

Academic Radiology in the New Health Care Delivery Environment

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Rationale and Objectives: Ongoing concerns over the rising cost of health care are driving large-scale changes in the way that health care is practiced and reimbursed in the United States.

Materials and Methods: To effectively implement and thrive within this new health care delivery environment, academic medical institutions will need to modify financial and business models and adapt institutional cultures. In this article, we review the expected features of the new health care environment from the perspective of academic radiology departments.

Conclusions: Our review will include background on accountable care organizations, identify challenges associated with the new managed care model, and outline key strategies—including expanding the use of existing information technology infrastructure, promoting continued medical innovation, balancing academic research with clinical care, and exploring new roles for radiologists in efficient patient management—that will ensure continued success for academic radiology.

Key Words: Accountable care organization; research; informatics; quality; value.

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Continued growth in health care spending with a constantly aging population has propelled concerns about the solvency of the current health care system in the United States. Health expenditure has risen dramatically over the past 50 years (17.4% of gross domestic product compared to 11.4% for Canada in 2009); however, US health performance lags behind by comparison based on indicators such as life expectancy, quality, access, efficiency, and equity (1,2). Nonalignment of cost with performance triggered the 2010 panel discussion by the Institute of Medicine. Factors identified by the Institute of Medicine as contributing to the cost-performance nonalignment included prevalence of chronic disease, lifestyle, and population health demographics (such as the obesity epidemic), but also inefficient delivery of services (excess administrative costs, unnecessary services, high pricing, deficiency in preventive care, and fraud, amounting to \$765 billion) (3). Furthermore, considerable

variation in quality of care (as indicated by readmission rates per Medicare beneficiary) has been reported without correlation to regional costs (4,5).

In this article, we will broadly review the landscape of the new health care delivery environment from the perspective of academic medical institutions and anticipated impact on the future of radiology. Our review will include a background on accountable care organizations (ACOs) and challenges associated with the new managed care environment, use of technology for managing data-intensive environments, role of radiologists in medical innovation, defining new boundaries and roles for radiology in patient management, and implications of balancing academics and clinical care.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Payment reform is based on the premise that the current fee-for-service (FFS) payment incentivizes physicians to increase services with consequent excess utilization. Overuse of subspecialty services relative to perceived appropriate level of management in the primary care environment has resulted in the targeting of subspecialist physicians including radiologists and procedure-centric physicians such as interventional cardiologists or gastroenterologists. In an attempt to avoid overuse of imaging and subspecialist referral, several payment models have been put forward ranging from prospective payment for discrete episodes of care to global payment or risk-based care (6).

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Direct Mechanisms for Reduced Reimbursement

Global prospective payments were a key feature of managed care programs that peaked in the 1990s. However, anticipated payment capitations were stemmed by unpopular restrictions on choice and access to services. More than a decade later, concerns regarding nonalignment of health care cost and quality have renewed the interest in global payment schemes, in part through ACOs, introduced by the Patient Protection and Affordable Care Act (ACA) of 2010. The ACA also directly addresses expenditure on imaging services under the existing Fee For Service (FFS) model through increases in: (1) “assumed utilization rates” and (2) “multiple procedure payment reduction (MPPR).”

a) The assumed imaging utilization rate is used to determine practice expense relative value units for “expensive” imaging equipment (ostensibly encompassing computed tomography, magnetic resonance imaging, and positron emission tomography). A higher assumed utilization rate results in a lower technical component reimbursed through Medicare for each imaging study under such modalities. Since 1997, the assumed utilization rate was set at 50%; however, this has been increased to 90% beginning in 2014, as the result of the American Taxpayer Relief Act of 2012.

b) Multiple procedure payment reduction (MPPR) is a reimbursement model designed to capture savings from efficiencies consequent to multiple services being rendered in the same session. Originally applied to surgical procedures, MPPR permitted the highest-paying surgical procedure to be reimbursed in full while additional procedures would be reimbursed at a discounted rate. In 2006, the Centers for Medicare and Medicaid Services (CMS) introduced the MPPR into imaging services by instituting a 25% reduction to the technical component of computed tomography [CT], CT angiography, magnetic resonance imaging [MRI], magnetic resonance angiography [MRA], and ultrasound performed on contiguous body parts within one of 11 “imaging families.” Each of these families contained billing codes for an imaging modality paired with an anatomical region (e.g., CT of the spine; MRI or MRA of the chest, abdomen, or pelvis; CT or CT angiography of the lower extremities). In 2011, MPPR was broadened so that the reduction in reimbursement applied when contiguous body parts were scanned regardless of the relevant code family (7). In addition, the ACA has instigated a reduction in imaging reimbursement through increasing the MPPR of the technical component of a study from 25% to 50%. In 2012, CMS also decreased imaging reimbursement by reducing the professional component of a study by 25%. CMS further intends to apply the reduced payment scheme when different physicians provide diagnostic services to the same patient in the same session and has considered extending the MPPR to the professional and technical components of all imaging modalities (8).

In an attempt to address self-referral, the ACA requires physicians to disclose when referring patients to imaging facilities

they own. However, the likelihood of such disclosure limiting self-referral may be restrained because it is not accompanied by any direct impact on imaging reimbursement. However, transition of reimbursement schemes away from the FFS model would likely reduce self-referral.

ACOs

Although not specifically described by the ACA in the context of medical imaging, ACOs may have the largest impact on the future practice of radiology. ACOs have been described as networks of physicians and other providers that could work together to improve the quality of health care services and reduce costs for a defined patient population. The ACO comprises, at minimum, primary care physicians who can serve 5000 Medicare beneficiaries. Specialists and hospitals may be contracted. Evidence-based medicine, quality and cost control measures, and coordinated care must be demonstrated. Practitioners, including radiologists, do not have to work exclusively with an ACO.

From the outset, the ACA prescribed ACO reimbursement under an FFS model, with additional shared savings revenue available in exchange for reducing expenditures below benchmarks set by the Secretary of the Department of Health and Human Services. In 2013, CMS entered the first phase of its Bundled Payments for Care Improvement initiative, which has chosen select health care organizations as partners in episodic bundling of payments. By assuming more financial risk, providers can potentially net higher reimbursement under a bundled payment model as compared to the FFS model with shared savings. In the future, with expected growth of ACOs, payment models could move to partial or full capitation as providers take on full financial risk of caring for larger populations. A capitation model would theoretically reward organizations for delivering coordinated care in an effective and efficient manner. Private insurers have also experimented with bundled payments and capitation and will likely continue to do so as the results of the various CMS payment arrangement experiments are brought to light.

Payment Structure for Providers Under the ACO Model

The method of payment received by an ACO for services rendered may differ from that which it chooses to pay its providers. For example, although the ACO of the future may receive payment under a capitation model, it may pay its individual providers on an FFS basis or through direct employment. The American College of Radiology (ACR) Future Trends Committee argues for preserving imaging reimbursement under an FFS payment model, or some derivative thereof. The ACR argument is based on their belief that alternative models could prove unsustainable to the ACO in the setting of high technical costs associated with unchecked overuse. In other words, preserving the FFS model for reimbursement of imaging services within an ACO could be used to incentivize ordering providers to limit the utilization of

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