The Affordable Care Act: Part IV of V

By Tom Szostak

This is the fourth in a five part series on the changes due to healthcare reform and their impact on imaging. Part IV addresses medical imaging's role in supporting clinical transformation.

The Affordable Care Act (ACA) is framed around three core tenets: improving access to care for patients, increasing the quality of care from providers, and reducing the total cost of care to the federal government that will help to ensure the Medicare program remains solvent for years to come. It sounds simple. But putting all the programs, policies, and players into motion is equivalent to piecing together a 100,000 piece jigsaw puzzle. Some parts look as if they should fit, when in reality, they really don't. It is a massive undertaking when one considers that the healthcare sector represents one-sixth of the US economy.

Providers of healthcare services are having to make decisions regarding the future of their practices based on shifts in the marketplace that are being driven by several variables of the ACA. Delivery reforms are driving alliances, mergers, acquisitions, and consolidation between physician practices, hospitals, health systems, and insurance providers. Insurance reforms have created new health plan products that have shifted increased responsibility and accountability to policy holders for managing their health and healthcare costs. The healthcare consumer has emerged as health insurance plans have transformed in concert with delivery reforms and employers have increased the cost burden of health premiums to employees.

So what about medical imaging? What is the role of medical imaging in the midst of these reforms and marketplace shifts that have transformed faster than clinical care? Medical imaging, once the most lucrative outpatient profit center within the hospital setting, has seen its world flip upside down as it struggles with the paradigm shift to cost center management driven by the emergence of alternative payment models. Freestanding centers and office-based medical imaging have shifted as patients with commercial insurance products are increasingly requesting prices before scheduling appointments; forcing providers to reinvent pricing that appeals to the new healthcare consumer and to consider the implications of failing to make prices transparent. The end result of these changes is supposed to make care more affordable, accessible, connected, and elevate the quality of the service.

Medical imaging, for the most part, is diagnostic in nature. It is usually an ancillary procedure adjunct to a primary service. There are therapeutic services, but for the most part, it represents a small percentage within the domain of radiology. The emergence of alternative payment models has seemingly neutralized the profitability aspect of medical imaging. Understanding the implications that excessive and medically unnecessary imaging can have in terms of spending will be the key to success in radiology's profitability paradigm shift.

So, medical imaging is at the crossroads of change. And providers of imaging services have challenges and opportunities to elevate the value of imaging services for patients and the referring physician community, which seeks more than a transactional service. Cost or spending is a recurrent theme throughout quality initiatives and new delivery models of care. Within the context of reform, there is no escape from it.

Accountable Care Organizations (ACOs) require Medicare providers to share risk with the federal government in managing cost and quality measurements for a defined beneficiary population. Patient management and risk are assumed by a collective of primary care physicians. The cumulative spending of the population is weighted based upon the last three years of Medicare healthcare spending. A per capita spending measurement is established and it becomes the key financial benchmark that will determine whether the ACO is eligible for a shared savings payment from Medicare. Quality metrics are tied to the financial benchmark and must be achieved in order for a payment distribution to occur. So, how would a radiologist participate in a program that is defined by a cooperative of primary care physicians?

When a patient enters the healthcare maze presenting with a symptom that a primary care physician is uncertain of,

TABLE 1. ADDENDUM B. CY 2015 RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING FINAL MEDICARE PAYMENT

CPT1/ HCPCS	Modifier	Modality	Description	Annual Units of Service for 5,000 beneficiaries	2015 Medicare Free Schedule Payment Rates	2015 Hospital OPPS Rates	Net Spending Savings/ Per Procedure	Estimated Savings Based on Assumptions & Volumes
70450	TC	CT	Ct head/brain w/o dye	1,200	$73.08	$119.97	($46.89)	($56,268.00)
70553	TC	MR	Mri brain stem w/o & w/dye	800	$262.22	$482.89	($220.67)	($176,536.00)
71020	TC	XR	Chest x-ray 2vw frontal&latl	600	$16.84	$59.34	($42.50)	($25,500.00)
72141	TC	MR	Mri neck spine w/o dye	450	$149.02	$286.30	($137.28)	($61,776.00)
72142	TC	MR	Mri neck spine w/dye	450	$233.92	$426.88	($192.96)	($86,832.00)
72158	TC	MR	Mri lumbar spine w/o & w/dye	600	$262.58	$482.89	($220.31)	($132,186.00)
73221	TC	MR	Mri joint upr extrem w/o dye	500	$167.29	$286.30	($119.01)	($59,505.00)
73223	TC	MR	Mri joint upr extr w/o&w/dye	500	$361.09	$482.89	($121.80)	($60,900.00)
73560	TC	XR	X-ray exam of knee 1 or 2	120	$19.70	$59.34	($39.64)	($4,756.80)
74176	TC	CT	Ct abd & pelvis w/o contrast	750	$112.13	$236.76	($124.63)	($93,472.50)
78451	TC	NM	Ht muscle image spect sing	200	$286.58	$1,140.10	($853.52)	($170,704.00)
78452	TC	NM	Ht muscle image spect mult	1,200	$411.25	$1,140.10	($728.85)	($874,620.00)
93350	TC	US	Stress tte only	1,200	$170.87	$422.58	($251.71)	($302,052.00)
93880	TC	US	Extracranial bilat study	200	$164.78	$189.55	($24.77)	($4,954.00)
				Total Estimated Net Benefit to ACO from Imaging Patients in Non-Hospital Setting				**($2,110,062.30)**

Rates are based on national rates with geographic payment or labor weighted adjustments.

medical imaging or pathology is usually one of the first orders placed to get a better understanding of what is wrong with the patient. Ensuring that the primary care, mid-tier, or physician specialist community is well-educated as to what is the most appropriate imaging test for the patient's symptoms is critical to moving the patient through the care cycle as quickly as possible.

In this newly created and evolving culture of ACOs, medical imaging spending can wreak havoc on the per capita benchmarks assigned to the cooperative of primary care physicians if there is no formal education, outreach, or decision support tools from the radiologist community. As mentioned previously, per capita spending is one of the key shared savings metrics that determines incentive payments.

Radiologists can support the quality and cost initiatives for an ACO by serving as managers of medical imaging utilization. Providing guidance as to the "right test for the right ailment" is just one of the key roles that radiologists can play to better serve the physician community. Reviewing trends in ordering patterns and the pathology of imaging studies associated with disease types can serve as a baseline measurement that enables clinicians to better understand what was or was not appropriate for the patient's condition.

This signifies a shift in the passive, order-taker culture that has evolved within the specialty as "more reads" translate to "more money." The culture of an ACO is contrary to this behavior and demands a change by all providers to be engaged with what is appropriate for the patient. It aligns with Medicare's cultural shift from being "passive payers" to "active purchasers" of healthcare services. Radiologists who can demonstrate their clinical value in the context of health economics will be invaluable to the primary care cooperatives.

How can a radiologist elevate his brand by adding value as it relates to cost and quality? Radiologists who provide office-based imaging maintain significant competitive advantages over hospital-based outpatient imaging. First, statutes defined by the Deficit Reduction Act of 2005 and the Multiple Procedure Payment Reduction (MPPR) had significant impacts on Medicare reimbursements for medical imaging provided in the freestanding center or office-based place of service. Once considered a detriment to practices in this setting, the emergence of an ACO model within the Medicare program supports moving patients to facilities that can provide high quality imaging services that are lower in cost.

Table 1 shows an example of the reduced spending impact that would benefit an ACO if it moved all imaging from hospital-based outpatient facilities to freestanding imaging centers or office-based imaging facilities. This assumes that all imaging studies were previously referred to hospital outpatient facilities and transitioned to Medicare Fee Schedule based facilities. The potential improvement to the bottom line of annual per capita spending is significant and would benefit the primary care physicians participating in the shared savings program. In addition, Medicare beneficiaries would have an economic benefit from a lower copayment requirement.

Freestanding centers offer ease of access and scheduling, customer service focused on the patient's experience, and decreased risk of infection from keeping the population out of the hospital. The staff at freestanding facilities understand how good service can influence future referrals from the physician community. Patients also discuss their experiences with family members and peers which can have positive or adverse effects on operations.

Hospitals haven't been historically known for marketing their brands to the local physician communities or patient populations they serve. Hospitals have taken their community presence as a "known entity" and not a "brand." As healthcare evolves, primary care physicians share risk and consumers become more engaged with all aspects of their care, which has forced hospitals to re-evaluate their marketing game plan. As patients become better educated, hospitals will have to create or build a brand that can effectively compete with the freestanding or office-based imaging centers within the context of delivery reform. Radiologists who support this type of enterprise would need to ensure that they work with their referral base to ensure that the studies provided were of the highest quality and guided the physician to the correct course of treatment for the patient. As pioneering radiologists transform the delivery of care through taking an active role in managing the patients alongside primary care, mid-tier, and specialists, this evolves into other aspects of delivery reform that elevates the services that radiologists provide.

Payment bundling initiatives that are being administered through Medicare's Innovation Center work in a similar manner as they translate to the radiologist's role in managing the imaging services for a defined cohort based upon a patient's disease state. Measurement of effectiveness of payment bundling initiatives will be based upon spending and quality metrics associated with the defined episode. Radiologists can participate in this initiative by aligning with the specialists who elect to share risk with providers who assume responsibility for managing the care of a patient's episode from pre-admit, inpatient stay, and all services post-discharge from 30, 60, or 90 days. Radiologists work in concert with providers to ensure that the most clinically cost-effective imaging studies or therapies are utilized in order to ensure the patient has the best possible outcome. Overutilization of services within any phase of the patient's care can drive up costs and reduce the profitability of the assigned payment that the contracted entity has negotiated with the Medicare program.

Radiologists and the medical imaging sector have a great opportunity to elevate the specialty under the guise of delivery reform. Aligning with stakeholders who are focused on increasing quality, reducing cost, and improving the health and satisfaction of patient populations will help to redefine the value of imaging services. Participating in delivery reform programs can increase local market share and result in the redefining role of medical imaging in patient care as it builds a bridge leading toward clinical transformation.

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