

RADIOLOGY TRENDS

November 2019

MA Plans Per Beneficiary To Reach Record Level

The average number of Medicare Advantage plans per beneficiary will increase in 2020 to the highest level since 2010. The **analysis released** from the Kaiser Family Foundation found there will be 3,148 MA plans in 2020, an increase of 414 plans compared to 2019. Medicare Advantage has become a lucrative option for insurers, with 13 new insurers entering the market next year compared to one insurer exiting the market. The average Medicare beneficiary will have access to 28 Medicare Advantage plans next year, an increase from 24 in 2019.

The number of plans per beneficiary is the highest since 2010 when Medicare customers could choose from 33 plans, according to the Kaiser analysis. However, there is a difference on the number of plans offered based on where in the country the beneficiary is located. For example, beneficiaries in metropolitan counties can choose from an average of 31 plans compared to 16 plans in non-metropolitan counties. Interestingly, six counties in Ohio and Pennsylvania will offer more than 60 plans per beneficiary on average. However there will be no plans offered in 77 counties, "accounting for less than 1% of beneficiaries."

The agency estimates that 24.4 million Medicare beneficiaries out of about 60 million members will get an MA plan in 2020. Currently there are 22.2 members participating in Medicare Advantage. Premiums for Medicare Advantage plans are expected to decline next year by 14% compared to 2019, according to CMS data. The Trump administration has sought to boost MA in recent years and points to growth in the program as a counter to the Democratic proposals to expand Medicare to every American. "Proposals for more government in our healthcare--- such as Medicare-for-All---would eviscerate the progress we've made to strengthen the program by empowering patients to make informed decisions in choosing high-quality plans that best fit their needs," CMS Administrator Seema Verma said in a release announcing the 2020 star ratings for Part D and MA plans. Medicare open enrollment started October 15th and will run through December 7th.

Medical School Without Cadavers?

Medical training using cadavers dates back as far as the 13th century; however, that may be changing. Beginning in 2020, Kaiser Permanente School of Medicine will begin its first class of medical school students to use virtual reality rather than cadavers for their training. While there are pros and cons for both schools of thought, cost is a big factor. The cadavers are donated but the cost to maintain a cadaver lab at a medical school can cost millions of dollars. Kaiser Permanente is not the only medical school making this paradigm shift. James Young, chief academic officer at the Cleveland Clinic Lerner College of Medicine, has also reported that they are going to virtual reality as well. Young told Bahar Gholipour in a Scientific American article (October, 2019), "That shift is going to take several years. But if you asked me how is anatomy education going to be done in a decade? It's not going to be done with cadavers. That's my prediction."

Stanford University School of Medicine began using virtual reality in 2016 for training in their Neurosurgical Simulation and Virtual Reality Center. They use the "Surgical Theater," as they call it, to view and explore organs from many angles then move to the anatomy lab to see and touch the same structures on cadavers. There are two main types of mediated reality: Virtual reality (VR) and augmented reality (AR). VR uses a computer generated 3-D environment using a head-mounted display and an input device, such as a controller or data glove, to interact with that virtual environment. It tries to eliminate external stimuli and simulate natural interactions through sight, touch and sound. AR does not immerse the user in an alternative reality, but rather uses computer generated images to enhance the real environment. "It's really driving the creativity of a lot of the schools, which is a great position for us to be in. Of course, all of that creativity must above all serve our learners and their patients," says Warren Wiechmann, MD, Associate Dean of Clinical Science Education and Educational Technology at the University of California Irvine School of Medicine.

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Are your radiologists overworked? Here are 2 ways to delegate their workload.

10:15 AM on October 11, 2019 by [Matt Morrill](#) and Catherine Kosse. The Advisory Board Company is the owner and publisher of this article.

One of the most common metrics measuring radiologist productivity is turnaround time, with radiologists continually pushed to work more efficiently. But the push towards faster turnaround times, combined with greater imaging utilization, continues to **stretch radiologist capacity**.

While this push benefits the speed of care delivery, it can negatively affect radiologists' work-life balance. In fact, the **2019 Medscape National Physician Burnout, Depression, and Suicide Report** found that 45% of radiologists suffer from burnout. It's on radiology group and hospital imaging leaders to uncover ways to balance radiologist workload and ambitious productivity goals.

Leaders should consider ways to leverage non-radiologist staff to delegate radiologist workload. Specifically, they should allow non-physician providers to read x-rays and use support staff to minimize radiologist interruptions.

1. Delegate some imaging exam reads to non-physician providers

While other service lines rely heavily on non-physician providers (NPPs) to deliver care, radiology has largely resisted this shift. However, a recent study from the American Journal of Roentgenology found that Medicare diagnostic imaging exams read by NPPs increased by 14,711% from 1994 to 2015, with X-ray and fluoroscopy accounting for the vast majority (94%) of this total. However, it's worth noting that NPPs accounted for only 1.27% of imaging in 2015.

At the same time, scope-of-practice laws for NPPs, including radiology assistants (RAs) are evolving. Last year, CMS **changed the supervision requirements** for diagnostic tests furnished by RAs from "personal" to "direct," meaning that instead of requiring physicians to be in the room during tests, they must be immediately available.

In response to these trends, leaders should consider incorporating NPPs into diagnostic and interventional radiology workflow to reduce radiologist workflow. Typically, NPPs provide preliminary exam reads under the supervision of a radiologist and makes clinical recommendations to referring providers for interventional radiology exams. Ultimately the role of NPPs depends on state scope-of-practice laws and organizational preferences, but these staff members can increase overall efficiency, deliver high-quality patient care, and lower overall cost.

2. Minimize radiologist interruptions

On average, radiologists experience interruptions **five times an hour**, which increases their read time. These interruptions take many forms, from responding to referring physician requests, answering a phone call, talking to a colleague, or managing critical results.

Asheville Radiology lessened this burden by delegating all radiologist critical result calls to non-radiologist staff, called RadReach, so as to minimize interruptions during reads. When a radiologist identifies a critical result, he or she clicks a button in his or her picture archiving and communication system (PACS) enabled by Primordial from Nuance. An alert then goes to one of the two RadReach staff members, who calls the referring physicians and transfers the call to the radiologist. This approach ensures that the radiologist doesn't waste any time tracking down the physician or waiting on hold. Overall, RadReach staff monitor all critical findings and personally manage about 60% on physician calls. Radiologists own the remaining 40% of calls, because sometimes it is more efficient for the radiologist to call directly. When RadReach manages communication, they save radiologists an average of 18 minutes per case, which equates to 450 minutes daily across the practice. It's been so successful that Asheville uses the same model to track quality initiatives, like incidental findings. Read more [here](#).



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