Foundational Changes Critical to Payments for Radiology Services

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Abstract

In early 2015, Sylvia Burwell, Secretary of the Department of Health and Human Services, described the federal administration's goals for delivery of health care in the United States. Prominently featured was a conversion from volume to value through the incorporation of Alternative Payment Models. The Department of Health and Human Services laid the framework, but recognized significant knowledge gaps in how providers and institutions would develop Alternative Payment Models. To that end, the Health Care Payment Learning and Action Network was conceived. On March 25, 2015, the Health Care Payment Learning and Action Network held its first meeting, which included a broad swath of industry participants. This collaboration was considered mission critical to achieving success in the goals of advancing Alternative Payment Models. This article highlights the Health Care Payment Learning and Action Network and the framework it is proposing for Alternative Payment Models that would have meaningful implications for radiologists.

Key Words: Health policy, Alternative Payment Models, fee-for-service, population health, radiology practice

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INTRODUCTION

The US health care system is challenged by high cost and the perception that many of the medical services provided add little value to overall patient care. Over 17% of the gross domestic product, an amount exceeding $3 trillion dollars, is spent on health care per year [1,2]. As a standalone, that enormous sum would represent the fifth largest economy in the world when compared with national gross domestic products (ie, larger than the United Kingdom's entire economy). Thus, increasing value is imperative.

In 2006, Elliot Fisher first introduced the term *accountable care* into the national dialogue [3]. The Affordable Care Act (ACA) moved discussions of accountable care dramatically forward [4]. Section 3021 of the ACA established the Centers for Medicare and Medicaid Services (CMS) Innovation Center, the purpose of which is to test "innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care" [5].

CMS Innovation Center has focused on seven distinct payment and health care delivery categories. These include Accountable Care, Episode Based Payment Initiatives, Primary Care Transformation, Initiatives Focused on the Medicaid and Children's Health Insurance Program (CHIP) population, Initiatives Focused on the Medicare-Medicaid Enrollees, Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models, and Initiatives to Speed the Adoption of Best Practices [6]. Prior articles have provided insights into how radiological care might be delivered in many of these systems [4,7].

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In January 2015, Sylvia Burwell laid out three central tenets for the administration's overarching vision for the future delivery of US health care [8,9];

1. Incentives will be used to motivate higher value care by increasingly tying payment to value through Alternative Payment Models (APMs).
   - Eighty-five percent of all Medicare fee-for-service (FFS) payments will be tied to quality or value by 2016 (and 90% by 2018).
   - Thirty percent of Medicare payments will be tied to APMs by the end of 2016, and 50% of payments by the end of 2018.
2. The way care is delivered will be changed through greater teamwork and integration, more effective coordination of providers across settings, and greater attention by providers to population health.
3. The power of information to improve care for patients will be harnessed.

Considering the relatively recent introduction of APMs to the Medicare discussion and the small number of patients participating in those models, the goal of shifting 50% of all Medicare payments to being tied to APMs by the end of 2018 is quite extraordinary. Furthermore, early data have raised questions about the economic viability of some of APMs [10]. Passed on the heels of Burwell's road map for the delivery of health care, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided CMS the legislative framework to develop the Medicare Quality Payment Program (QPP). Regulations outlining the initial QPP rollout were updated in October 2016 and defined the relationships between quality and FFS arrangements in the Merit Based Incentive Payment System (MIPS), which begins affecting physician payments in 2019. The QPP also outlined requirements for obtaining incentives by participating in certain APMs. These requirements for qualifying for these incentives include (1) more than nominal financial risk for providers or a medical home; (2) embedded quality measures for base payments similar to the MIPS; and (3) use of certified electronic health record technology.

APMs meeting these requirements can be designated Advanced APMs and participants can qualify for more significant incentive payments. However, in the initial QPP rollout, only eight plans qualified for Advanced APM status, and CMS expects less than 10% of all physicians will qualify for significant incentives for participation in APMs [11-13].

ENTER THE HEALTH CARE PAYMENT LEARNING AND ACTION NETWORK

One reason for slow participation in APMs is that at present only a few qualify as Advanced APMs, and most of these are centered on primary care providers. CMS recognizes that more models need to be developed, particularly those that promote greater specialist participation. However, many novel payment models remain untested in widespread use, and a road map for creating APMs that meet the criteria for an Advanced APM and work in clinical practice are still in development. Even before passage of MACRA legislation, the Department of Health and Human Services recognized the need to bring all stakeholders together to develop ways to create successful APMs.

Indeed, while focusing on developing APMs, the administration recognized that optimized ways of achieving APMs were unclear. Thus, the Health Care Payment Learning and Action Network, generally referred to as the LAN, was conceived. Its mission is to accelerate the transition to APMs by aligning stakeholders across sectors [14]. On March 25, 2015, the LAN held its inaugural meeting in Washington, DC. Over 200 groups participated, representing multiple stakeholders potentially involved in health care delivery. The LAN operates as a public-private partnership.

Secretary Burwell and President Obama spoke at the inaugural meeting. As documented in a meeting summary provided by the LAN, the president stated during the meeting: "We're moving Medicare toward a payment model that rewards quality of care instead of quantity of care. We don't want the incentives to be skewed so that providers feel obliged to do more tests; we want them to do the right tests." President Obama also stated: "We want them to save—to invest some money on the front end to prevent disease and not just on the back end to treat disease. And so these changes are encouraging doctors and hospitals to focus on getting better outcomes for their patients" [15].

Additionally, at that meeting it was announced that the MITRE Corporation was selected to administer the LAN. MITRE has its roots in Cambridge, Massachusetts at the computer labs of the Massachusetts Institute of Technology. In 1958, the MITRE Corporation was chartered as a private, not-for-profit corporation that provided engineering guidance to the federal government and hence, by definition, serves the public interest. MITRE operates federally funded research and development centers. In 2012, 2 years after the passage of the

ACA, CMS founded the Alliance to Modernize Healthcare (CAMH), a federally funded research and development center [16]. CAMH seeks to advance the nation's progress toward an integrated health system with improved access and quality at a sustainable cost, and the LAN is one project within CAMH. In the spring of 2015, MITRE established the LAN's Guiding Committee to identify priorities and provide recommendations back to MITRE in its role as the LAN convener. In consultation with the Guiding Committee, MITRE set up five work groups to address a wide range of topics, including the Alternative Payment Model Framework and Progress Tracking Work Group, whose major work product to date has been a white paper released January 12, 2016, that describes a framework for categorizing APMs [17]. Interested readers are encouraged to directly review this white paper, which is publicly available online [17].

THE LAN's APM FRAMEWORK

In its white paper, the Work Group proclaims they reached consensus on a set of conventions for describing payment reform that is capable of supporting the delivery of person-centered care. Though not specifically part of its charge, the work group also developed a working definition of that type of patient-centric care. The definition recognizes high-quality care that is evidence-based and delivered in an efficient manner, and for which patients' and caregivers' individual preferences, needs, and values are paramount. Although it seems that all providers and institutions would be happy to support such goals [17], simple examples such as the timing of hospital visiting hours often demonstrate the complexity of the issues of balancing the needs of the patients and the efficiencies of the caregivers. For instance, do set visiting hours in hospitals, which have been a part of health care dating back many decades, support the preferences or needs of patients and family or caregivers, or do they support the most efficient practice for the institutions and providers that are treating them?

The work group considers it mission critical for US health care to transition away from FFS to provide this optimized vision of patient-centered care. The Work Group points to population-based payments as opportunities for providers to deliver high-value health care. Table 1 summarizes seven principles of the APM Framework, as indicated in the LAN white paper [17].

Table 1. Seven principles of the Alternative Payment Model Framework described by the Health Care Payment Learning & Action Network (from reference 17)

1. Changing providers' financial incentives is not sufficient to achieve person-centered care, so it will be essential to empower patients to be partners in health care transformation.
2. The goal for payment reform is to shift US health care spending significantly towards population-based (and more person-focused) payments.
3. Value-based incentives should ideally reach the providers that deliver care.
4. Payment models that do not take quality into account are not considered APMs in the APM Framework, and do not count as progress toward payment reform.
5. Value-based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.
6. APMs will be classified according to the dominant form of payment when more than one type of payment is used.
7. Centers of excellence, accountable care organizations, and patient-centered medical homes are examples, rather than categories, in the APM Framework because they are delivery systems that can be applied to and supported by a variety of payment models.

Independent from the LAN, CMS has also defined a four-part framework of progressive accountability for quality and value, ranging from pure FFS to population-based health [18]. The LAN has taken this concept further by articulating multiple new categories and subcategories that refine the original CMS proposal.

Category 1 is FFS with no link to quality or value. The LAN views this as the one of the least effective methods of achieving an optimized health care system, clearly believing that continued utilization of this system will not allow the United States to achieve an ideal state. Beyond that, the LAN argues that diagnosis-related groups that are not linked to quality or value fall within this overall category [17].

Category 2 is the next step on the evolutionary chain in that it still is composed of FFS payments, though these payments are linked to quality and value. At present, the FFS remains the dominant form of physician reimbursement. However, linking payments to quality is a necessary step in the evolution toward true APMs. As shown in Table 2, the LAN describes four subcategories in ascending order that demonstrate the evolution in the development of a high-performing quality program from initially providing the incentives to build a quality

Table 2. Four subcategories of category 2 (fee-for-service with link to quality and value) in the Alternative Payment Model framework described by the Health Care Payment Learning & Action Network (from reference 17)

2A	includes payment for infrastructure investments that can improve the quality of care while not reliant on performance in quality metrics.
2B	provides incentives and disincentives to report quality data.
2C	rewards high performance on clinical quality measures.
2D	rewards providers that perform well on quality metrics and/or penalizes providers that do not perform well, thereby materially linking payment and quality.

infrastructure, to providing incentives for reporting quality metrics, to rewarding high-performing providers, and to penalizing low performers [17].

Category 3 is APMs built on FFS architecture. The LAN views this as a big leap forward over category 2 in that payments are based on cost performance against a fixed target. Importantly, providers that meet their targets for both cost and quality are eligible for shared savings while being at risk for penalties. Moreover, the LAN believes that the transition to category 3 encourages the provision of efficient care, such as through bundled payments or episodic care.

As with category 2, the work group further refined this category. Category 3A gives providers the opportunity to share in the savings they generate. As in the prior category, the LAN projects movement forward in the evolution to optimized care with progressive letters. As such, category 3B involves providers participating in upside gains and downside risks [17]. Radiologists may be surprised to learn that bundled payments and episodic care, which have been the subject of much discussion within the specialty, only make it to category 3 in this four-level hierarchy.

Category 4 represents the LAN's opinion of how the US health care system would ideally function and represents what may be considered population-based payments. Tying back to the LAN's originally developed working definition, the LAN believes that category 4 can provide high-quality, person-level care. As with other categories, the LAN has further subdivided population health. Category 4A payments are person-focused in that providers are accountable for the total cost and quality of care related to a specific condition. Bundled payment for cancer care serves as an example. Category 4B expands beyond a single condition to individual patients' entire needs; this category represents true integrated care [17]. As illustrated in Figure 1, the framework is not meant to suggest that all health care payments can or should be fully capitated. Rather, given broad recognition of significant problems with FFS-only payments, the LAN's aim is to support a successful shift toward value-based care by building recognition that current methods can be improved. Beyond that, they believe that models in categories 3 and 4 hold the most promise to achieve the triple aim.

DISCUSSION

Health care providers are learning a new vernacular. For the last 25 years, the current FFS system, where physician payments have been largely determined by an interplay between the CMS and physician-led advisory committees, the CPT Editorial Panel and the AMA-Specialty Society RVS Update Committee, have dominated how physicians are paid [19,20]. Under our current FFS system, payment is made for providing distinct medical services, and those payments are largely determined by CMS; despite reductions in individual physician payments, overall payments and costs to the system per beneficiary can grow based on the volume of services provided. To move away from a system that encourages increasing volume and progressive expense without an associated requirement for quality, many believe that the US health care delivery system needs to shift away from this FFS system. To that end, a multiyear effort has sought to shift payment policy to that of alternative payment mechanisms. The ACA moved that agenda forward in meaningful ways, including the popularization of accountable care [21-23]. When one considers the size and scale of the US health care delivery system, the transition from volume to value is a complex undertaking, and it may be particularly challenging to envision how radiologists will be compensated for providing fewer traditional radiology services in these future value-based paradigms. However, this stance is partially related to radiologists' mindsets. Radiologists provide many value-added services beyond study interpretation. Radiologists triage proper studies through decision support and care coordination, along with attending case-based conferences and providing institutions' electronic infrastructure for diagnostic care. Moreover, radiologists play a key role in population health via screening programs including mammography, lung cancer, and possibly colon cancer, each of which has central imaging components.

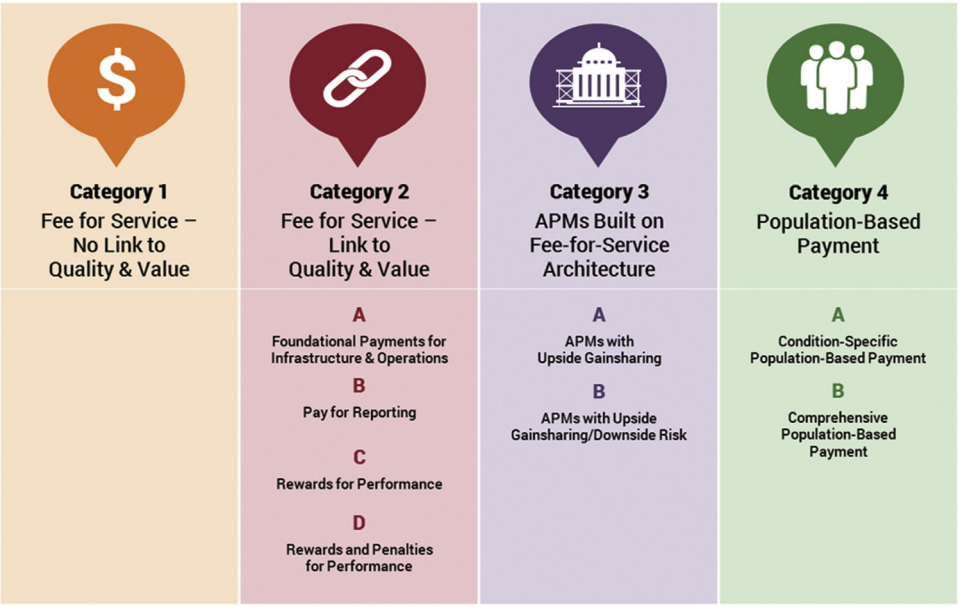

Fig 1. Four categories of the Alternative Payment Model (APM) framework described by The Health Care Payment Learning & Action Network. (Figure used with permission from The Health Care Payment Learning & Action Network.)

The Department of Health and Human Services offered the administration's vision of the future of US health care in January of 2015, proscribing in broad strokes tectonic shifts toward APMs [8]. The MACRA to some degree has solidified that plan, although as is often the case in creating the regulation that implements legislation, implementation will likely lag behind the aggressive timetable offered by Secretary Burwell in 2015. The LAN was holding its inaugural meeting at the same time MACRA was presumably being debated, and a short time later it was passed into law.

As multiple earlier publications have described in detail, radiologists under MACRA will almost certainly participate predominantly in the MIPS rather than APMs starting in 2019 [12,13]. MIPS are associated with multiple reporting requirements related to quality and value. APMs simplify reporting requirements and ultimately offer higher reimbursement for those that successfully qualify and participate. Recognizing that

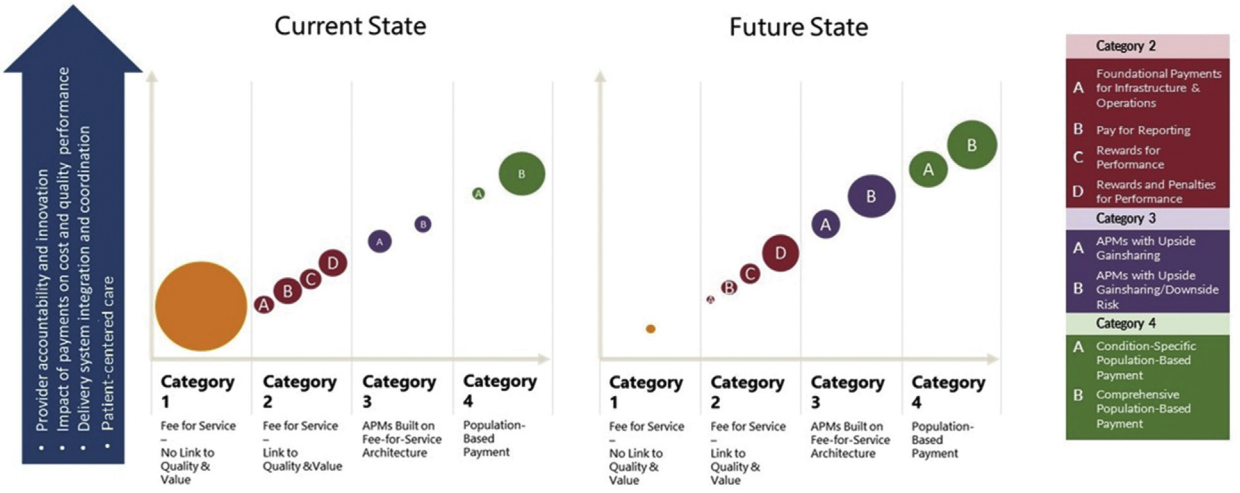

Fig 2. Current and future states of payment model activity. Sizes of the circles indicate the estimated relative degree of payment model activity in each category. APM = Alternative Payment Model. (Figure used with permission from The Health Care Payment Learning & Action Network.)

relatively few specialists were taking the lead in the development of these APMs, the MACRA provided a pathway forward. The legislation describes physician-focused payment models as APMs that address a new issue or specialty, with the hope that specialists will propose alternative payment schema within their domain. The highly anticipated proposed MACRA rule was disappointing for many given the limited number of physicians that are able to participate in Advanced APMs as well as the obstacles to achieving the better payments associated with these approaches [24].

Figure 2 demonstrates another reality of the system's proposed metamorphosis from category 1 to category 4. Compared with the present state, the dollars spent will clearly diminish in categories 1 and 2 and will increase at the higher levels, particularly category 4. However, the LAN is aware that even in the population health-dominated models of the future, category 3 and, to a lesser extent, category 2 will still play an important role.

The LAN has augmented the CMS framework and, at least at first, is likely intimidating for radiologists. Most specialists, including radiologists, currently participate in category 2 systems to some extent through the Physician Quality Reporting System. Some radiologists are considering pursuing, if not already taking the lead, in episodic care, bundled initiatives, and accountable care, though these only qualify as category 3. The LAN framework clearly indicates that the ultimate goal of this Department of Health and Human Services–inspired entity is category 3 or 4. The transition of present-day radiologists to that paradigm is more challenging to envision. Nonetheless, given the remarkable influence LAN enjoys, along with the perception that CMS-sponsored programs are only the first step in this transition, it clearly would behoove radiologists to be a part of determining this future.

CONCLUSION

The LAN is a public private partnership focused on health care. It has established an APM framework and a progress-tracking working group that broadens CMS' existing position on the transition of FFS to alternative payment arrangements. Although Department of Health and Human Services Secretary Burwell staked out the vision that led to this entity, the MACRA has truly institutionalized the transition to value-based care. Therefore, it is important for radiologists to familiarize themselves with this entity and its seminal work product—APMs—so as to meaningfully contribute to its discussions going forward.

TAKE-HOME POINTS

- The MACRA replaced the sustainable growth rate while putting forward a new approach to paying for part B health care services. APMs are rewarded financially in this new system.
- The LAN, which was launched by the Center for Medicare & Medicaid Innovation, formalizes this framework, categorizing payment systems from straightforward FFS (category 1) to population health (category 4).
- The majority of APMs that radiologists are currently contemplating are category 3, which are APMs built on FFS architecture.
- The LAN developed subcategories for category 3. Subcategory 3A allows providers to gain share, whereas subcategory 3B involves providers participating in upside gains and downside risks.

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