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# Radiology Trends

## CMS Projects Higher Healthcare Spending Growth Through 2024

U.S. health spending is expected to grow 5.8% annually between 2014 and 2024, according to projections from CMS economists and actuaries. The amount spent on healthcare in 2014 alone is projected to have risen 5.5% — the first time since 2007 that the growth rate exceeded 5%. Total Medicare spending is expected to increase more between 2018 and 2024, according to the projections, and by 2024, total Medicare expenses could go up by 7.9% since older Medicare patients require more intensive and expensive treatment options. Baby boomers started becoming eligible for Medicare in droves in 2011. CMS officials say the Affordable Care Act's insurance expansion, an improving economy, an aging population, and expensive new drugs are pushing up health costs once again.

Although healthcare expenditures now are on a faster growth trajectory than they were over the past five years — when spending never exceeded 4% a year — CMS officials don't think increases will reach the unsustainable rates seen before the Great Recession. That's because high-deductible health plans will constrain health spending, said Gigi Cuckler, an economist with the CMS' Office of the Actuary.

Higher deductibles and increased cost-sharing have raised questions about whether people are skipping necessary care and if those mechanisms disproportionately hurt the pocketbooks of less-affluent Americans. Overall U.S. economic growth is a major variable. “By far the biggest impact on healthcare spending is how much you have to spend,” said Tom Getzen, a health economist at Temple University. “It really critically depends on how the economy grows.”

### *Did You Know?*

*A dual breast exam using MRI and Near Infrared Spectral Tomography (NIRST) is feasible and more accurate than a MRI alone.*

## Employers Warming Up To Private Insurance Exchanges

Employers and health insurance companies have shown a visible appetite for private health exchanges, building on executives' desires nationwide to keep the growth of healthcare costs manageable. But private exchanges still remain far from widespread. Private exchanges are online health insurance marketplaces for a company's employee base. Employers often give their workers a defined contribution to buy medical plans, and then they choose coverage from one or several participating insurance companies. The private exchange market has been a boon to outsourcing firms like Aon Hewitt, Mercer and Connecture, which build the marketplaces.

The Affordable Care Act has promoted the exchange concept through the public individual and small-group markets. The central idea of the exchanges is that consumers will have ample health plan choice, therefore keeping premiums in check through competition and allowing consumers to find a plan that fits their needs. Many studies and surveys have shown people care more about their doctors and provider networks than the actual number of coverage choices they have. Private exchanges indirectly encourage plans where employees will shoulder more out-of-pocket costs. About 6 million workers selected their health plans through private exchanges for 2015, double the amount from 2014 but still a very small amount of the employed market overall, according to consulting firm Accenture. They predict 40 million of the roughly 150 million nonelderly people with employer health insurance will be choosing their plans through private exchanges by 2018.

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## Bad Metrics Put Patients At Risk, Prevent Provider Improvement

Hospitals most often penalized by CMS for not reducing hospital-acquired conditions are those that do well on other publicly reported quality measures and are accredited by the Joint Commis-sion. This could lead to patients being inadvertently steered away from better performing facilities and it could also prevent low performers from receiving the feedback necessary to improve.

The researchers, led by Dr. Karl Bilimoria, director of the Surgical Outcomes and Quality Improvement Center at Northwestern University, co-authored the new study. Bilimoria and his colleagues evaluated which types of facilities were most likely to be issued a 1% penalty by CMS on all Medicare revenue if they failed to reduce a dozen hospital-acquired conditions, such as pressure ulcers, postoperative hip fractures, surgical-site infections and central-line associated bloodstream infections. They found 24% of the penalized facilities were Joint Commission accredited while only 14% were not; 28% were safety net hospitals while only about 1 out of 5 were not; and 62% were "very major" (or, those with the highest resident-to-bed ratios) teaching hospitals compared with only 17% of non-teaching hospitals. They developed a hospital quality summary score in which facilities got one point based on eight characteristics, such as Joint Commission accreditation, provision of transplant services; level I trauma center status; and others. The factors indicated quality and the complexity of patients treated. Hospitals with the highest score of eight were penalized five times more frequently than those with the lowest score.

CMS bases more than a third of a facility's overall HAC score on a composite patient-safety indicator that comprises eight measures, including one for a type of blood clot called deep vein thrombosis. Use of that measure in the composite led to a surprising amount of variation in the study. Hospitals with better surveillance systems to search for the condition were more likely to identify and report the event, which the authors said made it appear their performance was worse.

Under the current CMS system, facilities spend a full year reporting data, and they are either rewarded for high performance or penalized for poor performance the following fiscal year. Although the delays make sense from a programming perspective, the format may have not have the intended impact on behavior change, according to healthcare and behavior economists who focus on the design of value-based purchasing programs. "You don't have that frequent feedback, the link between how you're doing and what that means for payments," said Andrew Ryan, of the University of Michigan's School of Public Health. "It's hard for hospital administrators and practices to understand exactly how they are doing and give feedback to physicians on how to adjust and recalibrate," he said. Setting standards for publicly reported measures would ensure the metrics be accurate and allow findings to be validated, said Dr. Peter Pronovost, director of the Armstrong Institute for Patient Safety and Quality. Right now there is somewhat of an "any data is better than no data approach," he said.

## Coding and Compliance Tips by Lori Shore, CPC, RCC

### CMS Provides One-Year Reprieve on Specificity

The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) have reached a truce of sorts on the issue of ICD-10. The AMA was pushing for a two-year transition period but has conceded to a one-year transition period under which CMS will not deny or audit claims strictly based on ICD-10 specificity. This will be in effect as long as the codes are from the correct family of codes. In other words, if the ICD-10 code is in the "right church, wrong pew" it will still be paid and won't be audited **BUT** only for the calendar year 2016. CMS has also said that ICD-10 codes that lack specificity in 2015 will not affect value-based modifier payments or meaningful use programs.

One year will go quickly, so rather than breathe a sigh of relief, use this year to increase the specific-ity of your reports. The first code that comes to mind is "Chest pain, unspecified." Begin to incorporate details such as "precordial pain, or painful respiration."

There is good news though! There is **NO** national requirement to use the External Causes of Morbidity codes! Unless these codes are state mandated we will not be required to code them. Learn more about other ICD-10 Myths and Facts by clicking this link: http://www.cms.gov/Medicare/Coding/ICD10/downloads/icd-10mythsandfacts.pdf