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2009 MedPAC Report: A New Threat to High-quality Care

by Paul S. Viviano

In 1997, Congress created the Medicare Payment Advisory Commission (MedPAC) to provide recommendations regarding health care policy and reimbursement with respect to the Medicare program. Since then, MedPAC has performed an important and useful role, collecting and analyzing data and trends affecting the means and methods by which the US government provides for the health care of our senior citizens.

"In its own report, even MedPAC acknowledged that there is no empirical evidence about the actual use of high-cost diagnostic equipment and that it had not conducted any broad-based study to support its recommendation. Instead, MedPAC defended its recommendation purely on policy grounds, arguing that such an increase would significantly deter the proliferation of such equipment."

While sometimes controversial, and often opposed by various health care groups, MedPAC's recommendations have generally been characterized by reliance on credible empirical evidence and a balancing of important policy objectives, including access to care in rural areas. Unfortunately, MedPAC's *February 2009 Medicare report*¹ (which includes a recommendation that Medicare's formula for nonhospital MRI, CT, and PET/CT reimbursement be modified to increase the equipment-use factor from 50% to 90%) departs from this tradition.

Relying simply on a desire to drive imaging reimbursement beyond the 30% to 50% cuts imposed by the DRA, MedPAC bases its 2009 recommendation on woefully insufficient survey data and fails to take into account the dire impact that such additional cuts would have on freestanding imaging centers and their ability to diagnose, treat, and care for Medicare patients. While the Association for Quality Imaging (AQI) supports accurate pricing for Medicare services, we believe that any recommendations to change the utilization formula should be based on real data and correct assumptions.



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Survey Flaws

The MedPAC survey is flawed on a number of fronts, starting with the study sample, which is not statistically valid or representative of today's diagnostic imaging environment. It is based on a pre-DRA impact study of 96 imaging providers, it includes only two imaging modalities (CT and MRI) in six urban areas, and it does not account for rural use. The study sample markets included Boston, Massachusetts; Miami, Florida; Greenville, South Carolina; Minneapolis, Minnesota; Phoenix, Arizona; and Orange County, California.

These markets aren't representative of the United States as a whole; their patient populations are more likely to be able to support more costly, higher-utilization equipment. The survey does not account for the different degrees of sophistication and age of the equipment that is used in different facilities, in different regions of the country, serving different populations of patients.

In fact, most imaging providers are not equipped with the state-of-the-art imaging devices (64-slice CT and 3T MRI) that MedPAC used to revise its assumptions about equipment efficiency and throughput. Further, as reimbursement has been dramatically reduced over time, the availability of funds to upgrade to the latest technology is limited to only the most affluent providers, such as hospitals and self-referring physicians.

If 64-slice CT and 3T MRI are considered the standard, a majority of imaging providers will not have the equipment on which the revised efficiency/throughput factor is based. Consequently, those providers still using earlier-model technology would need to address the lower per-scan reimbursement through the performance of more scans, thus spending less time with each patient. This is particularly worrying in terms of caring for older and less healthy patients, who typically require more time.

In addition, in many rural areas, where providers offer everything from emergency services to imaging and radiologists are limited in number, it may be literally impossible for providers even to come close to a 90% utilization rate. With providers facing inadequate payment for their services due to the increased rate, Medicare patients—especially those in rural areas, who often already travel long distances for care—may have great difficulty accessing the care that they so urgently need.

Ultimately, to be valid, a utilization assessment needs to take into account a variety of factors, from the type of patient to the equipment to the location to the myriad services offered. Anything else is a threat to patients' access to high-quality care.

Analysis Contradicts Assumptions

The MedPAC study also neglected to take into account the effects of the federal DRA mandate. It has already reduced payments to the point where AQI has seen some of its members go out of business.

Recently, in response to MedPAC's recommendation, the Access to Medical Imaging Coalition performed an analysis² to illustrate the impact of the DRA on spending and utilization for advanced imaging. This analysis, which was performed by the Moran Co, found that Medicare spending on advanced imaging services was reduced by 19% from 2006 to 2007, while the volume of service grew by only about 2%. This challenges the committee's assumptions regarding mispricing and overutilization, and it reflects the increased regulatory burden that imaging providers have faced over the past few years.

In its own report, even MedPAC acknowledged that there is no empirical evidence about the actual use of high-cost diagnostic equipment, and that it had not conducted any broad-based study to support its recommendation. Instead, MedPAC defended its recommendation purely on policy grounds, arguing that such an increase would significantly deter the proliferation of such equipment. According to the MedPAC report, while the proposed use-factor increase would reduce nonhospital outpatient imaging reimbursements by approximately 8%, the estimate does not account for reimbursement caps imposed under the DRA. The report also acknowledges that the DRA caps could substantially reduce or mitigate the negative impact on reimbursement.

Based on the insufficient data from the MedPAC survey, AQI has requested that MedPAC and CMS perform accurate studies. AQI supports a comprehensive look at the entire reimbursement formula—not just one portion—and a comprehensive and statistically valid study of outpatient imaging utilization.

If decisions are made without the support of statistically valid study data, further reductions in reimbursement due to policy changes will reduce the likelihood of provider investment in upgraded technology, leading to a result that is the opposite of what CMS is seeking under its policy to promote improved efficiency and appropriate utilization. With the Moran Co report² highlighting the reality that utilization has already slowed significantly, increased utilization rules and further cuts threaten the provider and, in turn, patients' access to high-quality care.

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