RADIOLOGY MANAGEMENT

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Cover photo (top): AHRA EF Chair, Lori Ann Burns, 2015 AHRA Award for Excellence recipients: James H. Scrivner, CRA, Belinda Escamilla, Deborah Clark, CRA, Terry Lynn Bucknall, CRA, 2014-15 AHRA President David Fox, CRA, FAHRA

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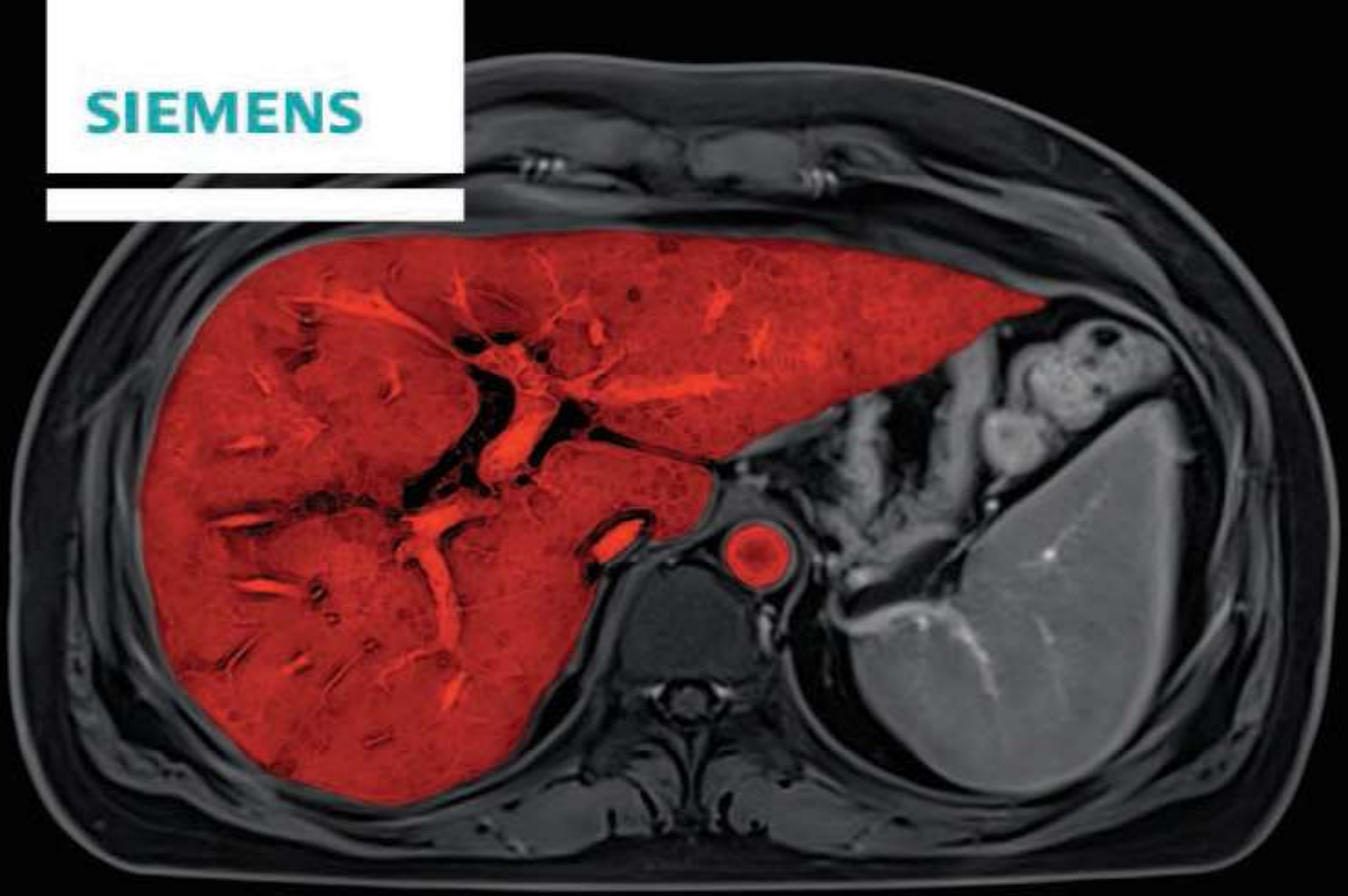

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MRI is "the best test for characterizing liver lesions" according to the ACR's appropriateness criteria[1]. While body MR imaging has grown 28% since 2013[2], abdominal MRI exams are still challenging and results can vary due to patient motion and breathing artifacts. At Siemens, we're helping make body MR imaging easier with FREEZEit—the exclusive technology named by Frost and Sullivan as the industry's most effective solution in abdominal MRI.

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Another example of Sustainable Healthcare Technology from Siemens.

[1]American College of Radiology Appropriateness Criteria 2014
[2]IMV 2014 MR Market Outlook Report
[3]This option is Pending 510(k) clearance, and is not yet commercially available in the United States.

[4]MR scanning has not been established as safe for imaging fetuses and infants less than two years of age. The responsible physician must evaluate the benefits of the MR examination compared to those of other imaging procedures.

Answers for life.

Full Circle

By Debra L. Murphy

A large member survey was conducted in early 2015 to gather feedback from you as to what AHRA is doing well, and where we can focus our attention and resources going forward. (Details on the survey results are provided by AHRA President Ernie Cerdena on p. 9). In this survey, by far, the attribute members cited as most important for their career development was expanding their knowledge of medical imaging management and keeping pace with the changing environment (69%). Next (41%) was to monitor regulatory issues that impact medical imaging management and keeping them informed.

With that, launching in this issue of *Radiology Management* is a new column "Regulatory Affairs" (p. 12). Sheila M. Sferrella is chair of the AHRA Regulatory Affairs Committee and provides on overview on some of the changes ahead for medical imaging (XR-29, clinical decision support, etc). The committee is working diligently on behalf of AHRA members and in collaboration with industry associations (ACR, HFMA, RBMA) to make sure CMS and other entities are well aware of your needs. There's also a lengthier feature article on site neutral payments (p. 16) in this issue. If there's something specific you want more in depth coverage on, let us know!

Professional associations like AHRA are unique in that its members are the owners, customers, *and* workforce.[1] Members have a relationship with the association because they have already made a financial commitment by paying dues. Associations also rely on member input to design, shape, and create product offerings, which they, in turn, purchase. The AHRA Board of Directors understands this and has taken the member survey and used it as an integral part of updating the AHRA strategic plan. This full circle process ensures we will continue to provide you with the tools and services you need for success.

[1] *Tecker GH, Meyer PD, Crouch B and Wintz L. "The Will to Govern Well." Second edition. Tecker International, L.L.C. 2010.*

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Greetings from China

By Paul Dubiel, MS, RT(R), CRA, FAHRA

I recently had the opportunity to go back to China with my family. As some of you know, my two girls were both adopted from China (the first in 1997, the second in 2003). The trip served two purposes. First was as tourists seeing the more historic and beautiful parts of the country. We went from Beijing where we saw the Great Wall and the Forbidden City to Xian to see the Terra Cotta Soldiers to Chengdu to see the Giant Pandas. All of the stops on the tour were well planned out and brought a new perspective of what China is like. Make no mistake—there is no place in the world like China, it is a beautiful country and I recommend anyone who has the time and desire to visit.

The second part of the trip was to take the girls back to their home towns. For my oldest, this was her second time back. Two years ago she went back as part of a high school exchange program. For my youngest it was her first trip back since we picked her up as a scrawny, sick 15 month old. Both girls' orphanages are now gone, but we still got to see the sites and visit the new orphanages and spend time with the staff and kids who were waiting for their chance to have a family like ours.

While both parts of the tour were inspirational and enlightening, one of the things that struck me is how everything has changed and the speed in which it has changed since my first trip in 1997. The country I visited in 1997 is a completely different country today. China in 1997 was still stuck in the old ways. It was only 10 years removed from the incident in Tiananmen Square. The one child rule was in full swing and bicycles ruled the day. Beijing was full of the ancient housing Hutongs and people still wore old style Mao suits. To say China was stuck in the past would be an understatement. China, for lack of a better term, was a third world country struggling to be considered one of the big boys. But they weren't there yet and they knew it.

Fast forward to 2003 and then to today—China was and is in the midst of a huge revival and economic boom. China was moving from a socialist farming economy to a more capitalist driven economy and political force to be reckoned with.

In their drive for change and to meet the demands of the modern global economy, China had to change everything they did. This included moving away from the past and becoming more like the rest of the world—and, specifically, more like us Americans. They changed their economic policies and views of the world. They made an effort to compromise the past to reach the goals of the future and it worked. Gone were the days of bikes everywhere. Cars are now the main source of transportation in big cities. Capitalism became king. China became a world power, economically and militarily, and gained a new sense of influence.

Along with growth came many other changes that were not well received. A lot of the old history of China slowly disappeared. As new infrastructure was needed to support the new economy many of the old ways slowly disappeared. Ancient city walls, neighborhoods that started during the old emperors' dynasties, and other historic places were all disappearing to make way for office buildings, highways, shopping malls, and apartments. New was good while old just got in the way and needed to be replaced in order for China to get ahead. China changed quickly, but not always for the better.

Eventually, the growth slowed down. The economy, while still growing, was not growing as fast as it once was. The real estate bubble burst with a huge number of apartments left unfinished. It was time to slow the growth and look around at what that growth had done to the country and it was not always what the people wanted. The Chinese people realized that they were losing their history and culture. Our tour guides all talked about the new found desire to remember the past and save what was left of historic sites that were slowly being destroyed in the name of progress. Slowly but surely the government realized that forgetting the past was sacrificing part of China's heritage. And there is a new sense of urgency in preserving and remembering the past as not something that should be forgotten, but as a building block for what the future needs to be.

I write this column not just to talk about my trip to China (although I can talk about that for days if you're willing to listen), but to emphasize the fact that American healthcare is similarly undergoing tremendous change. Article after article talk about how healthcare is evolving and will never be the same. That we need to leave the old behind and move forward with a new philosophy in order to survive and thrive. While all this is true, healthcare, just like China, cannot forget the past and where it's come from. We need to move forward, but we can't forget where we've been and the history of our organizations that helped us get to where we are today.

Each organization, regardless of for profit, not for profit, faith based community, or corporate, all have a history and story as to how they got to where they are. My organization has a faith based Catholic heritage. We can trace our core values back centuries to St Vincent DePaul and more recently Elizabeth Ann Seton. We, like every other healthcare organization, are faced with having to change our whole way of operating to meet the new realities of healthcare. Through it all we're still committed to keeping the message of our founders alive and well. And just like China who lost their way in the quest for a new way of doing things, holding true to the past is the only way to move forward in the future.

Paul A. Dubiel, MS, RT(R), CRA, FAHRA has been the senior director, imaging at Seton Family of Hospitals in Austin, TX since 2002. An AHRA member since 1993, he is currently editor-in-chief of Radiology Management *and has volunteered for numerous other task forces and committees. Paul can be contacted at pdubiel@seton.org.*

AHRA Member Survey Results: 2015

By Ernesto A. Cerdena, PHDc, RT, CRA, FAHRA

An online survey was conducted in February and March 2015. An email was sent to 4,325 members with 541 completing the survey (a response rate of 13%). Among participating members, 37% have been members from one to five years, 51% have been AHRA members for between two and ten years, and 40% have been members for more than 10 years. More than half are in administrator/director positions and a quarter are in manager positions. As for work setting, 61% work in a hospital, while 21% work in both a hospital and outpatient center. Only 32% of members manage departments other than radiology. There were slightly more female (54%) than male (46%) respondents, 59% were between the ages of 50–64, while 36% were between the ages of 30–49. There was good geographic distribution among all groups, with most participants coming from the Midwest, Southeast, or Northeast.

The four key challenges that were rated highest by members were all the types of concerns typical of a manager or senior manager:

1. Reimbursement
2. Regulatory issues/preparedness
3. Budgeting and financial management
4. Staffing

By far, the most important attribute members cited for their career development was expanding their knowledge of medical imaging management (69%). Next (41%) was to monitor regulatory issues that impact medical imaging management and keep members informed. This was followed by educational programs and training opportunities (31%).

Gap Analysis

A significant portion of this research was an Importance-Perception-Expectation (IPE) gap analysis. The IPE gap analysis is used to help understand the relationship between what members view as important and the perceived difference between performance and expectations. For example, a member might say that "price" is very important in their decision to purchase an item. But when asked what else is important in that decision, the member might also list another 10 items or attributes that are equally important. Thus, how does price actually "rank" in comparison to the entire set of decision criteria?

For members, the attributes with the highest importance and the greatest negative gap between expectation and performance were:

- Expanding knowledge of medical imaging management, keeping pace with changing environments
- Monitor regulatory issues that impact medical imaging management, and provide resources that address these issues
- Educational programs and training opportunities
- Advanced professional development opportunities in business and management
- Executive leadership development opportunities

This suggests that these are the areas that require the greatest degree of attention and resources from AHRA and which will also have the greatest return on investment because of their relative importance to members.

Net Promoter Score

Based on the concepts described in the book *The Ultimate Question*, by Fred Reichheld, respondents were asked one simple question: Would you recommend us to a friend or colleague? The ratings 0 (not likely to recommend) through 10 (likely to recommend) are calculated as: % of Promoters – % of Detractors = Net Promoter Score (NPS).

There are three categories of people:

- 77% of AHRA members are considered Promoters (those who answer 9 or 10)—loyal enthusiasts who keep buying from a company and urge their friends to do the same.
- 17% are considered Passives (those who answer 7 or 8)—satisfied but unenthusiastic customers who can be easily wooed by the competition.
- 5% are considered Detractors (those who answer 0 through 6)—unhappy customers trapped in a bad relationship

AHRA's Net Promoter Score is 72, up from 64 in 2012. This is an excellent score.

Figure 1 • Reasons for Being a Member

On Being a Member

In an open-ended question, members were asked to give the single most important reason they are members of AHRA. Top reasons included information, networking, education, information, and opportunities. Figure 1 is a word cloud that illustrates the responses. In a word cloud, words are sized in proportion to the frequency in which they appear in responses—the larger the word, the more times it was used.

By far, the most valuable AHRA member benefit is the *Radiology Management* journal, selected by two-thirds of members. The other top benefit is the AHRA Annual Meeting and Exposition, selected by nearly half of members. And 95% of members agreed with the statement "AHRA is the leader in creating, expanding, refining, and transferring the body of knowledge of imaging management to healthcare professionals."

Awareness of the CRA designation has inched up from 92% to 95% since 2012. 41% of respondents said that they are CRAs, compared with 31% of respondents in 2012. In an open-ended question, participants said the top reasons they have not pursued the CRA credential were: cost, time, and not yet qualified. Members had many reasons for pursuing the CRA credential: 36% became accredited for their own personal satisfaction and 27% became accredited for the professional recognition. Fewer members became accredited to become a better administrator, to meet career objectives, or because their companies or boss recommended it.

Regarding the Education Foundation, 78% of members have heard of it. Only 14% of members have applied for a scholarship through the Foundation. And 30% say they are likely to donate to the Foundation.

The Future

Several key themes emerged when members were asked to identify the knowledge and skills the best medical imaging leaders would need over the next five years:

- Flexibility and ability to successfully manage change
- Business acumen
- Financial and budgeting skills
- Regulatory knowledge and compliance
- CRA designation
- Ability to innovate
- Leadership skills
- Communications and people skills

As a result of this survey, the AHRA Board of Directors has been working diligently on updating the association's strategic plan. Stay tuned for details around its deployment this fall.

Ernesto A. Cerdena, PHDc, RT, CRA, FAHRA is the president of the 2015–2016 AHRA Board of Directors. He is the director of diagnostic imaging/radiology services at Waterbury Hospital in Waterbury, CT. He can be reached at ecerdena@wtbyhosp.org.

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SAMSUNG

Regulatory Changes ahead for Medical Imaging

By Sheila M. Sferrella, CRA, FAHRA

There was a time when radiology administrators had to worry about regulatory issues and changes only once a year. It was called the Current Procedural Terminology Manual update, which we ordered and received each October in time to make all of the changes to our charge description master for January 1. We were finished until the following October and could then focus on the operations of the department. Today, regulatory changes occur all year long, and—in addition to the incredible amount of work required to manage the department, imaging center or practice—it is almost impossible to keep abreast of them. Most administrators are not prepared for all of the changes coming in the next two years.

It's not unusual to hear people say they won't worry about these changes until they're sure the regulations will go into effect, a case in point being the ICD-10 delays. Waiting until the last hour hoping for a repeal or extension is probably not the best strategy. While most of the regulatory changes discussed here speak to the Medicare program, we all know that where Medicare goes, other payors follow.

This article was adapted from an article published in the June/July 2015 issue of Radiology Business Journal.

Cost Yin and Yang

Since the adoption of the Deficit Reduction Act (DRA) of 2005, regulatory changes have drastically increased the costs of delivering imaging services. Reductions in reimbursement and increases in paperwork and oversight required to meet regulatory mandates are challenging administrators to keep abreast. The only way to compensate for reduced reimbursement and increased costs was through an increase in volume, which could theoretically lower the cost per study if all else was equal. Of course, in these times of change, the status quo is a moving target.

The downward pressure on price is unlikely to disappear, and the "2013 Comparative Price Report" from the International Federation of Health Plans tells part of the story.[1] The average price of a CT/abdomen scan (Figure 1) ranges from $94 in Spain to $864 in the United States. The average price of an MRI study ranges from $135 in Switzerland to $1,145 in the United States.

The other side of the story is that prices in the outpatient setting have been reduced so significantly that the ability of freestanding outpatient imaging centers to survive on the Medicare Physician Fee Service (MPFS) technical component is beginning to have repercussions in the marketplace. For example, an analysis of multiple regulatory and legislative actions by radiologist Rodney Owen, MD, FACR, co-vice president of Southwest Diagnostic Imaging, Ltd., Scottsdale, AZ, found that payments for 2014 global charges for services performed at the practice's outpatient centers were just 65.9% of 2004 payments (Figure 2).

Michael Mabry, executive director of the Radiology Business Management Association (RBMA), recently shared two sobering statistics from a survey of RBMA members that operate imaging centers. A total of 24% of respondents reported a net loss of imaging providers in their markets, and 21% were looking to sell and/or close imaging centers.[2]

The Advisory Board reported a similar decline in their Health Care Industry Trends 2015 presentation. It cites data published in *Radiology Business Journal* showing the first decline in the total number of imaging centers (outside a recession linked correction in 2009) in the United States after nine years of growth.

Clinical Decision Support

The implementation of clinical decision support (CDS), which goes into effect January 1, 2017, will have the largest impact on imaging since the DRA. The mandate was included in the federal statute known as Protecting Access

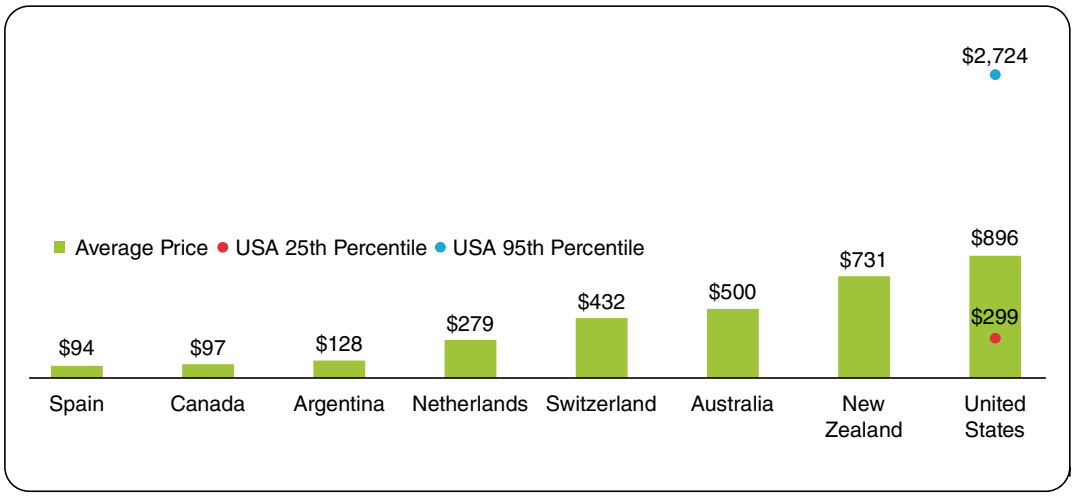

Figure 1 · The 2013 cost of a CT/abdomen in the U.S. is compared to the cost in seven other developed countries. The International Federation of Health Plans calculated prices from commercial claims data from the Truven MarketScan Research database. Reprinted with permission: International Federation of Health Plans.

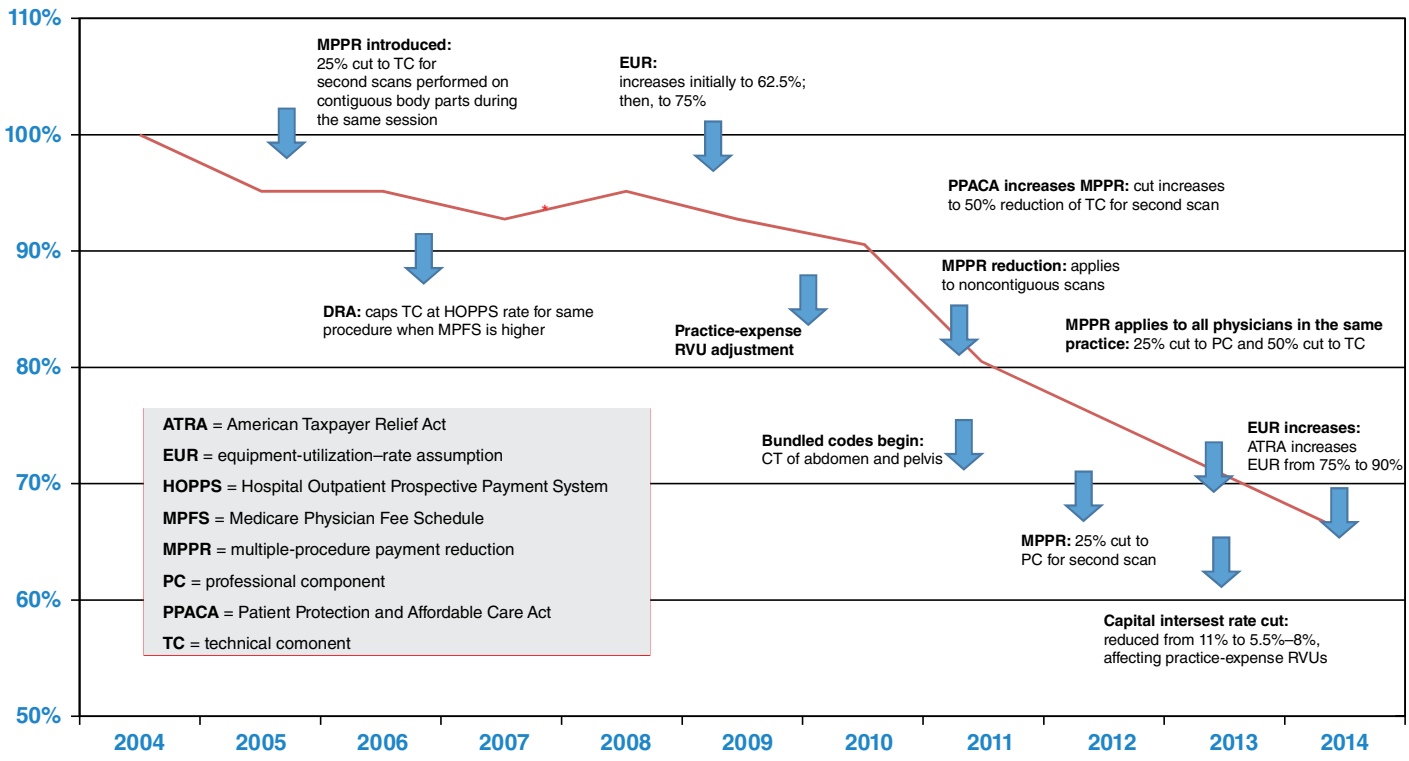

Figure 2 · The red line charts the impact on global payments, over ten consecutive years, of Medicare reimbursement cuts for medical-imaging services performed at the outpatient imaging centers of Southwest Diagnostic Imaging Ltd. The amount collected as a percentage of global billing in 2004 was defined as 100%. Courtesy of Rodney Owen, MD, FACR.

to Medicare Act (PAMA) Promoting Evidence-Based Care. It establishes a required process for clinicians who order advanced imaging services in physician offices, hospital outpatient departments, and ambulatory surgical centers to consult appropriateness criteria for certain outpatient advanced imaging services. Those services are defined as CT, MRI, nuclear medicine, and PET studies performed on Medicare outpatients.

CMS conducted a two year demonstration project to determine the efficacy of using CDS for these advanced imaging studies. In those studies, utilization of advanced outpatient imaging procedures for Medicare beneficiaries was reduced 20–30% on average. That reduction on top of all of the other imaging revenue reductions is staggering. What's more, the imaging provider has the responsibility to manage this process and report to HHS. This will place the radiologist and the imaging service in the middle of the decision process with the referring physicians—but at what cost?

In truth, there have been many times when technologists questioned why we were performing a particular study with the indications provided by the referring physician. The American College of Radiology (ACR) has been developing appropriateness criteria for more than 20 years, now available electronically as ACRSelect™. When a study is ordered, the system assigns an appropriateness score based on the diagnosis code entered by the ordering provider. If the test ordered receives a score that is questionable or inappropriate, an alternative that is more appropriate for the patient study is suggested.

I've never heard anyone question the appropriateness or necessity of CDS. What my colleagues tell me is that many of them cannot get their IT departments to address the implementation of CDS based on the precedent of so many ICD-10 delays. HHS does not even intend to release its list of approved vendors until April 1, 2016. This is, nonetheless, a way for imaging to bring value back into the equation for physicians, patients, and payors.

The impact this mandate will have on radiology benefits management (RBM) companies is unclear. Most RBMs currently use some form of automated CDS to pre-authorize tests for their patients. Will RBMs morph into another type of business?

Beginning in 2017, the HHS Secretary will collect appropriateness criteria and other data to identify ordering providers who are outliers. It is not clear how data will be collected, but I believe the imaging providers will have to identify ordering practitioner outliers. Currently, the number of ordering providers who will not have met the criteria for complying with CDS is projected to be no more than 5%. They will be required to submit pre-authorization requests for two years beginning January 1, 2020.

XR-29, Dose Reduction Monitoring

Another regulation that threatens imaging reimbursement is the requirement to move to XR-29, which refers to meeting the National Electrical Manufacturers Association (NEMA) standards for CT scanner dose, known as MITA Smart Dose, also implemented by PAMA. If a CT does not meet these standards, a 5% reduction in reimbursement will be applied for 2016, and a 15% reduction will be applied for 2017.

What will this cost hospitals and imaging centers? There are significant cost differences between vendors of $20,000 to more than $150,000 to upgrade existing scanners. Some CT equipment cannot be upgraded, so those departments or centers would have to buy a new CT scanner to comply with the regulation. According to estimates, 30% or more of existing CT installations cannot be upgraded and would need to be replaced. For some hospitals or imaging centers, it may make more financial sense to take the reduced payment than to purchase a new CT scanner with Smart Dose at a cost of $500,000.

Both CDS and XR-29 were included in a bill whose primary purpose was to provide a temporary, 12-month patch for the sustainable growth rate (SGR) formula, and the trade off to avoid a 24% reduction in payments to physicians who treat Medicare patients, which was passed shortly before midnight on March 26, 2014.

MPFS Final Rule

More than 200 imaging codes in the MPFS will be reduced because CMS is removing film cost inputs. The agency had asked for invoices for the cost of PACS and did not receive any, although it did receive recommendations from the Specialty Society Relative Value Update Committee (RUC) workgroup, of which ACR was an active participant. As a result, CMS used the negligible cost of a desktop personal computer to insert as a proxy for the cost of PACS. The ACR is now heading up a workgroup to develop the PACS inputs that will be presented to CMS in 2015 for consideration in the 2016 MPFS proposed rule.

AHRA also registered its disappointment with the formula to replace the film costs (E.J. Cronin, written communication, December 2014): "The AHRA agrees with the removal of the items associated with film technology for the 604 imaging codes provided by the RUC, but only where an actual migration of valid inputs takes place that reflects appropriate related PACS inputs. The cost of monitors for interpreting the images exceeds the cost of a desktop computer significantly. In addition, there are expensive information systems related to PACS that are not included in a PAC system, such as radiology information systems and speech recognition systems."

Site Neutral Payment

If a physician office is designated as an off-campus provider-based department (PBD), the hospital that owns the physician practice can bill Medicare for a

facility fee for the office visit, in addition to charge for the physician's professional service. In the 2015 Proposed Rule, CMS stated its intention to create a new modifier in order to track services performed in off-campus PBDs. Based on comments, they have decided to track this information on physician claims through the use of a new place of service (POS) code rather than a modifier.

CMS plans to delete POS code 22 (Outpatient-hospital) and request two new POS codes from the POS Workgroup. One code will represent outpatient services furnished in on-campus, remote, or satellite locations of a hospital. The other code will represent services furnished in an off-campus hospital PBD that is not a remote location of a hospital, a satellite location of a hospital, or a hospital emergency department. CMS does not expect the new POS codes to be available until July 1, 2015, but once they are available, providers must begin using them. Providers will continue to use POS code 23 (Emergency room-hospital) for emergency department services.

The new POS codes only apply to professional service claims. For hospital claims, CMS is creating a new modifier, PO (Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments). The hospital must apply this modifier to every code for off campus PBD services. The modifier went into effect January 1, 2015, but use of the modifier will be voluntary until 2016.

Site neutral payment policies have been on the agenda of the Medicare Payment Advisory Commission (MedPAC) for many years. The panel again recommended site neutral payments to lawmakers in its March report and, if adopted by Congress, the change could mean a $1.44 billion annual drop in reimbursement.[3,4]

The cost of providing service in a hospital setting is higher than in a freestanding facility. It takes less time to perform a study in an outpatient imaging facility. Most of the time, the patient is able to ambulate on their own, and the centers typically are open 8–10 hours per day. In a hospital environment, the staff has to manage inpatients who are transported on wheelchairs, stretchers or beds, emergency room patients, patients from physician offices and other sources. Moving inpatients on and off tables can add 10–15 minutes to each study. At a basic level, most hospitals have to provide diagnostic x-ray and CT services 24/7.

The potential impact of a site neutral payment system where hospital and freestanding facilities are paid the same rate would be tremendous considering the projected savings over 10 years is in excess of an estimated $30 billion, more than would result from raising the Medicare eligibility age to 67.[4] Health plans, cancer patients, nursing homes, primary care physicians, and internists have formed the Alliance for Site Neutral Payment Reform and are lobbying Congress for payment policies that would reduce Medicare spending while increasing pay for providers in the coalition. Site neutral payment appears to be at the top of the list of offsets that Congress is considering to offset SGR reductions,

What is interesting about these regulatory changes is that it is the first time there is involvement from so many different parties. We have vendors, physician groups, hospital associations, professional associations, and various industry and patient alliances trying to get a seat at the table. One thing is certain: the regulatory changes won't end anytime soon.

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Site Neutral Payments: An Overview

By Adrienne Dresevic, Esq and Leslie Rojas, Esq

The credit earned from the Quick Credit™ test accompanying this article may be applied to the CRA fiscal management (FM) domain.

EXECUTIVE SUMMARY

- A site neutral payment policy would entail CMS paying the same rate for the same healthcare service regardless of the location in which the service is provided. From the government's perspective, the reason behind this policy is potentially billions of dollars in savings.
- The rationale for using various payment systems is that there are different costs associated with providing healthcare services in different locations. Each payment system has a separate methodology for determining rates for services based on these costs.
- Hospitals may choose to prepare early for the inevitable through accurate cost reporting, shifting certain ancillary services to more appropriate outpatient, off site locations, and participating in the Medicare Shared Savings Program.

Every year, the healthcare community braces itself for new proposals seeking to cut healthcare spending. Imaging services often are on the receiving end of these payment cuts. One proposal that has captured the attention of the imaging community, as well as the wider healthcare community and hospitals in particular, involves site neutral payments.

Currently, the Centers for Medicare & Medicaid Services (CMS) pays different rates for the same healthcare service depending on the location where the service was provided (eg, hospital vs physician's office). For example, payment rates for a service provided in a hospital outpatient department are typically much higher than rates for the same service provided in a physician owned medical practice. In its purest form, a site neutral payment policy would entail CMS paying the same rate for the same healthcare service regardless of the location in which the service is provided. From the government's perspective, the reason behind a site neutral payment policy is simple: potentially billions of dollars in savings.

Payment Systems and Rates

In order to understand site neutral payment policies, one must understand how payment rates are determined for particular services. CMS established different payment systems for different healthcare settings. For example, payment rates for healthcare services provided in a physician owned medical practice are determined by the Medicare Physician Fee Schedule (MPFS). On the other hand, payment rates for services provided in a hospital outpatient department are determined by the Hospital Outpatient Prospective Payment System (HOPPS). Similarly, ambulatory surgical centers (ASC), inpatient hospital departments, skilled nursing facilities, etc, each have their own payment systems, which determine rates for the services provided at each location. The payment rate for a particular service is based on the location where the service was provided. As a result, payment rates may vary widely across locations—even when the same exact service is provided.

The rationale for using various payment systems is that there are different costs associated with providing healthcare services in different locations. Each payment system has a separate methodology for determining rates for services based on these costs. Typically, payment rates are meant to reflect the costs (both operation and capital) of providing the service, costs of operating the site, and the demographic of patients served at the site (eg, economic status). Rates usually

Due to the different methodologies used by the HOPPS and the MPFS, the payment rates vary dramatically across these two payment systems.

do not take into account the rates paid at other locations, and each location's payment system is often entirely independent from another payment system. However, the rates across payment systems for some advanced imaging services are interrelated. For example, with the enactment of the Deficit Reduction Act of 2005, Congress reduced rates for certain imaging services provided in the physician office location to the lower rates for the same services provided in the hospital outpatient location.

So, if payment rates are based on the costs associated with providing a particular service at a particular location, then how are these "costs" determined? In the hospital outpatient setting, the HOPPS uses a number of factors to estimate costs. Facilities such as hospitals are required to submit annual cost reports as a condition of participation in Medicare, and the cost reports are intended to show the actual costs incurred by the hospital. Simplified, the HOPPS methodology uses hospital claims data and annual hospital costs reports to determine estimated costs. More specifically, under the HOPPS methodology, costs are estimated by calculating the median costs (operational and capital) of the services within an ambulatory payment classification (APC) group using the most recently filed cost reports and claims data across similar providers.[1] Next, hospital specific and department specific "cost-to-charge ratios are used to convert billed charges to costs for each HCPCS code."[1]

On the other hand, the MPFS has its own methodology for determining payment rates for services provided by physicians in, for example, a physician owned medical practice. Each MPFS rate takes into account the physician's work, the practice expense, and the malpractice expense associated with a particular service, which is then adjusted for geographical differences.[2] The practice expense component is similar to the "facility fee" a hospital would receive for a particular service in that it is intended to reflect the individualized costs the physician incurs for staff, productivity enhancing technology, and materials.[2] Unlike hospitals, physicians do not submit annual cost reports to CMS. Instead, CMS estimates the costs associated with the practice expense component of a particular service.

Due to the different methodologies used by the HOPPS and the MPFS, the payment rates vary dramatically across these two payment systems. In June 2014, the National Institute for Health Care Reform reported on a study conducted by the Center for Studying Health System Change.[3] In the article, the authors discussed a number of common procedures for which the price differential based on location is significant. One example cited was the 2014 payment rates for an MRI of the knee with contrast (CPT code 73721), which, on average, paid out at a rate of $919 in the outpatient department setting versus $606 in the community based setting (eg, physician office).[3] This is just one example of payment discrepancies that have brought the issue to the forefront. Not surprisingly, in an effort to cut costs, the site neutral payment policies proposed by the government often involve neutralizing payments to whichever rate is lowest.

Because rates are calculated based on costs, then isn't the payment differential justified if different locations incur higher costs when providing the same service? The answer to this question often depends on who you ask (ie, the government, hospital providers, or other providers). Additionally, this question is complicated by the fact that many physician practices are now owned by hospitals. If these practices meet certain requirements, then they are reimbursed at the (typically) higher HOPPS rate rather than the lower MPFS rate – simply because they are hospital owned. Hospitals argue that it costs more for a hospital to run a medical practice than it does for a physician. In any event, the recent prevalence of hospital owned physician practices has caused the most recent push for site neutral payment policies.

The Move to Site Neutrality

Site neutral payment proposals are not new. The Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare payment policies, has advocated for site neutrality for years. In a June 2013 "Report to Congress," MedPAC advocated for site neutral payments and stated that[4]:

> [T]hese payment differences between settings may cause Medicare and beneficiaries to pay more than necessary and may encourage arrangements among providers that result in more care being provided in higher paid settings. Therefore, in its fee-for-service payment systems, Medicare should strive to base payment rates on the resources needed to treat patients in the most efficient (ie, highest quality, lowest cost) setting, adjusting for differences in patient severity to the extent that severity differences affect costs. In the absence of comparable data on providers' costs and quality across settings, *Medicare should base payment rates on the setting where beneficiaries have adequate access to care at the lowest cost to the program and beneficiaries.*

MedPAC recommended site neutral payments for certain services, including imaging services, that[4]:

1. are safe and appropriate to provide in physician offices and where the MPFS payment rate is sufficient to ensure access to care;
2. involve payment rates across payment systems (ie, HOPPS and MPFS) that include a similar set of services (ie, similar packaging);
3. are unlikely to incur costs associated with emergency room department visits;

4. have patient severity that would be no greater in outpatient departments than in physician offices; and
5. are not 90-day global codes, which are associated with higher costs when performed in the hospital setting.

Using these factors, MedPAC identified 66 categories of services organized by APC code and placed them into two groups.[5] Group 1 included 24 services that met all five of the above mentioned criteria, and for which MedPAC recommended equalizing payment rates across all locations. Group 2 included 42 services that met four of the five criteria, and for which MedPAC recommended reducing the difference (albeit not completely) between the HOPPS and MPFS rates. Imaging services in group 1 included: level I and level III diagnostic and screening ultrasounds; level II echocardiograms without contrast; MRI and magnetic resonance angiography without contrast; and axial skeleton bone density tests. Imaging services in group 2 included: level I radiation therapy and cardiac CT imaging. MedPAC estimated that the site neutral payment policies referenced in its June 2013 Report, coupled with its previous recommendations for site neutrality to be applied to evaluation and management services across locations, will result in Medicare program and beneficiary cost-sharing savings of approximately $1.8 billion per year.[4]

However, the American Hospital Association (AHA) vehemently objected to MedPAC's proposals and argued that HOPPS payment rates have already been reduced to unsustainable levels in the MPFS and that lowering hospital payments to such a rate would be devastating for hospitals.[6] The AHA argues, and MedPAC acknowledges, that hospitals incur costs that justify the higher payment rates. For example, hospitals are open 24 hours a day and are required "to screen and stabilize (or transfer) patients who believe they are experiencing a medical emergency, regardless of their ability to pay."[6] Additionally, patients treated in hospitals may have more severe conditions than patients in a physician's office. Hospitals also incur additional costs in the form of having to comply with more stringent licensing, accreditation, and regulatory laws. Hospitals also argue that the HOPPS payment rates include more "packaging" of items and services into a single payment than under the MPFS, and that the higher payment rates under the HOPPS reflect this increased packaging. In all, MedPAC estimates that hospitals would lose $1.44 billion in revenue in one year under the proposed site neutrality policies.[6]

MedPAC addressed some of these concerns directly in the five criteria used to determine which services should be subject to site neutrality policies (eg, choosing services with similar packaging and patient severity across locations). To address other concerns, MedPAC recommended that policymakers consider: (i) "a stop-loss policy that would limit the loss of Medicare revenue for hospitals that serve a large share of low-income patients;" and (ii) "a mitigation policy… to prevent access problems for rural beneficiaries."[6] These recommendations may not do much to alleviate hospitals' concerns. However, MedPAC is not backing down on its recommendations. In fact, MedPAC recommended similar policies across hospital outpatient department and ambulatory surgical center settings.[4] And, most recently, MedPAC expanded its recommendation of site neutral payments to locations such as skilled nursing facilities and inpatient rehabilitation facilities.[7]

CMS has also considered how to best implement site neutrality. However, CMS's approach often differs from that of MedPAC, and CMS is not obligated to adopt MedPAC's recommendations. Rather than targeting high HOPPS payments rates, CMS first targeted payments under the MFPS. By way of brief background, there are a number of services paid at a higher rate under the MPFS than the HOPPS due to what CMS believes is the use of flawed data. CMS maintained that the higher HOPPS rates were necessary due to the higher costs of operating a hospital, but sought to reduce certain payment rates under the MPFS that exceeded the rates paid under the HOPPS.[8] Ultimately, CMS did not adopt this proposal.

In its 2015 HOPPS and ASC Payment System Proposed Rule, CMS sought public comments on how to collect data to analyze payment rates for services provided in the off campus, provider based outpatient departments (eg, physician's office) in light of the increase in hospital acquisition of physician practices. In finalizing this rule, CMS created the HCPCS modifier "PO" to be attached to every code for outpatient hospital services furnished in an off campus, provider based department of a hospital.[9] It is yet to be seen what the data will reveal and how CMS will react during the rulemaking process. But the signs point to CMS adopting some form of site neutrality.

This is made all the more likely by the release of President Obama's 2016 Fiscal Year Budget. The 2016 budget includes a provision to reduce payment for services provided in provider based, off campus hospital outpatient departments to either the lower MPFS rate or the ASC payment system rate.[10] If the MPFS rate is used, this would essentially equalize payments for the same services whether provided in a physician owned medical practice or in an off campus, hospital owned physician office. The estimated savings could equal $30 billion over the next decade.[11]

Patient Benefits

Closing the payment differential will not only result in savings for the federal government, but patients will experience savings as well. Patients often have options as to where to receive a particular service. For example, many surgeries can be performed either in a hospital or an ASC, and sometimes even in a physician's office. Similarly, patients often have the choice of whether to receive imaging services at a hospital or physician's office. Many patients have copayment obligations of 20% of the cost of the service (eg, Medicare pays 80% of the allowable

charge for physician services after the patient's deductible is met).[2] Because the cost of the service is determined by the location in which the service is provided, a patient's copayment may vary widely for the same exact service depending on the location the patient chooses.

As the healthcare benefit landscape continues to change (eg, many patients find themselves with high deductible insurance plans), patients are becoming well informed consumers of healthcare services and seek the best care for the lowest price. While site neutrality would certainly lower patients' copayment obligations for many services, the question many are asking is, at what price? Many healthcare providers argue that the real challenge in implementing site neutrality will be in maintaining a high level of quality care in light of the decrease in revenue hospitals will experience.

Preparing for Site Neutrality

In April 2015, The Advisory Board Company published an article which projected that it is a matter of "when, not if" site neutrality will be implemented.[12] So, what can hospitals and their departments do to prepare? First, accurate hospital cost reporting and claims data submission are essential to ensuring hospitals are properly reimbursed for costs incurred. For many hospital departments, including imaging departments, preparing the annual departmental cost reports is a huge undertaking. It is imperative that hospitals dedicate the time and resources necessary to ensure accurate cost reports and claims data so that the payment rates—which are calculated based on this data—accurately reflect the cost of providing the services.

Second, the Advisory Board recommends that hospitals prepare for the shift to site neutrality by redesigning their healthcare delivery models and shifting certain ancillary services to more appropriate outpatient, off site locations. According to the Advisory Board, returning certain outpatient services to the practice setting will lower costs, provide greater access to care, reduce duplication of equipment and labor, and allow hospitals to backfill hospital outpatient space with services that are truly needed in that setting. But hospitals should take care to transition slowly by reevaluating operational activities such as current management of outpatient services, revenue cycle operations, physician compensation, and patient access.

Third, the Advisory Board recommends that hospitals seek to regain some of the lost revenue by participating in the Medicare Shared Savings Program or Medicare Advantage. These programs incentivize providers by providing rewards for reducing utilization and increasing Medicare savings. The Advisory Board recognizes that participation in these programs will not entirely offset the losses incurred from site neutrality policies, but they can help tremendously. The Advisory Board also recommends exploring entering into meaningful risk sharing arrangement for greater impact.

Conclusion

Some hospitals and imaging departments may be asking not what they can do to prepare for site neutrality, but how they can fight against it. With the government inevitably focused on the cost savings associated with site neutrality, those wishing to shift the focus to the negative effects site neutrality may have on healthcare can advocate their position—whether it be for, against, or somewhere in the middle—through the rulemaking and commentary process. When CMS issues proposed regulations, there is a comment period for interested parties in the community to submit comments to the drafters. For example, the comment period for the 2016 HOPPS and ASC Payment Proposed Rule ended on August 31, 2015, and the comment period for the 2016 Proposed MPFS ended on September 8, 2015. Interested providers can expect the 2017 HOPPS and ASC Payment Proposed Rule and the 2017 MPFS Proposed Rule, both of which will likely discuss site neutrality, to be released in or around July 2016 with a comment period of about 60 days. Providers may also consider appealing to their professional organizations to advocate on behalf of them and fellow members.

The real challenge lies in determining which payment system most accurately reflects the cost of providing a particular service. It is difficult to compare payment rates across locations due to different methods for calculating costs and different policies on packaging items and services into one service code (ie, CPT or HCPCS code). For now, the healthcare community will wait to see how CMS will tackle these issues, and hospitals may choose to prepare early for the inevitable.

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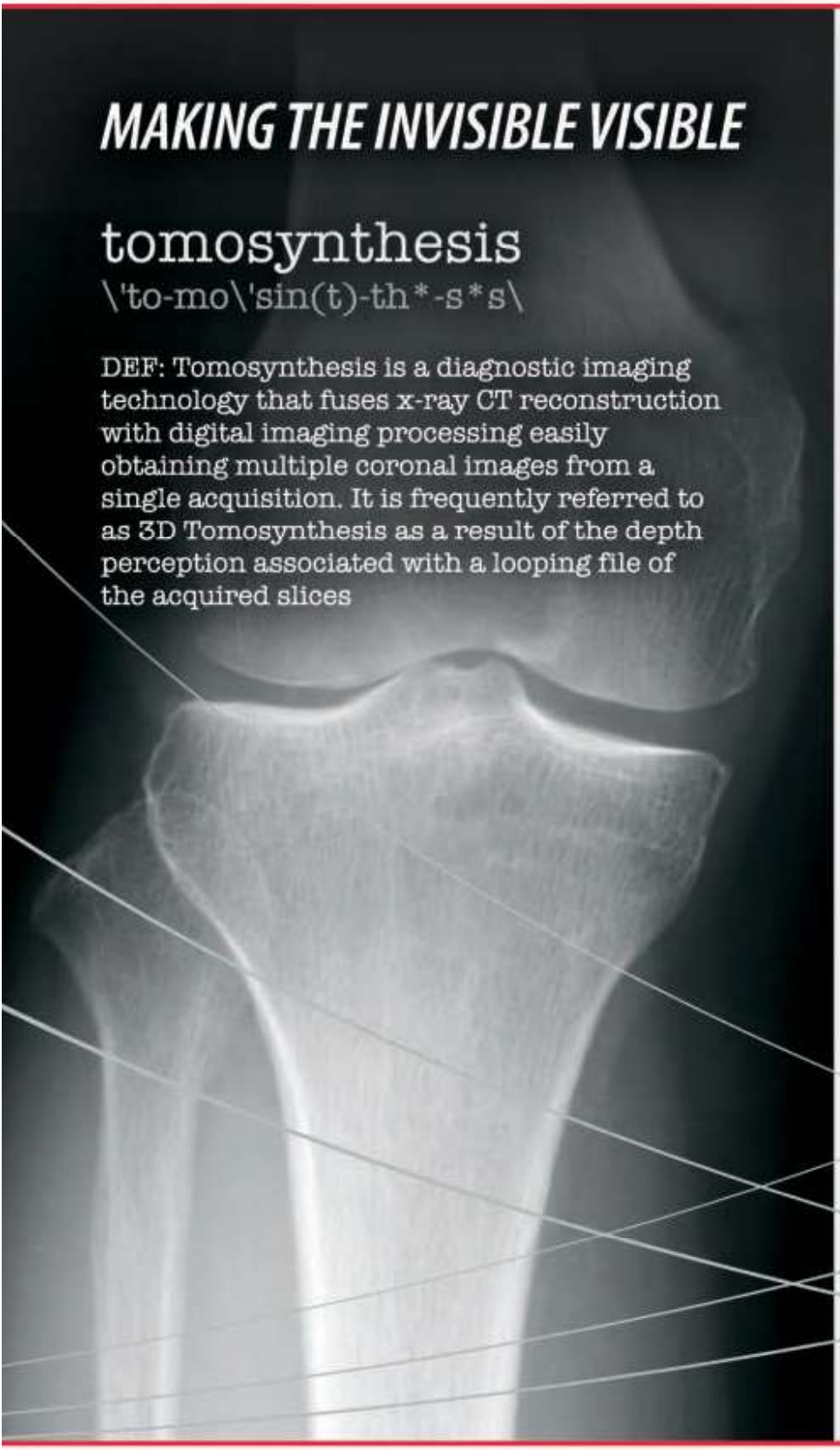

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QUESTIONS

Instructions: Choose the answer that is most correct.

1. **Currently, the Centers for Medicare and Medicaid Services (CMS) pays different rates for the same healthcare service depending on the:**
   a. Frequency of the service provided
   b. Time the service was provided
   c. Location where the service was provided
   d. Provider of the service

2. **From the government's perspective, the reason behind a site neutral payment policy is potentially saving:**
   a. Trillions of dollars
   b. Billions of dollars
   c. Millions of dollars
   d. Hundreds of dollars

3. **Payment rates for healthcare services provided in a physician owned medical practice are determined by the:**
   a. Medicare Physician Fee Schedule (MPFS)
   b. Medical Payment Plan (MPP)
   c. Private Physician Fee Association (PPFA)
   d. Healthcare Coverage Payment Division (HCPD)

4. **Payment rates may vary widely across locations, even when the same exact service is provided.**
   a. True
   b. False

5. **Congress reduced rates for certain imaging services provided in the physician office location to the lower rates for the same services provided in the hospital outpatient location with enacting the Deficit Reduction Act of:**
   a. 2011
   b. 2009
   c. 2007
   d. 2005

6. **Under the Hospital Outpatient Prospective Payment System (HOPPS) methodology, costs are estimated by calculating the:**
   a. Highest costs of the services
   b. Lowest costs of the services
   c. Median costs of the services
   d. Have not been determined yet

7. **For determining payment rates for services provided by physicians, each Medicare Physician Fee Schedule (MPFS) takes into account the physician's**
   a. Work
   b. Practice expense
   c. Malpractice expense associated with a particular service
   d. All of the above

8. **Due to the different methodologies used by the HOPPS and the MPFS, the payment rates across these two payment systems:**
   a. Are the same
   b. Vary dramatically
   c. Differ slightly
   d. Are unknown

9. **In a "Report to Congress," MedPAC advocated for site neutral payments in:**
   a. October 2014
   b. April 2015
   c. December 2012
   d. June 2013

10. **MedPAC recommended site neutral payments for certain services, including imaging services, that:**
    a. Are likely to incur costs associated with emergency room department visits
    b. Involve payment rates across payment systems that do not include a similar set of services
    c. Are 90-day global codes, which are associated with lower costs when performed in the hospital setting
    d. Have patient severity that would not be greater in outpatient departments than in physician offices

11. **How many categories of services did MedPAC identify that are organized by APC code and placed into two groups?**
    a. 87
    b. 66
    c. 45
    d. 31

12. **MedPAC estimated the site neutral payment policies coupled with its previous recommendations for site neutrality will result in Medicare program and beneficiary cost-sharing savings of approximately:**
    a. $1.8 billion per year
    b. $3.2 billion per year
    c. $5 billion per year
    d. $6 billion per year

13. **Hospitals also incur additional costs in the form of having to comply with:**
    a. More stringent licensing
    b. Accreditation
    c. Regulatory laws
    d. All of the above

14. **CMS sought public comments on how to collect data to analyze payment rates for services provided in the off campus, provider based outpatient departments in the:**
    a. 2015 HOPPS and ASC Payment System Proposed Rule
    b. 2014 Increased Cost Adoption
    c. 2013 Decrease the Cost Questionnaire
    d. 2012 Data Implementation Survey

15. **Many patients have copayment obligations of:**
    a. 20% of the cost of the service
    b. 40% of the cost of the service
    c. 50% of the cost of the service
    d. 65% of the cost of the service

16. **Many healthcare providers argue that the real challenge in implementing site neutrality will be in maintaining a high level of quality in light of the increase in revenue hospitals will experience.**
    a. True
    b. False

17. **In April 2015, The Advisory Board Company published an article which projected that it is a matter of "when, not if" site neutrality will be:**
    a. Reviewed
    b. Completed
    c. Implemented
    d. Terminated

18. **According to The Advisory Board, returning certain outpatient services to the practice setting will:**
    a. Lower costs
    b. Provide greater access to care
    c. Reduce duplication of equipment and labor
    d. All of the above

19. **The Advisory Board recommends that hospitals seek to regain some of the lost revenue by participating in the:**
    a. Medicare Plus Programs
    b. Medicare Shared Saving Program or Medicare Advantage
    c. Medicaid Funding Plan
    d. Medicaid Revenue

20. **Interested providers can expect the 2017 HOPPS and ASC Payment Proposed Rule and the 2017 MPFS Proposed Rule to be released in or around July 2017 with a comment period of about:**
    a. 30 days
    b. 45 days
    c. 60 days
    d. 90 days