2015 Imaging Market Update

Key Forces Shaping Imaging Economics

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The Bigger Health Care Picture

Key Takeaways for Radiology Providers

Questions
I’ll Just Uber There

Request, Ride, and Pay Via Your Mobile Phone with Uber

Company in Brief: Uber

- GPS-enabled smartphone app, launched in San Francisco in 2010
- Allows users to schedule, in real time, and pay for a town car, SUV, or taxi, all with one touch of a button

Uber: Just an App?

- $41B Valuation in December 2014
- 45 Countries in which Uber operates
- 200 Cities in which Uber operates

## Driving Away with Key Drivers of Value

<table>
<thead>
<tr>
<th></th>
<th>Taxi</th>
<th>Uber</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Convenience</strong></td>
<td>• Call to request or hail from curb; location of free taxis unknown</td>
<td>• GPS map shows available cars, estimated wait time, driver’s exact location</td>
</tr>
<tr>
<td></td>
<td>• Cash preferred; credit card machine often out of order</td>
<td>• Automatic billing; receipt emailed</td>
</tr>
<tr>
<td><strong>Affordability</strong></td>
<td>• Base + mileage charge, not including tip and eight additional surcharges (passengers, luggage, phone dispatch, etc.)</td>
<td>• Simple base + mileage charge, tip inclusive</td>
</tr>
<tr>
<td></td>
<td>• Driver’s taxi license displayed inside vehicle</td>
<td>• GPS-enabled fare estimator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Surge pricing during peak demand</td>
</tr>
<tr>
<td><strong>Transparency</strong></td>
<td></td>
<td>• Automatic text message with driver’s name, photo, cell phone, license plate, quality rating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Post-ride quality rating required</td>
</tr>
</tbody>
</table>

Source: Imaging Performance Partnership interviews and analysis.
The Big Picture

Fundamental Forces Challenging Future of Health Care

Patients:
Activated, Consumer-Oriented

• Patients more cost-conscious and consumer-oriented when “shopping” around for outpatient exams
• Patients basing care decisions on accessibility, cost, service

Payment:
Declining

• Unfavorable FFS\(^1\) economics decreasing hospital reimbursement
• Drive to make payments site-neutral may exact steep impacts on hospital rates

Providers:
Taking On Risk, Retail Players Joining

• Efforts to reduce payment, rein in expenditures
• Emphasis on linking reimbursement to quality metrics and patient outcomes, jeopardizing operating margins
• Growth of risk-based delivery models such as bundled payments and ACOs\(^2\)

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1) Fee for Service
2) Accountable Care Organizations.

Source: Imaging Performance Partnership interviews and analysis.
Key Observations Impacting Radiology Providers

**Volumes and Growth Outlook**

- We’re getting diminishing returns from traditional growth

**Total Cost Management**

- Imaging exams are firmly on the chopping block in risk-based payment

**Reimbursement**

- The worst is yet to come with hospital reimbursement cuts

**Health Care Consumerism**

- Imaging patients actively “shopping” for convenient access, more affordable care

Source: Imaging Performance Partnership research and analysis.
2015 Imaging Market Update

Partnership Observations and Impact on Imaging Strategy

<table>
<thead>
<tr>
<th>Volumes and Growth Outlook</th>
<th>Total Cost Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Inpatient imaging volume contraction to accelerate, modest outpatient growth expected</td>
<td>7) Low-value imaging exams represent an early target for efforts to reduce total cost of care</td>
</tr>
<tr>
<td>2) Burgeoning Medicare population a stronger driver of imaging growth than coverage expansion</td>
<td>8) New mandate for clinical decision support by 2017 prompts additional focus on appropriate care</td>
</tr>
</tbody>
</table>

**Reimbursement**

| 3) Fewer negative structural changes to imaging reimbursement expected; cuts likely to be on par with overall payment reduction | 9) Changes in insurance coverage models increasingly shifting financial responsibility to patients |
| 4) CMS increasingly bundling diagnostic and ancillary outpatient services to align reimbursement with episodes of care, not services | 10) Retail medicine fueling demand for easy access to care but not yet a direct threat to imaging |
| 5) Imaging disproportionately impacted by efforts to implement “site neutral” payments | 11) Providers must deliver on all fronts (quality, cost, service, and access) to become the imaging provider of choice |
| 6) Permanent 2015 SGR\(^1\) repeal signals a significant shift toward value-based payment | |

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1) Sustainable growth rate.

Source: Imaging Performance Partnership research and analysis.
1. The Bigger Health Care Picture

2. Key Observations for Radiology Providers

3. Questions
MedPAC\(^1\) Report Shows Decreases in Growth in MPFS\(^2\)

Percent Change in Utilization of Imaging Services Furnished by Physicians

*Per Medicare Beneficiary; 2005-2013*\(^3\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Units of Service</th>
<th>Volume of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>6.5%</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>3.2%</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>3.8%</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>2.8%</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>1.4%</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>2.0%</td>
<td>(1.5%)</td>
</tr>
<tr>
<td>2011</td>
<td>(2.5%)</td>
<td>(2.3%)</td>
</tr>
<tr>
<td>2012</td>
<td>(1.9%)</td>
<td>(3.2%)</td>
</tr>
<tr>
<td>2013</td>
<td>(0.6%)</td>
<td>(1.0%)</td>
</tr>
</tbody>
</table>

\(^1\) Medicare Payment Advisory Commission.  
\(^2\) Medicare Physician Fee Schedule.  
\(^3\) Volume of services equals units of service multiplied by each service’s relative value unit (RVU) from the physician fee schedule.
Variable Outpatient Growth Among Institutions

2013-2014 Outpatient Radiology Volume Growth by Modality

Middle 50th Percentile Range (Bars) and Median (Diamonds)

<table>
<thead>
<tr>
<th>Modality</th>
<th>2013-2014 Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>11.7% (4.0%)</td>
</tr>
<tr>
<td>MRI</td>
<td>9.3% (1.0%)</td>
</tr>
<tr>
<td>X-ray</td>
<td>4.0% (2.0%)</td>
</tr>
<tr>
<td>Mammo</td>
<td>4.7% (0.0%)</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>8.6% (3.0%)</td>
</tr>
<tr>
<td>Nuc Med</td>
<td>9.5% (0.6%)</td>
</tr>
<tr>
<td>IR</td>
<td>0.0% (0.0%)</td>
</tr>
<tr>
<td>PET/PET-CT</td>
<td>16.1% (1.0%)</td>
</tr>
</tbody>
</table>

2015 Volumes Benchmarking Survey

- 29 responding institutions including hospitals and imaging centers, children’s hospitals and academic medical centers, systems and non-systems
- Reported 2013 and 2014 calendar year outpatient, inpatient and emergency volumes by modality as well as questions about slot times and CT and MR capacity

Historical Outpatient Volumes

Member Survey Reports Mixed Results

Outpatient Imaging Volume Changes

*Median Hospital, By Modality*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>1.0%</td>
<td>4.0%</td>
<td>1.7%</td>
<td>1.7%</td>
<td>4.0%</td>
</tr>
<tr>
<td>MRI</td>
<td>1.4%</td>
<td>2.2%</td>
<td>2.1%</td>
<td>2.0%</td>
<td>0.9%</td>
</tr>
<tr>
<td>X-ray</td>
<td>3.6%</td>
<td>0.9%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Mammography</td>
<td>(2.2%)</td>
<td>(8.8%)</td>
<td>(1.5%)</td>
<td>(1.5%)</td>
<td>(0.9%)</td>
</tr>
</tbody>
</table>

Historical Outpatient Volumes (cont.)

Outpatient Imaging Volume Changes
Median Hospital, By Modality

- **Ultrasound**
  - 2009-2010: 2.6%
  - 2010-2011: 4.3%
  - 2011-2012: 1.5%
  - 2012-2013: 0.9%
  - 2013-2014: 3.0%

- **Nuclear Medicine**
  - 2009-2010: 2.3%
  - 2010-2011: 4.1%
  - 2011-2012: 2.3%
  - 2012-2013: 3.0%

- **PET/PET-CT**
  - 2009-2010: 3.5%
  - 2010-2011: 0.7%
  - 2011-2012: 1.6%
  - 2012-2013: 2.7%
  - 2013-2014: 2.6%

- **IR**
  - 2009-2010: 1.5%
  - 2010-2011: 1.0%
  - 2011-2012: 1.6%
  - 2012-2013: 1.5%
  - 2013-2014: 0.0%

Uninsured Rate Reaches All-Time Low

Coverage Expansion Hitting Its Mark

Uninsured Rate Continues Its Decline After Second Open Enrollment Period

Percentage of Americans Without Health Insurance

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2009</td>
<td>16.1%</td>
</tr>
<tr>
<td>Q1 2010</td>
<td>16.4%</td>
</tr>
<tr>
<td>Q1 2011</td>
<td>16.6%</td>
</tr>
<tr>
<td>Q1 2012</td>
<td>17.5%</td>
</tr>
<tr>
<td>Q1 2013</td>
<td>16.3%</td>
</tr>
<tr>
<td>Q3 2013</td>
<td>18.0%</td>
</tr>
<tr>
<td>Q1 2014</td>
<td>15.6%</td>
</tr>
<tr>
<td>Q1 2015</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

Record high since pre-Medicare

Record low

Public Health Care Coverage Driving Imaging Growth

Medicaid expansion

Insurance exchanges

Medicare enrollment

Source: Gallup, “In U.S., Uninsured Rate Dips to 11.9% in First Quarter,” April 13, 2015, available at: [www.gallup.com](http://www.gallup.com)
Medicaid Expansion Positively Impacting Hospital Finances

29 States + DC Have Approved Medicaid Expansion¹
As of April 2015

Medicaid Admissions increased 21% for investor-owned hospitals in expansion states

Self-Pay Admissions decreased by 47% for investor-owned hospitals in expansion states

Uncompensated Care costs reduced by $5 billion in expansion states in 2014

1) Montana’s expansion requires federal waiver approval.

Consumers Continue to Flock to Public Exchanges

High Volumes, Especially in Older Demographic, Promising for Imaging

8M
Enrollment on public exchanges, 2014

8.8M
Enrollment on public exchanges, 2015

Age Distribution of Public Exchange Enrollees
2014 and 2015 Open Enrollment Periods

Growing Medicare Population a Boon for Imaging

U.S. Demographics a Major Source of Growth—But Not the Only One

Age Demographics for Imaging Utilizers
Projected, 2018

- <50 Years Old: 36.2%
- 50+ Years Old: 63.8%

Number of Medicare Beneficiaries
 Millions

- 2000: 40
- 2010: 47
- 2020: 58
- 2025: 79

Three Primary Sources of Imaging Growth in 2015

- Growing Medicare population
- Payer coverage of screening exams
- Continuing physician employment and consolidation

Source: Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, “Essential Health Benefits: Individual Market Coverage; Advisory Board Imaging Outpatient Market Estimator; Imaging Performance Partnership interviews and analysis.”
Resulting in a Positive Overall Outlook

Outpatient Volume Growth Projections

*All Providers, by Modality*

2014-2024

<table>
<thead>
<tr>
<th>Modality</th>
<th>5 yr growth</th>
<th>10 yr growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>8%</td>
<td>16%</td>
</tr>
<tr>
<td>MRI</td>
<td>9%</td>
<td>18%</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>11%</td>
<td>24%</td>
</tr>
<tr>
<td>Mammography</td>
<td>5%</td>
<td>11%</td>
</tr>
<tr>
<td>X-ray</td>
<td>6%</td>
<td>12%</td>
</tr>
<tr>
<td>PET</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>2%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Market-specific volume forecasts can be found in [The Outpatient Imaging Market Estimator](#).

Source: Advisory Board Imaging Outpatient Market Estimator; Imaging Performance Partnership interviews and analysis.
CMS Begins Reimbursement for Tomosynthesis

CMS Adopts Screening CPT, Diagnostic G-Codes

**CMS Policy for Screening Tomosynthesis**

CMS agreed to use new DBT¹ screening CPT code (77063) in conjunction with digital screening mammography G Code (G0202)

**CMS Policy for Diagnostic Tomosynthesis**

CMS created a new G Code (G0279) for diagnostic DBT as an add-on to the existing digital mammography G Codes

**CMS 2015 Tomosynthesis Reimbursement**

<table>
<thead>
<tr>
<th>Exam Type</th>
<th>Film</th>
<th>Digital</th>
<th>Digital with DBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Mammogram</td>
<td>$82.70</td>
<td>$134.97</td>
<td>$191.54</td>
</tr>
<tr>
<td>Unilateral Diagnostic Mammogram</td>
<td>$90.22</td>
<td>$129.60</td>
<td>$186.17</td>
</tr>
<tr>
<td>Bilateral Diagnostic Mammogram</td>
<td>$116.00</td>
<td>$164.69</td>
<td>$221.26</td>
</tr>
</tbody>
</table>

1) Digital Breast Tomosynthesis.

Source: Centers for Medicare and Medicaid Services; Imaging Performance Partnership research and analysis.
c-APCs: Fixed Lump Sum for All Services Provided

Payment for Adjunctive Services to be Packaged with Primary Procedure

1. **Primary Service**\(^1\) Determines c-APC

   - Neurostimulator Procedures
   - Electrophysiology & Endovascular Procedures
   - Musculoskeletal Procedures

2. **Examples of Adjunctive Services**

   - Imaging Scans
   - Therapeutic Services
   - Lab Tests
   - Administered Drugs
   - Devices, DME\(^2\), Prosthetics, Orthotics

3. **Single Lump Payment for All Services**

4. **Key Changes Finalized for CY15**
   - Finalized program expanded to include:
     - 219 of the most costly procedures\(^3\) (mainly device-dependent) packaged into
     - 25 c-APCs across
     - 12 clinical families
   - Payment adjustment finalized for complex combinations of procedures (see following slides)
   - Minor restructuring of APCs finalized for CY15 compared to CY14 to improve resource and clinical homogeneity

5. **Inclusions/Exclusions Finalized for CY15**
   - Adjunctive services will include:
     - Diagnostic procedures and laboratory tests;
     - Visits and evaluations;
     - DME, prosthetic, and orthotic items;
     - Perioperative therapy-like services;
     - All drugs, biologicals, pharmaceuticals (except pass-through drugs and SADs)
     - Other uncoded services and supplies
   - Excluded from packaging:
     - SADs and pass through drugs and devices;
     - Services excluded from OPPS (recurring therapy, ambulance, diagnostic and screening mammography, etc.);
     - Annual wellness visits and preventative services

---

1) Services with status indicator J1; c-APC program finalized to cover all current device dependent APCs (except for 0427, 0622, and 0652) as well as Single Session Cranial SRS (c-APC 0067) and High Level Intraocular Procedures (c-APC 0351).
2) All services except for those explicitly excluded from the program can be considered “adjunctive” and have their payment packaged when conducted alongside or in support of a primary service.
3) For complete list of procedures covered by c-APCs, payment rates, and complexity adjustments, please download the addenda to the CY15 HOPPS Final Rule.

Source: CMS, Imaging Performance Partnership analysis.
### Final Rule: Only Minor Tweaks to c-APC Groupings

**Full list of CY 2015 c-APCs and Clinical Families with Primary Service Examples**

<table>
<thead>
<tr>
<th>Clinical Family Abbreviation</th>
<th>Clinical Family Name</th>
<th>c-APC</th>
<th>Example Primary Service HCPCS Code</th>
<th>Example Primary Service Name</th>
<th>c-APC Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>AICDP</td>
<td>Auto ICD, Pacemakers, etc.</td>
<td>0108 - Level II ICD and Similar Procedures</td>
<td>33249</td>
<td>Insj/rplcm defib w/lead(s)</td>
<td>$30,806.39</td>
</tr>
<tr>
<td>AICDP</td>
<td>Auto ICD, Pacemakers, etc.</td>
<td>0107 - Level I ICD and Similar Procedures</td>
<td>33263</td>
<td>Rmvl &amp; rplcm dfb gen 2 lead</td>
<td>$22,907.64</td>
</tr>
<tr>
<td>AICDP</td>
<td>Auto ICD, Pacemakers, etc.</td>
<td>0655 - Level IV Pacemaker/Similar Procedures</td>
<td>33229</td>
<td>Rmvl&amp;repl pm gen mult leads</td>
<td>$16,400.98</td>
</tr>
<tr>
<td>AICDP</td>
<td>Auto ICD, Pacemakers, etc.</td>
<td>0089 - Level III Pacemaker/Similar Procedures</td>
<td>33214</td>
<td>Upgrade of pacemaker system</td>
<td>$9,489.74</td>
</tr>
<tr>
<td>AICDP</td>
<td>Auto ICD, Pacemakers, etc.</td>
<td>0090 - Level II Pacemaker/Similar Procedures</td>
<td>33282</td>
<td>Implant pat-active ht record</td>
<td>$6,542.78</td>
</tr>
<tr>
<td>BREAS</td>
<td>Breast Surgery</td>
<td>0648 - Level IV Breast and Skin Surgery</td>
<td>19357</td>
<td>Breast reconstruction</td>
<td>$7,461.40</td>
</tr>
<tr>
<td>ENTXX</td>
<td>ENT Procedures</td>
<td>0659 - Level VII ENT Procedures</td>
<td>69930</td>
<td>Implant cochlear device</td>
<td>$29,706.85</td>
</tr>
<tr>
<td>EPHYS</td>
<td>Cardiac Electrophysiology</td>
<td>0085 - Level II Electrophysiologic Procedures</td>
<td>93656</td>
<td>Tx atrial fib pulm vein isol</td>
<td>$14,356.62</td>
</tr>
<tr>
<td>EPHYS</td>
<td>Cardiac Electrophysiology</td>
<td>0086 - Level III Electrophysiologic Procedures</td>
<td>93620</td>
<td>Electrophysiology evaluation</td>
<td>$4,633.33</td>
</tr>
<tr>
<td>EPHYS</td>
<td>Cardiac Electrophysiology</td>
<td>0084 - Level I Electrophysiologic Procedures</td>
<td>93642</td>
<td>Electrophysiology evaluation</td>
<td>$872.92</td>
</tr>
<tr>
<td>EYEXX</td>
<td>Ophthalmic Surgery</td>
<td>0351 - Level V Intraocular Procedures</td>
<td>0308T</td>
<td>Insj ocular telescope prosth</td>
<td>$23,075.30</td>
</tr>
<tr>
<td>EYEXX</td>
<td>Ophthalmic Surgery</td>
<td>0293 - Level IV Intraocular Procedures</td>
<td>65770</td>
<td>Revise cornea with implant</td>
<td>$8,446.54</td>
</tr>
<tr>
<td>GIXXX</td>
<td>Gastrointestinal Procedures</td>
<td>0384 - GI Procedures with Stents</td>
<td>44397</td>
<td>Colonoscopy w/stent</td>
<td>$3,173.83</td>
</tr>
<tr>
<td>NSTIM</td>
<td>Neurostimulators</td>
<td>0318 - Level IV Neurostim./Related Procedures</td>
<td>61886</td>
<td>Implant neurostim arrays</td>
<td>$26,152.16</td>
</tr>
<tr>
<td>NSTIM</td>
<td>Neurostimulators</td>
<td>0039 - Level III Neurostim./Related Procedures</td>
<td>63655</td>
<td>Implant neuroelectrodes</td>
<td>$17,099.35</td>
</tr>
<tr>
<td>NSTIM</td>
<td>Neurostimulators</td>
<td>0061 - Level II Neurostim./Related Procedures</td>
<td>64581</td>
<td>Implant neuroelectrodes</td>
<td>$5,288.58</td>
</tr>
<tr>
<td>ORTHO</td>
<td>Orthopedic Surgery</td>
<td>0425 - Level V Musculoskeletal Procedures</td>
<td>24363</td>
<td>Replace elbow joint</td>
<td>$10,220.00</td>
</tr>
<tr>
<td>PUMPS</td>
<td>Implantable Drug Delivery Systems</td>
<td>0227 - Implantation of Drug Infusion Device</td>
<td>62362</td>
<td>Implant spine infusion pump</td>
<td>$15,566.34</td>
</tr>
<tr>
<td>RADTX</td>
<td>Radiation Oncology</td>
<td>0067 - Single Session Cranial SRS</td>
<td>77371</td>
<td>Stereotactic Radiosurgery (SRS) multisource</td>
<td>$9,765.40</td>
</tr>
<tr>
<td>UROGN</td>
<td>Urogenital Procedures</td>
<td>0386 - Level II Urogenital Procedures</td>
<td>54401</td>
<td>Insert self-contd prosthesis</td>
<td>$13,967.97</td>
</tr>
<tr>
<td>UROGN</td>
<td>Urogenital Procedures</td>
<td>0385 - Level I Urogenital Procedures</td>
<td>55873</td>
<td>Cryoablate prostate</td>
<td>$6,822.35</td>
</tr>
<tr>
<td>UROGN</td>
<td>Urogenital Procedures</td>
<td>0202 - Level V Gynecologic Procedures</td>
<td>57283</td>
<td>Colpexy intraperitoneal</td>
<td>$3,977.63</td>
</tr>
<tr>
<td>VASCX</td>
<td>Vascular Procedures</td>
<td>0319 - Level III Endovascular Procedures</td>
<td>37227</td>
<td>Fem/popl revasc stnt &amp; ather</td>
<td>$14,840.64</td>
</tr>
<tr>
<td>VASCX</td>
<td>Vascular Procedures</td>
<td>0229 - Level II Endovascular Procedures</td>
<td>92995</td>
<td>Coronary atherectomy</td>
<td>$9,624.10</td>
</tr>
<tr>
<td>VASCX</td>
<td>Vascular Procedures</td>
<td>0083 - Level I Endovascular Procedures</td>
<td>35476</td>
<td>Repair venous blockage</td>
<td>$4,537.45</td>
</tr>
</tbody>
</table>

1) For complete list of procedures covered by c-APCs, payment rates, and complexity adjustments, please download the [addenda to the CY15 HOPPS Final Rule](addenda_to_the_CY15_HOPPS_Final_Rule).
## APC Placement Changes in 2015

### Majority of APC Placement Changes Increase Reimbursement

<table>
<thead>
<tr>
<th>Exam</th>
<th>CPT Code</th>
<th>2015 APC</th>
<th>2014 Rate</th>
<th>2015 Rate</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Image guided fluid drainage by catheter</td>
<td>10030</td>
<td>0007</td>
<td>$159.66</td>
<td>$865.62</td>
<td>442.16%</td>
</tr>
<tr>
<td>Image guided fluid drainage transvaginal</td>
<td>49407</td>
<td>0005</td>
<td>$757.76</td>
<td>$1052.22</td>
<td>38.86%</td>
</tr>
<tr>
<td>Biopsy of breast first lesion including srt¹</td>
<td>19081</td>
<td>0005</td>
<td>$702.08</td>
<td>$1052.22</td>
<td>49.87%</td>
</tr>
<tr>
<td>Biopsy of breast first lesion including srt</td>
<td>19083</td>
<td>0005</td>
<td>$702.08</td>
<td>$1052.22</td>
<td>49.87%</td>
</tr>
<tr>
<td>Biopsy of breast first lesion including srt</td>
<td>19085</td>
<td>0005</td>
<td>$702.08</td>
<td>$1052.22</td>
<td>49.87%</td>
</tr>
<tr>
<td>Proton treatment simple w/o complications</td>
<td>77520</td>
<td>0664</td>
<td>$872.37</td>
<td>$507.55</td>
<td>-41.82%</td>
</tr>
<tr>
<td>Proton treatment simple w/ complications</td>
<td>77522</td>
<td>0664</td>
<td>$872.37</td>
<td>$1071.95</td>
<td>22.88%</td>
</tr>
<tr>
<td>Proton treatment intermediate</td>
<td>77523</td>
<td>0667</td>
<td>$1205.27</td>
<td>$1071.95</td>
<td>-11.06%</td>
</tr>
<tr>
<td>Proton treatment complex</td>
<td>77525</td>
<td>0667</td>
<td>$1205.27</td>
<td>$1071.95</td>
<td>-11.06%</td>
</tr>
</tbody>
</table>

1) Stereotactic.

Source: Centers for Medicare and Medicaid Services; Imaging Performance Partnership research and analysis.
Other Changes from 2015 Final Rule

2016 – New Process for Disclosing New RVU Values
Starting in 2016 CMS will include proposed values for new, revised and potentially misvalued codes in the proposed rule.

CMS Reviewing Mammography Codes
CMS is calling for review of mammography codes except for those for DBT and keeping G codes until review is completed.

No Payment for Secondary Interpretation of images
CMS decided to leave the issue of payment for secondary interpretation of images to future rulemaking.

Computer Workstation to Serve as PACS Proxy
CMS removed the practice expenses related to film supplies and will use desktop computer time as a proxy for PACS systems.

Source: Centers for Medicare and Medicaid Services; Imaging Performance Partnership research and analysis.
Impact of MPFS 2015 Final Rule

Revenue Impact of Recent MPFS Final Rules

By Provider

Radiology
Diagnostic Testing Facility
Interventional Radiology
Nuclear Medicine

For more analysis of the 2015 Final Rule, see our blog post and webconference:
8 takeaways for imaging leaders from CMS's 2015 final rule and 2015 Medicare reimbursement update

Increased Bundling in Store for Outpatient Services

CMS Signals Desire to Pay for Episodes of Care, not Services

Proposed Restructuring of Clinical APC Families

- CMS conducted a review of all nine clinical APCs, including those for diagnostic radiology and nuclear imaging
- CMS proposed new APC structures, arguing that the current level of granularity is unnecessary for a prospective payment system

Tracking of Services Related to C-APC Primary Procedures

- An analysis of C-APC billing revealed that services adjunctive to a primary procedure often billed separately
- CMS wants to create a HCPCS modifier to track these services, even when performed prior to delivery of the primary service to allow for more accurate payment rates

Takeaway: New APC structure would streamline coding, but the impact on reimbursement remains unknown

50% Proposed decrease in the number of imaging APCs

Takeaway: The modifier could potentially facilitate increased bundling of imaging services necessary to furnishing of a C-APC

Related Resource
Imaging APC Calculator

Source: Centers for Medicare and Medicaid Services; Imaging Performance Partnership interviews and analysis.
## List of Proposed Imaging-Related APCs

<table>
<thead>
<tr>
<th>Proposed CY 2016 APC</th>
<th>Proposed CY 2016 APC Group Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>5521</td>
<td>Level 1 X-Ray and Related Services</td>
</tr>
<tr>
<td>5522</td>
<td>Level 2 X-Ray and Related Services</td>
</tr>
<tr>
<td>5523</td>
<td>Level 3 X-Ray and Related Services</td>
</tr>
<tr>
<td>5524</td>
<td>Level 4 X-Ray and Related Services</td>
</tr>
<tr>
<td>5525</td>
<td>Level 5 X-Ray and Related Services</td>
</tr>
<tr>
<td>5526</td>
<td>Level 6 X-Ray and Related Services</td>
</tr>
<tr>
<td>5531</td>
<td>Level 1 Ultrasound and Related Services</td>
</tr>
<tr>
<td>5532</td>
<td>Level 2 Ultrasound and Related Services</td>
</tr>
<tr>
<td>5551</td>
<td>Level 1 Echocardiogram Without Contrast</td>
</tr>
<tr>
<td>5552</td>
<td>Level 2 Echocardiogram Without Contrast</td>
</tr>
<tr>
<td>5561</td>
<td>Level 1 Echocardiogram With Contrast</td>
</tr>
<tr>
<td>5562</td>
<td>Level 2 Echocardiogram With Contrast</td>
</tr>
<tr>
<td>5570</td>
<td>Computed Tomography Without Contrast</td>
</tr>
<tr>
<td>5571</td>
<td>Level 1 Computed Tomography with Contrast and Computed Tomography Angiography</td>
</tr>
<tr>
<td>5572</td>
<td>Level 2 Computed Tomography with Contrast and Computed Tomography Angiography</td>
</tr>
<tr>
<td>5581</td>
<td>Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast</td>
</tr>
<tr>
<td>5582</td>
<td>Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast</td>
</tr>
<tr>
<td>5591</td>
<td>Level 1 Nuclear Medicine and Related Services</td>
</tr>
<tr>
<td>5592</td>
<td>Level 2 Nuclear Medicine and Related Services</td>
</tr>
<tr>
<td>5593</td>
<td>Level 3 Nuclear Medicine and Related Services</td>
</tr>
<tr>
<td>8004</td>
<td>Ultrasound Composite</td>
</tr>
<tr>
<td>8005</td>
<td>CT and CTA without Contrast Composite</td>
</tr>
<tr>
<td>8006</td>
<td>CT and CTA with Contrast Composite</td>
</tr>
<tr>
<td>8007</td>
<td>MRI and MRA without Contrast Composite</td>
</tr>
<tr>
<td>8008</td>
<td>Level 1 Nuclear Medicine and Related Services</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare and Medicaid Services; Imaging Performance Partnership interviews and analysis.
Implications for XR-29 and Lung Screening Payment

Lung Cancer Screening Reimbursement Takeaways

1. CMS will create a G code to reimburse lung screening under the proposed APC 5570.
2. CMS will also create a G code to pay for the shared decision making visit as a Level 2 Health and Behavior Service.
3. CMS will provide more detail regarding lung cancer screening reimbursement in a separate rule.

NEMA¹ XR-29 Enforcement Takeaways

1. CMS proposes the creation of a modifier that must be included on all CT scans completed on non-compliant machines.
2. Reimbursement will be cut by 5% in 2016 and 15% in 2017.

Related Blog Post:
The Four Radiation Dose Requirements You Need to Meet

¹) National Electrical Manufacturers Association.
Proposed Rule Could Signal a Reprieve for Imaging

Revenue Impact of Recent MPFS Changes

By Provider

- **Radiology**
  - 2013 Final Rule: 3%
  - 2014 Final Rule: 2%
  - 2015 Final Rule: 1%
  - 2016 Proposed Rule: 0%

- **Diagnostic Testing Facility**
  - 2013 Final Rule: 7%
  - 2014 Final Rule: 2%
  - 2015 Final Rule: 2%
  - 2016 Proposed Rule: 3%

- **Interventional Radiology**
  - 2013 Final Rule: 0%
  - 2014 Final Rule: 3%
  - 2015 Final Rule: 2%
  - 2016 Proposed Rule: 1%

- **Nuclear Medicine**
  - 2013 Final Rule: 0%
  - 2014 Final Rule: 0%
  - 2015 Final Rule: 0%
  - 2016 Proposed Rule: 0%

Site Payment Differential Seizing National Attention

Obama Targeting Site Payment Gaps in 2016 Budget Request

- Budget provision would lower payments to services provided in off-campus hospital outpatient departments to applicable rate under either physician or ASC fee schedules
- Changes would be phased in beginning in 2017

Patients Confused, Angry About Facility Fees


“When [my doctor] called me after the procedure and told me I had to pay a facility fee […] I said: ‘You mean I have to pay separately for the building?!’”

Robert, Cincinnati

“Isn’t there a regulation or two against this sort of thing? Doctors and hospitals have found too many ways to squeeze money out of patients and insurance companies.”

Henry, New York

Payment Gap Making a Tangible Impact

Greater Payment for Echocardiograms Under HOPPS\(^1\)...

140%

Percent more Medicare currently pays for level II echocardiogram performed in HOPD\(^2\) rather than physician’s office

...Linked to Shift From Physician to HOPD Setting?

Percent Change in Echocardiogram Volume, 2010-2012

\[\begin{array}{c}
\text{In physicians' offices} & \text{In HOPDs} \\
-10\% & +33\%
\end{array}\]

Potential Savings from Implementing Site-Neutral Payments

$29.5 Billion

Estimated amount Medicare would save over 10 years

More than estimated savings from increasing Medicare eligibility from age 65 to 67

CMS to Begin Collecting Site-of-Service Data

Initiative Could Allow Agency to Question HOPPS\(^1\), MPFS\(^2\) Differentials

Site-of-Service Data Tracking Initiative

- CMS to identify sites that receive provider-based rates for ambulatory care but do not incur hospital facility costs due to being off-campus
- Hospitals billing under HOPPS required to report HCPCS\(^3\) modifier when services are performed at off-campus sites
- Physicians, other billing providers required to report site of care using new place of service code on professional claims

Finalized Timeline for Physicians, Hospitals to Report Site-of-Service Information

January 2015

- Reporting site-of-care HCPCS modifier voluntary for hospitals

January 2016

- Reporting modifier mandatory for hospitals
- Reporting POS\(^4\) code mandatory for physicians

New POS code to be introduced in mid-2015

MedPAC Says Collecting Site-of-Service Data Not Enough

“[The proposal] may have some value in helping policymakers understand the growing trend of hospitals acquiring physician practices. The information may also help CMS verify that PFS\(^1\) claims include the correct site of service. However, **the proposal does not address the fundamental problem of unjustified payment differences between settings.**”

*MedPAC Comment on CMS’s 2015 Proposed Physician Fee Schedule Rule, August 2014*

Advocates Payment Equalization or Reduction for Select Services

March 2012 Report to Congress

Recommended site-neutral payments for non-emergency E&M\(^2\) services at MPFS\(^3\) rates

March 2014 Report to Congress; August 2014 Letter to CMS

Reiterated earlier recommendations

June 2013 Report to Congress

- Developed five criteria for non-E&M services that may be reimbursed at MPFS levels
- Identified 66 non-E&M services that meet four or five criteria
- Recommended reducing HOPD\(^4\) payments either fully or partially down to MPFS levels for E&M and 66 services


---

1) Physician Fee Schedule.
2) Evaluation and management.
3) Medicare Physician Fee Schedule.
4) Hospital Outpatient Department.
MedPAC Refines Neutralization Recommendations

Calls Out Specific Exams to Target, Proposes Modifier for Tracking

Two Categories Under Consideration

Group 1
- HOPD rates should be set equal to office rates
- Affected APCs:
  - 265: Level I Ultrasound
  - 267: Level III Ultrasound
  - 269: Level II Echo w/o Contrast
  - 336: MRI and magnetic resonance angiography without contrast

Group 2
- HOPD rates should remain higher than office, but reduced from current levels
- Affected APCs:
  - 270: Level III Echos w/o Contrast
  - 377: Level II Cardiac Imaging
  - 383: Cardiac CT Imaging

Estimated Impact

$1.1B
Expected 1-year savings with reduction of 66 APC rates

(0.6%)
Estimated decrease in average hospital Medicare revenue

- CMS elects not to act on MedPAC discussion to level payment rates in CY 2014, but soliciting input on the methods to collect cost, payment data for off-campus, provider-based services, including claims-based modifiers and separated cost reports
- October 2014: Final 2015 rule enacts voluntary reporting requirement for new claim modifier for physician and off-campus, provider-based services; new modifier to become mandatory in 2016

The Potential Impact of Site-Neutral Payments

<table>
<thead>
<tr>
<th>APC</th>
<th>Most Frequent CPT Code</th>
<th>HOPPS Reimbursement</th>
<th>MPFS Reimbursement (TC¹ only)</th>
<th>Dollar (Percent) Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>0260– Level I Plain Film Except Teeth</td>
<td>71010 – Radiographic Procedure</td>
<td>$59.34</td>
<td>$13.23</td>
<td>-$46.11 (77.7%)</td>
</tr>
<tr>
<td>0261 – Level II Plain Film Except Teeth Including Bone Density Measurement</td>
<td>73030 – X-ray Exam of Shoulder</td>
<td>$94.98</td>
<td>$18.95</td>
<td>-$76.03 (80.0%)</td>
</tr>
<tr>
<td>0332 – CT w/o dye</td>
<td>70450 – CT head/brain w/o dye</td>
<td>$119.97</td>
<td>$72.94</td>
<td>-$47.03 (39.2%)</td>
</tr>
<tr>
<td>0266 – Level II Diagnostic Screening Ultrasound</td>
<td>93971 – Extremity Study</td>
<td>$134.80</td>
<td>$99.76</td>
<td>-$35.04 (26.0%)</td>
</tr>
<tr>
<td>0336 – MRI and MRA w/o Contrast</td>
<td>72148 – MRI lumbar spine w/o dye</td>
<td>$286.30</td>
<td>$146.95</td>
<td>-$139.35 (48.7%)</td>
</tr>
</tbody>
</table>

¹) Technical component.

MedPAC Methodology for Payment Alignment

### Five Criteria Used to Select APCs for Payment Alignment

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure frequently performed in physicians’ offices</td>
<td>more than 50 percent of the time</td>
</tr>
<tr>
<td>Minimal packaging differences across payment systems</td>
<td></td>
</tr>
<tr>
<td>Infrequently provided with an ED visit when furnished in an OPD</td>
<td></td>
</tr>
<tr>
<td>Patient severity that is no greater in OPDs than in freestanding offices</td>
<td></td>
</tr>
<tr>
<td>Not a 90-day global surgical code</td>
<td></td>
</tr>
</tbody>
</table>

### Methodology for Group Assignment

- **Group 1:** Satisfy all five criteria (24 APCs total)
- **Group 2:** Satisfy four of the five criteria but have a significantly higher level of packaging (the cost of packaged ancillaries was more than 5% of total HOPD cost) in the OPPS than in PFS (42 APCs total)

### Sample Methodology for Rate Adjustment

**APC 269 Level II Echo w/o Contrast (Group 1)**

Current Office: $188.31

Current HOPD: $390.49

Realigned HOPD: $188.31

52% reduction in payment to hospital

### Additional Considerations

- MedPAC considering proposal to apply policy to only top three CV imaging APCs instead of all 66 APCs
- MedPAC considering a “stop-loss” that would cap the reduction in payment for hospitals in under-served markets where impact could affect patient access

Two Potential Routes For Payment Equalization

Congress, CMS Both in Position to Push Proposal Forward

<table>
<thead>
<tr>
<th>Potential Opportunities for Adopting Proposal</th>
<th>CMS</th>
<th>Congress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any rulemaking cycle after mandatory site-of-service reporting begins in 2016</td>
<td>As part of larger deficit reduction package</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Obstacles</th>
<th>CMS</th>
<th>Congress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential hospital pushback: hospitals cite unique patient cohort and regulatory burdens to justify payment differential</td>
<td>Potential hospital pushback, challenge of securing bipartisan support, controversy around accompanying legislation (e.g. deficit reduction package)</td>
<td></td>
</tr>
</tbody>
</table>
Repeal of SGR Ends 13-Year History of Feared Physician Payment Cuts

Sustainable Growth Rate (SGR) Timeline
(1997-2015)

1997
Congress develops SGR, tying physician payments to economic performance of economy; initially led to physician payment increases because of economic upswing

2002
First year that Medicare spending grows faster than economy, forcing a 4.8% cut to PFS payments

2003-2014
Congress passes 17 “doc fix” bills either holding PFS payments steady or increasing them from between 0.2% and 2.2%

2015
Congress passes MACRA to comprehensively reform physician payments; became law on April 16


1) Sustainable growth rate.  
2) Physician Fee Schedule.  
SGR Repeal the Latest Push Toward Risk

Both Tracks Impose Greater Risk, Strong Incentives for Alternative Models

PFS\(^1\) Payment Models Beginning in 2019

1. **Merit-Based Incentive Payment System (MIPS)**
   - Consolidates existing P4P programs\(^2\)
   - Score based on quality, resource use, clinical improvement, and EHR use
   - Adjustments reach -9%/+27% by 2022
   - From 2019 through 2024, potential to share in $5M annual bonus pool

2. **Alternative Payment Models (APMs)**
   - Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS
   - Requires that physicians meet increased targets for revenue at risk
   - APMs must involve downside risk and quality measurement

---

**MIPS Performance Category Weights**

*For 2021*

- EHR Use: 25%
- Quality: 30%
- Clinical Improvement: 15%
- Resource Use: 30%

---

1) Physician Fee Schedule.
2) Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System.
3) Includes risk-based contracts with Medicare Advantage plans.

SGR Repeal: Key Implications for Physician Payment

1. **Slow payment increases locked in:** For the foreseeable future, Medicare provider payments will increase at a gradual annual rate that may not keep pace with inflation.

2. **Significant step in the shift toward value-based payments:** CMS recently set goals for transitioning to value-based payments; this law hardwires that transition for physicians.

3. **Boosts attractiveness of two-sided risk models:** Having a significant portion of revenue at risk will make a provider group eligible for higher payment rates that will compound each year.

4. **Reporting becoming less complex but more important:** By aggregating its three major provider reporting programs, CMS will cut down on a bureaucratic hurdle for many provider groups. However, the financial consequences of reported scores will be much greater.

5. **Payment is a zero-sum game:** Because the MIPS program is budget-neutral, penalties on low-performing providers must equal bonuses to high-performing physicians.

6. **Furthers the trend of price sensitivity:** The inclusion of two data transparency measures as well as an increased Medigap deductible indicate that the federal government is supporting and accelerating the trend of consumer price sensitivity.

---

1) The two exceptions to this rule are if all MIPS-eligible providers score below the performance threshold, or if the highest-scoring professionals reach a set payment adjustment ceiling.

Marching Toward Total Cost Management

CMS, Private Payers Committing to Alternative Payment Models

Medicare’s Proposed Timeline for Adoption of Alternative Payment Models

<table>
<thead>
<tr>
<th>Percentage of Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of 2014</td>
</tr>
<tr>
<td>End of 2016</td>
</tr>
<tr>
<td>End of 2018</td>
</tr>
</tbody>
</table>

Most ACOs Not Hitting Cost Saving Targets

Number of 114 ACOs who began in 2012 that did not generate enough savings to qualify for shared savings bonuses

Case in Brief: Health Care Transformation Taskforce

- Coalition of over 20 prominent health systems and private payers operating collaboratively to promote value; includes Advocate Healthcare, Ascension Health, Dignity Health, OSF Healthcare, Partners Healthcare, SSM Healthcare, Aetna, BCBS of California, BCBS of Massachusetts

Source: Imaging Performance Partnership interviews and analysis.
A Natural Target: Manage Imaging Utilization

Common Scenarios
- Most common exams ordered
- Most common patient indications leading to imaging
- Most common patient diagnoses with inappropriate imaging performed

Established Guidelines
- Exams with clear appropriate use guidelines
- Exams/indications included in Choosing Wisely lists

Financial Indicators
- Exams with highest average cost
- Exams with longest average lengths of stay
- Exams with highly variable lengths of stay
- Frequently denied exams

Ordering Clinicians
- Top ordering referring physicians
- Top ordering referring specialties or practices
- Most frequently denied ordering physicians

Related Resources

How to Tackle Utilization Management in Imaging
- Webconference teaches how to find imaging cost savings opportunities by addressing inpatients, ED patients and outpatients differently
- Learn how to modify clinical care pathways by assessing the downstream value of exams

Imaging Utilization Benchmark Generator
- Benchmarking tool generates imaging utilization benchmarks from Crimson national database
- Can customize data by region, case mix index, teaching status, and other metrics

Source: Imaging Performance Partnership interviews and analysis.
A New Federal Mandate around Appropriate Imaging

Demonstrating Value, Securing Reimbursement Rely on Getting It Right

#8: New Mandate for Clinical Decision Support by 2017 Prompts Additional Focus on Appropriate Care

Regulatory Timeline for Clinical Decision Support

- **November 2015**
  - MPFS\(^1\) CY 2016 Final Rule will finalize appropriate use criteria approval process

- **January 2017**
  - To receive **payment**, providers must include information about qualified clinical decision support mechanism used

- **November 2016**
  - MPFS CY 2017 Final Rule will establish appropriate use mechanism approval process

- **January 2020**
  - HHS will establish process for identifying **outlier** ordering providers and require them to obtain **preauthorization**


Beginning in 2017, to receive reimbursement, providers must indicate that the ordering clinician used an approved decision support mechanism to consult appropriate use criteria for all applicable outpatient imaging exams

Regulations in Brief: *MPFS Rules for CDS Specifications*

CMS will use MPFS rulemaking cycles to announce specific regulations regarding CDS. Rules will initially outline approval of CDS systems, then turn to payment changes and outlier identification process


1) Medicare Physician Fee Schedule.
Clinical Decision Support Shows Success on Multiple Metrics

- **$150 million** in savings for MN payers
- **24.4%** average utilization rate decrease for low-value procedures at Virginia Mason
- **7%** increase in appropriateness of primary care orders at Henry Ford
- **42%** decline in orders modified day of exam at Rockford Health System

Imaging Cannot Afford to Wait

- Starting 2017, technical and professional payments at risk if process not completed accurately
- Inability to explain and troubleshoot CDS may cause referring provider frustration, loss of referrals
- Radiologists unwilling to contribute to imaging guideline development face further commoditization as technology supplants radiologist as source of clinical information
- Proper implementation takes one year at the very least

#9: Changes in Insurance Coverage Models Increasingly Shifting Financial Responsibility to Patients

Patients Selecting High Deductibles, Narrow Networks

Insurers Betting Consumers Will Continue to Trade Choice for Price

**High-Deductible Health Plan Enrollment**

*Percentage of Commercially-Insured with Deductible of $1000 or More*

- **2003**: 7%
- **2005**: 10%
- **2010**: 18%
- **2012**: 25%

**Decline in proportion of individuals with a deductible under $500**

- **43%**

**Narrow Network Plan Designs Continue to Dominate Exchange Marketplace**

*Network Breadth in Largest City of Each State*

- **Ultra Narrow**: 22% in 2014, 21% in 2015
- **Narrow**: 38% in 2014, 41% in 2015
- **Broad**: 40% in 2014, 38% in 2015

Source:
- Imaging Performance Partnership interviews and analysis.

1) From 2003 to 2012.
Higher Deductibles Driving Increased Price Sensitivity

Consumers Increasingly Soliciting Pricing Information

Many Americans Lack Cash Flow to Cover Potential OOP Costs

Households Without Enough Liquid Assets to Pay Deductibles

- 24%
- 35%

More Consumers Attempting to Find Pricing Information

- Consumers who have tried to find out how much they would have to pay before getting care
  - 56%

- Those with deductibles of $500 to $3,000 who have solicited pricing information
  - 67%

- Those with deductibles higher than $3,000 who have solicited pricing information
  - 74%

“A surprising percentage of people with private insurance…simply do not have the resources to pay their deductibles.”

Drew Altman, President, Kaiser Family Foundation

1) $1,200 Single; $2,400 Family.
2) $2,500 Single; $5,000 Family.

New Purchasers and Providers Exerting Greater Influence

In Health Care, Customer Focus Now a Mandate

Employers Experimenting with New Services and Purchasing Mechanisms

Percentage of Employers with Strategies In Place or Planned for Next Year

- 38% Provide coverage for e-visits
- 60% Use COEs1 for non-transplant services
- 41% Use reference-based pricing
- 38% Offer onsite health services

Retail Clinics Stepping in to Meet Consumer Demand for Access

Six Largest Retail Clinics in the Nation

<table>
<thead>
<tr>
<th>Retail Clinic</th>
<th>Number of Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVS MinuteClinic</td>
<td>901</td>
</tr>
<tr>
<td>Walgreens Healthcare Clinic</td>
<td>437</td>
</tr>
<tr>
<td>Kroger Little Clinic</td>
<td>140</td>
</tr>
<tr>
<td>Walmart Retail Clinics</td>
<td>103</td>
</tr>
<tr>
<td>Target Clinic</td>
<td>80</td>
</tr>
<tr>
<td>RiteAid RediClinic</td>
<td>30</td>
</tr>
</tbody>
</table>


1) Centers of Excellence.
Retail Clinics Not a Threat to Imaging (For Now)

Consider Partnerships to Secure Referrals for Downstream Services

Common Retail Services

Wellness and Physicals
- One-time medication renewals
- Smoking cessation, weight loss

Screenings and Monitoring
- Cholesterol, diabetes screening
- High blood pressure, cholesterol monitoring

Labs and Tests
- A1c, blood sugar test, lipid panel

Potential Opportunities to Build Relationships and Referrals

Example: Retail sites provide smoking cessation programs and refer high-risk patients to provider’s lung cancer screening program

Sources: CVS Health; Imaging Performance Partnership research and analysis.
Understanding Imaging Patient Preferences

2015 Imaging Consumer Preferences Survey

• 2000+ patients
• 10 demographic questions
• Four non-max diff questions
• One max-diff question

What Do Imaging Patients Want….

Imagine you have injured your knee. Your physician has asked you to get an MRI to determine whether you need surgery. As such, you need to choose a facility to receive your MRI.

When selecting where to go for your imaging exam, which factor is the most important to you and which factor is the least important to you?

Why MRI?

• Represents an expensive, but fairly common imaging exam.
• Typically not an urgent exam, patients have time to shop around for the best “value”.
• Several providers that offer MRI scans, price for the service can vary widely.
• Facilitated testing for a variety of different imaging facility attributes including, price, service, access, and quality.

1) MaxDiff conjoint methodology requires participants to make trade-offs among various factors, revealing the relative importance of each factor tested.

Source: 2015 Imaging Patient Preferences Survey; Imaging Performance Partnership interviews and analysis.
Factors Range from Quality, Service, and Cost of Care

Max-Diff\(^1\) Question – Imaging Facility Factors Tested

| ✓ Provider credentials | ✓ Distance from office |
| ✓ Clinical outcomes   | ✓ Distance from errands |
| ✓ Academic affiliation| ✓ Scheduling options   |
| ✓ MRI technology      | ✓ Ancillaries available on-site |
| ✓ Total out of pocket costs | ✓ Other shopping available on-site |
| ✓ Cost transparency  | ✓ Scheduling options   |
| ✓ Insurance network status | ✓ Facility amenities and ambiance |
| ✓ Time to first available appointment | ✓ Provider empathy |
| ✓ Approximate wait-time at facility | ✓ Patient education during visit |
| ✓ Extended hours     | ✓ Patient satisfaction scores |
| ✓ Travel time        | ✓ MRI results report turnaround time |
| ✓ Distance from home | ✓ Recommendation by doctor |
|                      | ✓ Recommendation by friend |
|                      | ✓ Online review recommendation |
|                      | ✓ Hospital affiliation |
|                      | ✓ Partnership with best hospital used by patient |
|                      | ✓ Partnership with best hospital in the area |
|                      | ✓ Partnership with university hospital in the area |

1) MaxDiff conjoint methodology requires participants to make trade-offs among various factors, revealing the relative importance of each factor tested.

Source: 2015 Imaging Patient Preferences Survey; Imaging Performance Partnership interviews and analysis.
## The Value of Max-Diff Analysis

### Common Market Research Tool Used to Prioritize Product Features

### Creating the Perfect Family Car

<table>
<thead>
<tr>
<th>Feature</th>
<th>Most</th>
<th>Least</th>
</tr>
</thead>
<tbody>
<tr>
<td>Backseat cupholders</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>Third row seating</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>DVD player</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
</tbody>
</table>

### Attribute Ranking

<table>
<thead>
<tr>
<th>Rank</th>
<th>Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Built-in carseats</td>
</tr>
<tr>
<td>#2</td>
<td>Side airbags</td>
</tr>
<tr>
<td>#3</td>
<td>DVD player</td>
</tr>
<tr>
<td>#4</td>
<td>Backseat cupholders</td>
</tr>
<tr>
<td>#5</td>
<td>Third row seating</td>
</tr>
</tbody>
</table>

Source: 2015 Imaging Patient Preferences Survey; Imaging Performance Partnership interviews and analysis.
How to Interpret the Data

Results Provide Apples-to-Apples Comparison

Importance of Family Car Features

Utility Scores

Utility scores for the set of attributes sum to 100

Utility scores represent the relative value of each attribute, e.g., backseat cupholders are preferred 3:1 over third row seating

Advantages of Max-Diff Surveys

1. Allow researchers to understand the magnitude of difference between ranked attributes

2. Force respondents to choose between attributes, preventing ceiling effects

Source: 2015 Imaging Patient Preferences Survey; Imaging Performance Partnership interviews and analysis.
### Imaging Consumers’ Top 10 Preferences

**When deciding where to go for your imaging exam, what factors are most important, least important?**

*Mean Utility Scores*

*n=2,040*

<table>
<thead>
<tr>
<th>Preference</th>
<th>Utility Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-pocket costs will be less than $30</td>
<td>3.39</td>
</tr>
<tr>
<td>Same-day results</td>
<td>3.19</td>
</tr>
<tr>
<td>Provider is in-network</td>
<td>3.15</td>
</tr>
<tr>
<td>Imaging facility has most advanced level of technology</td>
<td>3.05</td>
</tr>
<tr>
<td>A radiologist who is subspecialized in reading this type of MRI will interpret my scan</td>
<td>3.00</td>
</tr>
<tr>
<td>Once I arrive at the facility, I will wait 5 mins or less</td>
<td>2.93</td>
</tr>
<tr>
<td>Doctor recommendation</td>
<td>2.89</td>
</tr>
<tr>
<td>Facility provides comprehensive understanding of procedure, condition, diagnosis</td>
<td>2.85</td>
</tr>
<tr>
<td>Quality scores far above industry average</td>
<td>2.81</td>
</tr>
<tr>
<td>Patient satisfaction scores far above industry average</td>
<td>2.76</td>
</tr>
</tbody>
</table>

Source: 2015 Imaging Patient Preferences Survey; Imaging Performance Partnership interviews and analysis.
## Doctor Recommendation Not Top of the List

When deciding where to go for your imaging exam, what factors are most important, least important?

*Mean Utility Scores*

n=2,040

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mean Utility Score</th>
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<tbody>
<tr>
<td>Out-of-pocket costs will be less than $30</td>
<td>3.4</td>
</tr>
<tr>
<td>Same-day results</td>
<td>3.2</td>
</tr>
<tr>
<td>Provider is in-network</td>
<td>3.2</td>
</tr>
<tr>
<td>Imaging facility has most advanced level of technology</td>
<td>3.1</td>
</tr>
<tr>
<td>A radiologist who is subspecialized in reading this type of MRI will interpret my scan</td>
<td>3.0</td>
</tr>
<tr>
<td>Once I arrive at the facility, I will wait 5 mins or less</td>
<td>2.9</td>
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<tr>
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Source: 2015 Imaging Patient Preferences Survey; Imaging Performance Partnership interviews and analysis.
## Cost Considerations Weigh Heavily

When deciding where to go for your imaging exam, what factors are most important, least important?

*Mean Utility Scores*

n=2,040

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Source: 2015 Imaging Patient Preferences Survey; Imaging Performance Partnership interviews and analysis.
## Patients Want Same-Day Results

When deciding where to go for your imaging exam, what factors are most important, least important?

*Mean Utility Scores*

n=2,040

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Source: 2015 Imaging Patient Preferences Survey; Imaging Performance Partnership interviews and analysis.
Consumers Searching Online for Quality Information

Which websites have you searched for quality performance data on an imaging facility or radiologists?

1 in 5 respondents report searching any website for quality performance data

- Healthgrades: 237
- Medicare: 177
- Hospital Compare: 166
- Physician Compare: 22
- Other

Source: 2015 Imaging Patient Preferences Survey; Imaging Performance Partnership interviews and analysis.
Introducing Two New Resources

2015 Imaging Patient Preferences Results Portal and Research Briefing

Imaging Consumer Preferences Results Portal

- View data on how patients select imaging providers and which factors are most important in patient decision making
- Users can modify cohort to create and save different patient subpopulations

Imaging Consumer Preferences Research Briefing

- See our top ten key takeaways from the imaging consumer preferences survey
- Get resources to help deliver on consumer preferences

Source: 2015 Imaging Patient Preferences Survey; Imaging Performance Partnership interviews and analysis.
The Bigger Health Care Picture

Key Observations for Radiology Providers

Questions