Potential Impact of the DRA of 2005 on the Outpatient Imaging Market

The DRA of 2005 has not been derailed yet. The fee scheduled is in place and the comment period on the rule change has been completed. Although a large number of Senators and Congressmen have co-sponsored bills to delay the impact of this legislation, there is no guarantee that these bills will be passed and become law. If you consider the statistics on the legislative process for bills that become law, approximately 100,000 bills are proposed in each session of Congress and less than 5% become law. The safer bet at this point is that the DRA will be activated on January 1, 2007 unchanged and unaltered by new legislation. If the DRA arrives on schedule, the remaining questions will be how will the outpatient imaging center market change as a result of the DRA, and how will access to care be affected for Medicare beneficiaries.

The recent report by the Moran Group suggests that a large number of high end procedures will be reimbursed at rates that are below their cost levels. In general their report projects an average overall revenue reduction of approximately 18% for most imaging centers. This will be a very difficult reduction for outpatient imaging centers to absorb based on their high fixed cost structure.

Within the outpatient imagining market, The DRA will function very much like a regressive tax. Regressive taxes such as sales taxes do not take into account the ability of the tax payer to pay the tax. If you are wealthy, and have lots of cash flow a sales tax is a non-issue. If you are living near the poverty line with limited cash flow a sales tax is a very large issue. For multimodality imaging centers that have made large capital outlays to have state of the art equipment in their facilities, the DRA is like the regressive tax on the low income tax payer. These centers are capable of doing the best work, but because they have invested in quality it is very likely that they have the lowest cash flow as a percentage of their revenue. The DRA represents a very difficult reduction in their revenue or essentially a regressive tax for centers of this type.

On the other hand as imaging centers mature they complete the payment of their imaging equipment leases and these centers then operate without the burden of large monthly lease payments for their imaging equipment. At this point in the center's life cycle, the financial condition of the center improves dramatically adding between $30,000 and $60,000 per month to the bottom line. For these centers the impact of the DRA will be painful, but manageable. Although their equipment leases are paid off at this point and

their cash flow and profitability are much improved, they are providing their imaging services with equipment that is generally more than five years old. The regressive nature of the DRA will reward outpatient imaging centers that have not invested in the newest systems and will penalize imaging centers who have invested in high quality state of the art systems.

The DRA will also cause centers with higher overhead costs and loss leader modalities to rethink their modality offerings. Financial executives sometimes talk about the concept of "addition by subtraction". This means that you can improve your profitability by eliminating services that do not add profit to your center or operate at a loss, thereby making the imaging center more profitable to help offset the loss of revenue from the DRA. In the past for most imaging centers the most profitable services have been MRI and CT. The change in reimbursement for these services reduces a multimodality imaging center's ability to provide services that are marginal or unprofitable as a continued service to the community. For example, if a multimodality imaging center provides x-ray, bone densitometry and mammography services, and for this center these services are not profitable, they may be forced to discontinue them reducing the access to care for the patients in their service area and at the same time improve their profitability allowing them the opportunity to improve their ability to cope with the DRA.

Generally single modality MRI centers have the best opportunity to survive the DRA on an economic basis because they have the lowest overhead costs outside of their equipment leases. Typically a single modality center leases or buys between 2,000 and 3,000 square feet of office space for its operation and employs between 6 and 12 people to provide its service. Multimodality centers range generally range in size from 8,000 to 16,000 square feet in size and can have a staff of as many as 75 people across all of its modalities.

Some radiologists have posted comments on various websites in favor of the DRA because they believe that it will eliminate the potential for over-utilization of high end imaging services by other medical specialties that have installed imaging systems in their offices. This is a relatively short sighted view that needs to be reconsidered. It assumes that all specialists who install imaging equipment in their practices will immediately increase their overall referral rates for imaging services and send these studies to their own imaging equipment. This view also assumes that the regressive nature of the rule change will stifle physician office installations. The DRA would stifle these installations if the financial models for office based installations were the same as for outpatient imaging centers; however these two business models are really very different.

In fact, the DRA rule changes may accelerate the deployment of high end imaging equipment into the physician office market. Neurology, cardiology and orthopedic practices that consider these purchases are usually very large groups. When their business managers conduct the imaging center financial analysis it is usually based on their current imaging referral rates at the time the project is being considered. They usually learn that there is no need to add volume to make the project viable. Their current referral base will support the investment.

If the large non-radiology group buys its own scanner, they will have to add a very small amount of office space and a small number of employees to operate this additional service. Their current staff already includes an office manager, receptionists, billing professionals, and other necessary staff. They will only need to add the technologists to operate the equipment. Therefore for the cost of leasing about 1500 square feet, and two or three employees and the imaging system of choice they can add this service to their practices. In addition since the patients will come from their own practices they will have no cost of sales and marketing to bring patients into their office based scanner.

This physician office model will be more cost effective than the local outpatient imaging center because it will have lower overall costs per scan when compared with the local outpatient imaging centers. Therefore it will be able to be profitable at lower volumes and lower reimbursement rates than the outpatient imaging centers in the same market. The outpatient imaging centers in the markets where these vertical integrations occur will also be faced with smaller available imaging patient pools in their local markets. The office practice model will remove their patients from normal market competition and make them an internal patient pool for their practice to draw from. The imaging centers will have to compete more aggressively for the remaining business in their areas, The DRA by itself could potentially become a driving force to move imaging services into the office practice market rather than curb this trend.

There have been many public policy discussions and a few congressional bills proposed over the last few years that promote pay for performance programs. This legislation would stimulate the market to meet well defined quality standards. Part of the Medicare budget would be set aside to pay a premium to those organizations that consistently meet the new standards of excellence. In most cases it is assumed that these proposals would also help to control imaging costs.

In September the Institute of Medicine published its position on patient centered care and pay for performance. Their committee report calls on Medicare to move forward with the development of a pay for performance program and the data monitoring system that would evaluate the effectiveness of this new approach. Their report suggests that a pay for performance system would benefit patients with improved care while also providing savings for the Medicare system.

Efforts of this type are very important to our healthcare system. We are faced with the challenge of lowering the rate of growth in healthcare expenditures, while improving the quality of the services provided as the baby boomer generation becomes Medicare eligible. This is certainly a daunting task. The DRA with its regressive mechanisms to control growth in spending has the real potential of reducing the number of high quality imaging centers that currently exist, even though they are well positioned to compete in a pay for performance environment. The DRA will not stop the spread of imaging modalities into specialists' offices; it might actually accelerate this trend. It will also the secondary effect of reducing the availability of outpatient imaging services that are not profitable, impacting the access to care for many patients. If the DRA is implemented

without the evaluation of its potential consequences over the next few years, it is very likely that the remaining traditional outpatient imaging market will be composed of imaging centers that provide their services with aging imaging equipment in a segment of the healthcare economy that has historically grown through developing new technology to provide improvements in quality and service to physicians and their patients.

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