New Payment Models and the Role of Radiology

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The Reasons Behind the Change

- Fee for service, without appropriate checks and balances, rewards volume
- More procedures equals more money for those performing procedures
- However, as the U.S. spends an alarming 17 percent of its GDP on healthcare, and this percentage has been continuing to grow, at some point healthcare will become unaffordable

The Reasons behind the need for change

- When healthcare costs go up, healthcare becomes less affordable for everyone, leaving many uninsured or underinsured
- If there is no system of checks and balances, other options have to be considered

MPFS Comparison 2015 to 1010

		2015			2010			Delta 2015 compared to 2010		
Exam		**Global**	**Tech**	**Prof**	**Global**	**Tech**	**Prof**	**Global**	**Tech**	**Prof**
MRI Brain w/o	70551	$250.16	$171.11	$79.06	$538.20	$459.91	$78.29	**($288.04)**	**($288.80)**	$0.77
MRI Brain w/	70552	$349.22	$253.13	$96.09	$601.25	$506.68	$94.57	**($252.03)**	**($253.55)**	$1.52
MRI Lspine w/o	72148	$241.49	$162.04	$79.45	$493.00	$414.31	$78.69	**($251.51)**	**($252.27)**	$0.76
MRI Lspine w/	72149	$348.79	$252.71	$96.09	$599.69	$505.12	$94.57	**($250.90)**	**($252.41)**	$1.52
MRI Pelvis w/o	72195	$411.47	$333.15	$78.32	$536.29	$458.74	$77.55	**($124.82)**	**($125.59)**	$0.77
MRI Pelvis w/	72196	$450.26	$356.80	$93.46	$593.92	$502.39	$91.52	**($143.66)**	**($145.59)**	$1.94
MRI Lower Extr Jt	73721	$256.42	$183.72	$72.70	$517.38	$445.49	$71.89	**($260.96)**	**($261.77)**	$0.81

MPFS Comparison 2015 to 1010

		2015			2010			Delta 2015 compared to 2010		
Exam		**Global**	**Tech**	**Prof**	**Global**	**Tech**	**Prof**	**Global**	**Tech**	**Prof**
CT Head w/o	70450	$126.00	$80.45	$45.56	$206.37	$161.37	$45.00	**($80.37)**	**($80.92)**	$0.56
CT Head w/	70460	$176.17	$115.53	$60.64	$268.27	$208.53	$59.75	**($92.10)**	**($93.00)**	$0.89
CT Abd/Pelvis w/o	74176	$217.24	$123.41	$93.83	$515.09	$394.05	$121.04	**($297.85)**	**($270.64)**	**($27.21)**
CT Abd/Pelvis w/	74177	$340.05	$241.67	$98.38	$654.38	$525.40	$128.98	**($314.33)**	**($283.73)**	**($30.60)**

Integrated Care Payment Models and Bundled payments

- As previous attempts to have Medicare use HMOs have not been successful, and as the government has difficulty controlling healthcare providers at a micro level, consideration began in the Centers for Innovation for a macro solution

- Instead of paying per procedure, which drove up the number of procedures, payment will now be grouped in various manners

Accountable Care Organizations

- The control is in the hands of the primary care physicians of the ACO (in Maryland)
- For an agreed upon number of lives, the cost of care is negotiated
- If the ACO is able to keep costs under the negotiated level, they may receive additional reimbursement (Incentive)
- If the ACO is not able to keep costs below a certain level, they may have to return money (Risk)

Bundled Payments

- Episodes of Defined Care types will be paid at a fixed rate
- The actual disbursement of payments to different providers is yet to be determined
- Currently most reimbursement for procedures is still fee for service, although this will likely change

The Role of Imaging

- While imaging has come under scrutiny for its cost and its increased usage over the last decade, imaging is highly useful and can help to diagnose disease, triage patients, and direct care

- Overutilization of imaging is harmful due to increased radiation exposure to the public, increased cost, as well as the detection of additional findings which cause worry to the patient and cost to the health care system

- Underutilization of imaging is harmful as patients may not be diagnosed and evaluated in a timely manner

Quality in Imaging

- Quality of imaging, and the appropriateness of imaging are of the utmost importance
- The right test, at the right time, performed optimally with results given promptly to the caregiver, for the benefit of the patient, is the goal of imaging
- Imaging must be performed with the least amount of radiation needed for the exam
- Radiation therapy should only be performed if necessary
- Anything less is unacceptable, and harmful to the patient

The Role of the Radiologist

- To help determine if the correct test is ordered
- To direct the best protocol for the examination with the highest quality equipment and to render an interpretation for the optimum patient care
- To be accessible to patients in many geographic locations
- To help guide other members of the ACO or other Integrated Care entity in the appropriateness of imaging
- To help avoid overutilization, while making sure imaging is not underutilized as patients should have appropriate care, and not withholding of care

Access does not equal Ownership

- Imaging and Radiation therapy may be accessible in many scenarios, without ownership by the ordering physicians
- Examples include hospitals, but can also include members participating in ACOs and Integrated Care Networks
- The necessary piece in this puzzle is integration of the Radiology information system into the Electronic Medical Record of the Healthcare Entity
- This allows ease in ordering, knowledge of other examinations the patient has had, and allows transmission of that information to other members of the ACO or other Integrated Care Entity

Examples

- Advanced Radiology and ARS have connectivity to over 2000 practices, with connectivity of web portal for images and reports, as well as connectivity to EMRs
- RadNet participates in New Jersey with a Healthcare system, with full integration and also has Radiologists who guide the performance of imaging, to assure the right test at the right time
- This has resulted in a significant savings in the last year for that healthcare system

Examples: American College of Radiology survey of members of the Radiology Integrated Care Network 2015

- Thirty-two percent of these practices have been capitated by a health plan prior, and only 27 percent (or six respondents) have been approached to work in an alternative payment model by either a community hospital, independent practice association (IPA), or Accountable Care Organization (ACO).

- The primary model proposed was an ACO, with disease-specific bundle and capitated model tied for second.

- Two of the groups are getting capitated payments, three groups report they continue to be paid fee-for-service in their models, and only one reports a shared-savings agreement.

Examples: American College of Radiology survey of members of the Radiology Integrated Care Network 2015

- It appears that all arrangements are tied to reporting of quality measures and cost savings. Five respondents in this sample reported having contracts with one ACO. A majority of them were involved in IT decision-making and were using some form of clinical decision support.

- Although there had been some discussions in sharing in the savings, it had not actually taken place, and the message was that it is too soon to tell how their efforts would translate to bonuses.

Examples: Radiology benefits managers (RBMA) data 2015

- Alternatively, 80 RBMA members participated in the RIMTF's Alternative Payment Models mini-Survey. Forty-seven percent represented hospital-based private practices and the other 53 percent were a combination of hospital-based and imaging-center based private practices. Thirty-seven percent (or 21) are either currently in an alternative payment model or planning to enter into such an agreement; about half (12) have entered into a final agreement.

Examples: Radiology benefits managers (RBMA) data 2015

- A majority of the 12 were able to provide some input into the process, whether it was hospital board participation, planning for the use of clinical decision support, or discussions of sharing in the savings.

- Only a few were in capitated agreements, some in shared savings/risk models, a majority (58 percent) reported being in fee-for-service with a potential bonus, with some indications of gain-sharing and episodic fee-for-service agreements as well. Almost all of the agreements are tied to reporting of some type of quality measure which varied significantly in the type of measure.

Conclusions by Radiology and RBMAs

- Both the ACR and RBMA encourage radiology practices to prepare for when the opportunity to become involved in new payment models arises. The recent announcement by Secretary Burwell (to tie 30 percent of fee-for-service Medicare payments to quality or value through APMs, ACOs, or bundled payments by the end of 2016, and 50 percent of payments to these models by the end of 2018) shows that the transition is inevitable. Medicare, private payors, and ACOs' focus has been centered on establishing primary care services for patients and has not yet given specialists the same kind of attention. However, radiologists and their practices can help their local institutions and communities realize their value-added services.

Conclusions from ACR and RBMA

- The ACA and MACRA mandate that fee-for-service payments be maintained. Therefore, moving forward, it is likely that radiology will continue to see a mixture of payment mechanisms in addition to fee-for-service

- It is important to reiterate that radiology practice's value-added contributions must be recognized in order to optimize radiology contributions and to participate in shared savings.

Question: If there is integrated care with risk, is the self referral law needed?

Answer: Yes

- While the SGR repeal bill does incentivize physicians to move towards coordinated care models, it also retains a modified fee-for-service policy now referred to as the Merit-based Incentive Payment System (MIPS)

- Self-referral restrictions will still need to be retained for the MIPS program to work well. Even in private markets within various states, some sort of modified fee-for-service component needs to be retained for the considerable future

- As a result, self-referral restrictions will help eliminate unnecessary imaging which will help preserve health care dollars plus improve patient care

Question: With Clinical decision support mandated by CMS starting 2017, will there still be a problem with self referral? Answer: Yes

- With respect to CDS policy and self-referral, the provisions passed within PAMA last year are NOT a panacea for abuse based on financial self-interest
- This is due to the fact that the policy only requires ordering physicians to consult, not adhere to, the appropriateness criteria
- While there is the outlier policy that mandates providers whose ordering behavior consistently deviates from the AC be subjected to prior authorization, that is restricted to 5% of the ordering physician population
- Without a hard stop, ordering physicians who are financially self-interested can still generate unnecessary referrals and continue overutilization

Maryland is Special and Unique

- Maryland is the only State to receive the Medicare Waiver, with additional Federal funding of approximately 1.6 billion annually

- In order for Maryland to maintain the Waiver, and receive its funding, it must maintain a cost of health care to Marylanders below a certain level

- Initially, this was only for hospitals, but will be expanded within the next year or two to the outpatient setting as well

Why is Self Referral Important in this Context?

- Self referral of Imaging and Radiation therapy has been shown over and over again to increase utilization
- While some studies with faulty designs have had some confounding data, the US government's own GAO has found that self referral drives procedures and increases costs
- Exceptions to the self referral law or its dismantling can only lead to more scanners, more Radiation therapy equipment and more utilization
- Increased utilization leads to increased cost and greatly threatens our unique Maryland Waiver

A Final Question

- Q. Does the Maryland self referral law keep ACOs and other Integrated Care models from incentivizing providers within their networks?

- A. No. While the Federal Stark laws invoking anti-kickback statutes may do so, Maryland's self referral law does not. CMS is considering these statutes in regards to the bonusing of physicians for meeting certain metrics, within an integrated care practice, which is covered under the Federal Stark Law.

Conclusions

- Radiologists are beginning to participate in the new Integrate Care Networks, with an import role in Clinical Decision Report and in Quality Metrics

- Radiology practices, in providing all types of imaging, to all patients, regardless of insurer, with ease of access due to multiple geographic locations, web access to images and reports, integration with referrers' EMRs, is best equipped to participate in the new Integrated paradigm

Conclusions, continued

- Access does not need Ownership!
- Multiple physician groups can work together in an integrated manner, without the need for the ordering physician to own the equipment or employ physicians of other specialties in order to obtain the technical component of high-cost procedures
- Our current Statute provides the opportunity for exemptions, if deemed appropriate, by the Secretary of DHMH
- Maryland's Self Referral Law is important to the maintenance of Maryland's unique waiver