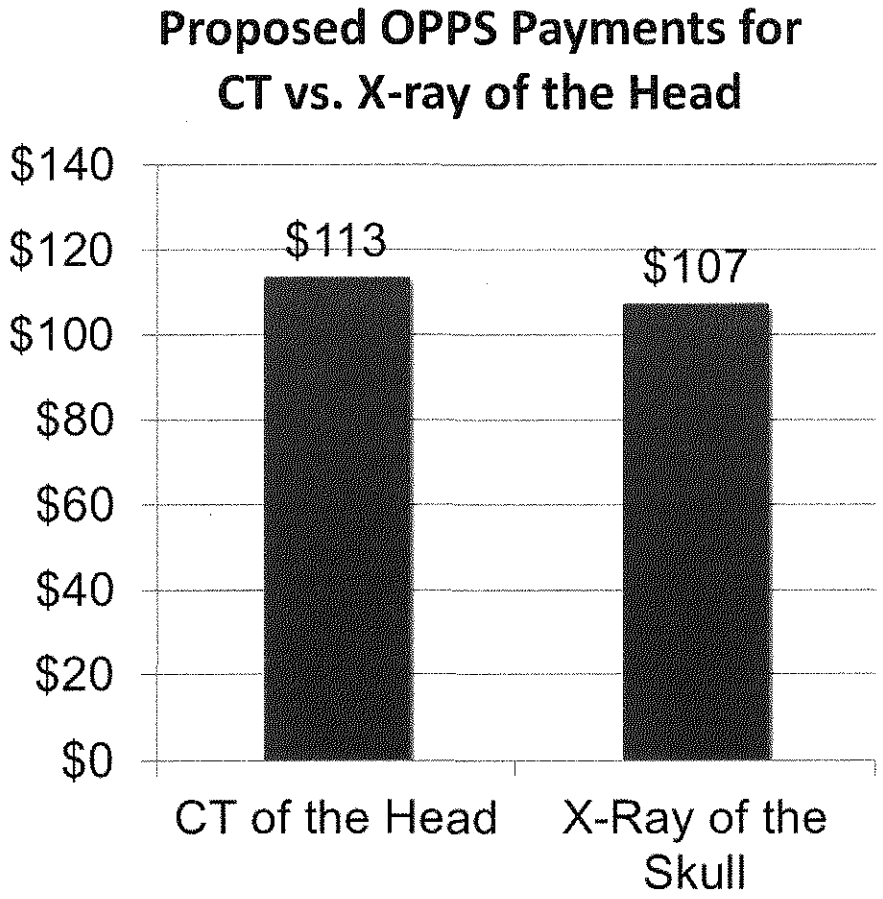

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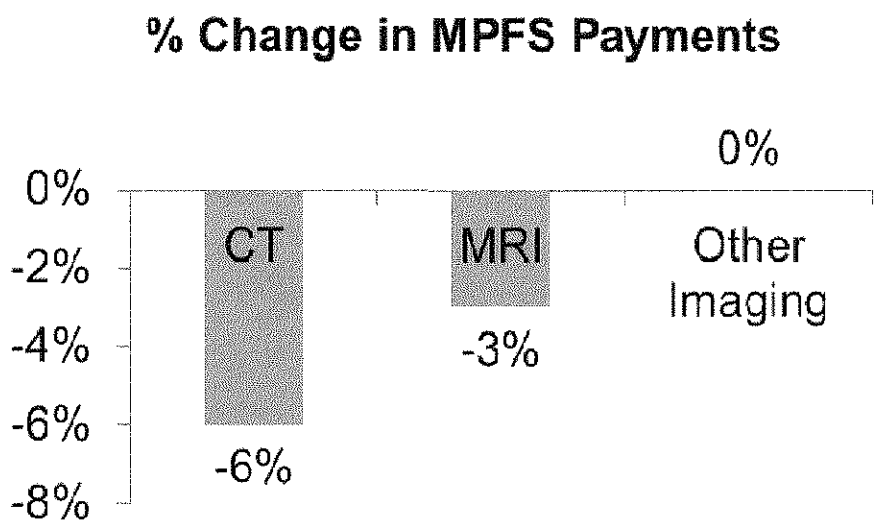

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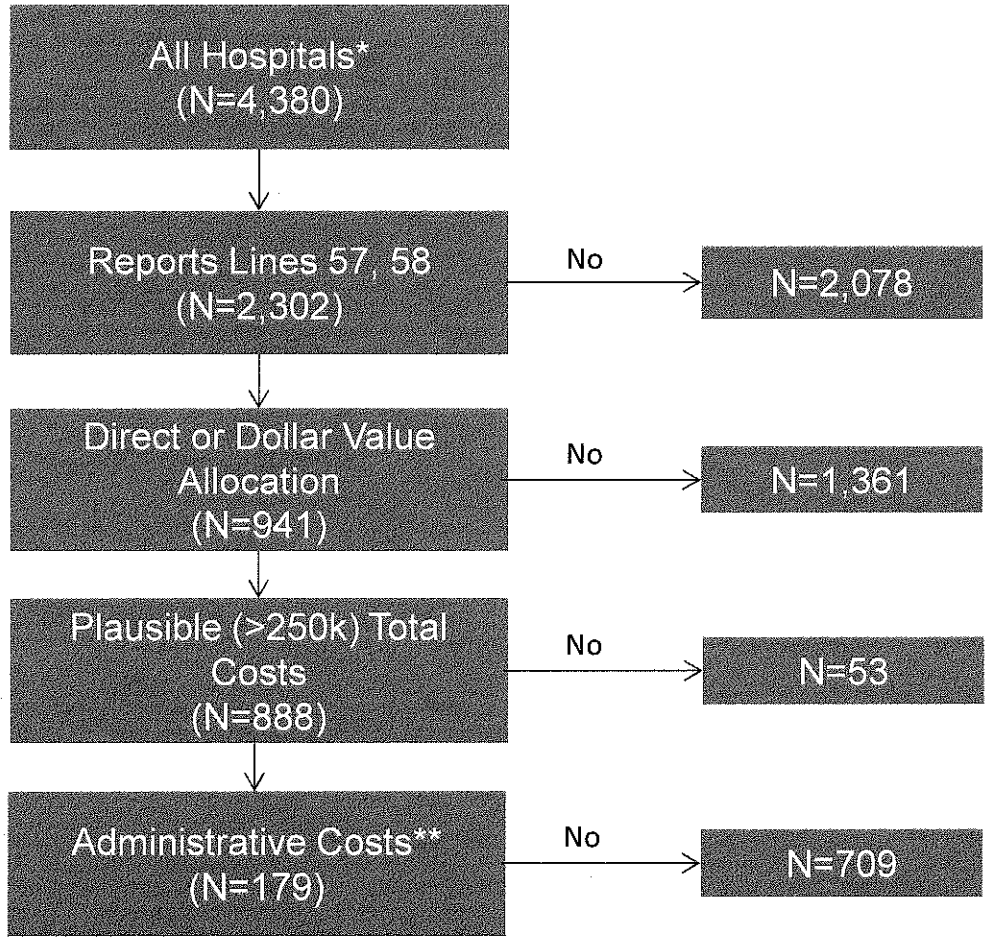

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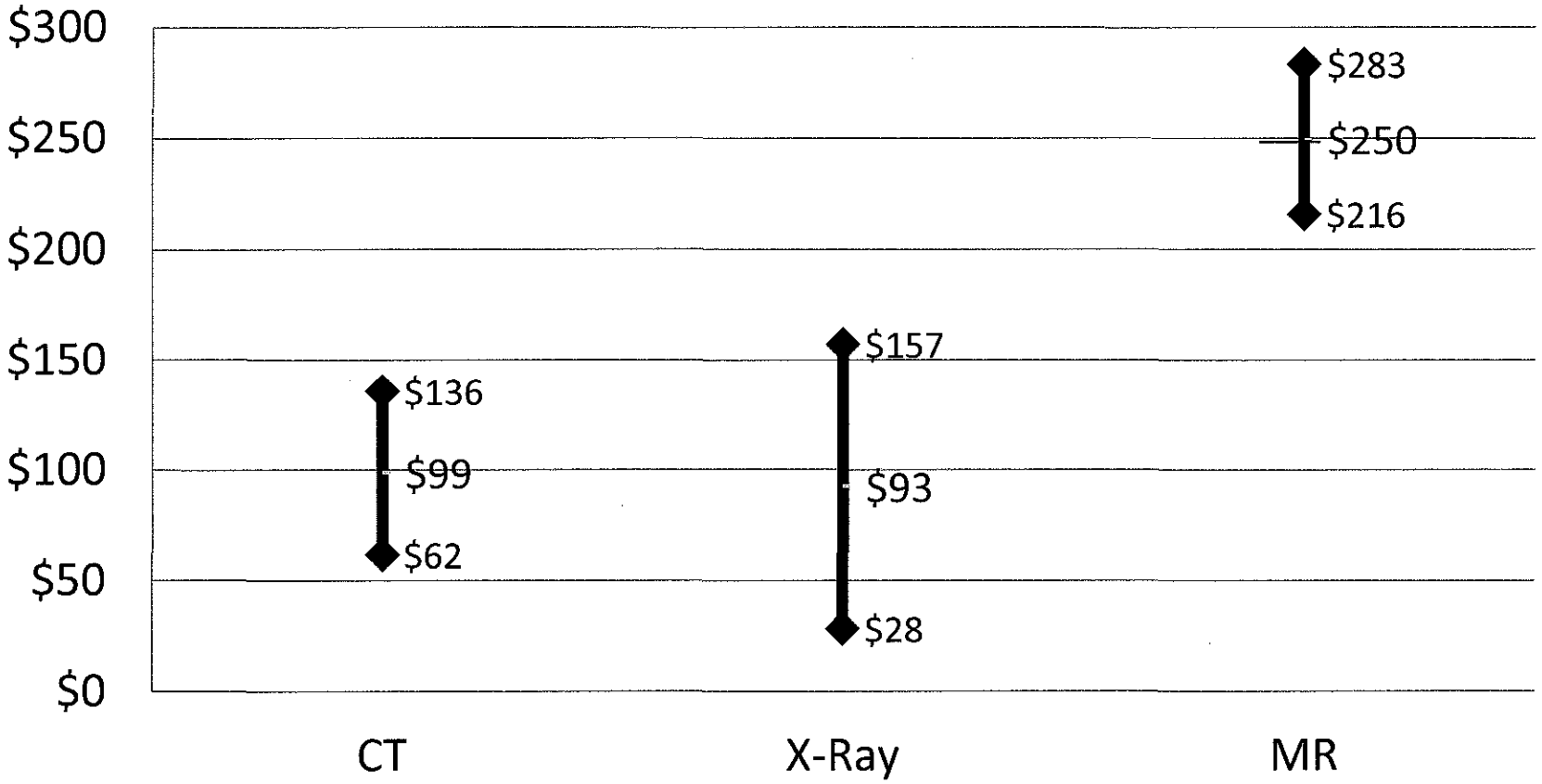

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