The American College of Radiology and the Radiology Business Management Association have been following the trend of physicians transitioning to new payment models with the goal of helping their members make these changes for radiology. The Affordable Care Act (ACA) and the most recent Medicare Access and CHIP Reauthorization Act (MACRA) mandate that all physicians work towards team-based, better quality care for patients, much of which would be reimbursed under bundled payments with efficiencies rewarded through bonus incentives tied to reporting of quality measures. The ACR’s Radiology Integrated Care (RIC) Network and RBMA’s Radiology Integrated Models Task Force (RIMTF) not only follow the activities of the Center for Medicare and Medicaid Innovation’s (CMMI) demonstrations and pilot projects, but also monitor the activities and progress of their members in order to learn what radiology practices are experiencing in their local markets and institutions. These experiences are then communicated as “lessons learned” to the rest of the RBMA and ACR community in the spirit of “Progress Through Sharing.”

This past year, the ACR ran its third annual survey of its RIC Network to learn which members were working in alternative payment models and how this work is progressing. During this timeframe, the RBMA’s RIMTF developed a mini-Survey for the RBMA membership to garner similar information. Although the two surveys were not coordinated, nor did they use the exact same questions, similar information was gathered about radiologists working in new payment models that the two organizations concluded was worth sharing.

The ACR’s RIC Network has 66 members, primarily radiologists, who have advised the ACR that they are working in alternative payment models or want to learn and prepare for when they do become involved in them. They discuss their experiences in a forum and meet face-to-face once per year. The ACR surveys this group each year to learn of their experiences and how they are progressing. About one-third of this group are involved in alternative payment models primarily in the community hospital setting, although some represent academic medical centers and also have sites in freestanding office/IDTF/imaging centers. The setting is primarily urban and suburban with only a few rural areas represented. The size of these practices ranges from two to 127 physicians, and about half of these practices are considered to be in larger groups of 25 physicians or more. Thirty-two percent of these practices have been capitated by a health plan prior, and only 27 percent (or six respondents) have been approached to work in an alternative payment model by either a community hospital, independent practice association (IPA), or Accountable Care Organization (ACO). The primary model proposed was an ACO, with disease-specific bundle and capitated model tied for second. Two of the groups are getting capitated payments, three groups report they continue to be paid fee-for-service in their models, and only one reports a shared-savings agreement. It appears that all arrangements are tied to reporting of quality measures and cost savings. Five respondents in this sample reported having contracts with one ACO. A majority of them were involved in IT decision-making and were using some form of clinical decision support. Although there had been some discussions in sharing the savings, it had not actually taken place, and the message was that it is too soon to tell how their efforts would translate to bonuses on the tail end of a performance period.

Alternatively, 80 RBMA members participated in the RIMTF’s Alternative Payment Models mini-Survey. Forty-seven percent represented hospital-based private practices and the other 53 percent were a combination of hospital-based and imaging center based private practices. Thirty-seven percent (or 21) are either currently in an alternative payment model or planning to enter into such an agreement; about half (12) have entered into a final
agreement. A majority of the 12 were able to provide some input into the process, whether it was hospital board participation, planning for the use of clinical decision support, or discussions of sharing in the savings. Only a few were in capitated agreements, some in shared savings/risk models, a majority (58 percent) reported being in fee-for-service with a potential bonus, with some indications of gain-sharing and episodic fee-for-service agreements as well. Almost all of the agreements are tied to reporting of some type of quality measure which varied significantly in the type of measure.

Although these statistics are weak by research standards, it still tells a story to the rest of the radiology community. Approximately two-thirds of both survey samples have no experience in new payment models and did not have specific information to share. This means that the majority of radiology practices are still working under fee-for-service agreements and haven’t had the opportunity to work in alternative payment models. Alternative payment models are still relatively new to radiology. With that said, only a few practices have maintained involvement in ACOs or other model agreements. There is little to no information regarding sharing-in-savings because it is still too soon to tell.

Both the ACR and RBMA encourage radiology practices to prepare for when the opportunity to become involved in new payment models arises. The recent announcement by Secretary Burwell (to tie 30 percent of fee-for-service Medicare payments to quality or value through APMs, ACOs, or bundled payments by the end of 2016, and 50 percent of payments to these models by the end of 2018) shows that the transition is inevitable. Medicare, private payors, and ACOs’ focus has been centered on establishing primary care services for patients and has not yet given specialists the same kind of attention. However, radiologists and their practices can help their local institutions and communities realize their value-added services. This protects the importance and integrity of this profession and keeps radiology from becoming commoditized. The ACA and MACRA mandate that fee-for-service payments be maintained. Therefore, moving forward, it is likely that radiology groups

### Alternative Payment Models mini-Survey Glossary

**Accountable Care Organization:** Groups of doctors, hospitals, and other healthcare providers that come together voluntarily to provide coordinated, high quality care.

**Capitation:** The group or entity is paid by the insurance plan a per-member-per-month fee for all services provided.

**Capitation with carve-outs:** The group or entity is paid by the insurance plan a per-member-per-month fee for certain services, and others are carved out and paid at negotiated fee-for-service rates.

**Episodic (fee-for-service):** Fee-for-service claims for covered services are aggregated and compared against targeted spending.

**Episodic (single bundled payment with other physicians/providers):** An alternative to fee-for-service in which a single payment is made for physician services associated with an episode of care.

**Episodic (single bundled payment with other physicians/providers and hospital):** An alternative to fee-for-service in which a single payment is made for physician and hospital services associated with an episode of care.

**Fee-for-service with a bonus:** The physician is paid on a fee-for-service basis, but is paid a bonus based on meeting quality measures to incentivize cost-efficient, quality care.

**Fee-for-service with a withhold:** The physician is paid on a fee-for-service basis, but a portion of the payment is withheld to incentivize cost-efficient, quality care. If the quality criteria are met, the physician is paid the withhold.

**Gain sharing:** A model in which the physician shares in any savings generated through lowering costs.

**Global fee:** A single fee that covers hospitalization services and post-hospital care.

**Integrated delivery system:** A healthcare organization for the provision of the full range of hospital and professional services.

**Shared risk/risk corridor:** In this payment scheme each party to the contract shares the financial risk. In the case of capitated arrangements, upper and lower limits are established for the number of treatments or patients treated. If utilization exceeds the upper limit, the payor agrees to reimburse the radiologist at a higher rate. If the utilization falls below the lower limit, then the radiologist agrees to refund to the payor a portion of the capitation payment.

**Sub-capitation:** The physician practice organization (e.g., independent practice association) or integrated delivery system is paid a capitated, per-member-per-month rate and then pays the radiology practice/entity a portion of the capitated payment, either at a per-member-per-month rate or as a fixed monthly fee.
will continue to see a mixture of payment mechanisms in addition to fee-for-service. It is important to reiterate that your practice’s value-added contributions must be recognized if there is any significant sharing of savings with the ACO or institution with which you are contracted.

The ACR and RBMA provide a wealth of resources to help radiology practices change their culture and transition into team-based quality care for their patients. The ACR’s Imaging 3.0 initiative offers case studies as positive examples of radiologists making a difference by adding value. The RBMA is contributing to this archive of pioneers. Imaging 3.0 also offers practice consultation services, resources to help implement clinical decision support, and educational programs to help radiology practices think about their customers in a new way. The patient-centric approach to radiology is quickly gaining traction across the radiology landscape. The RBMA has the Radiology Integration Models Forum and relevant sessions at its two major conferences (Radiology Summit and Fall Educational Conference) that share real-life experiences and offer opportunities for hands-on learning.

These survey results confirm that most radiology practices are not involved in bundled payments or sharing-in-the-savings. Although the transition has been slow to progress, there are lessons to learn from other radiology practices concerning team-based quality care in their communities while maintaining a healthy and sustainable radiology practice. For more information, visit the Imaging 3.0 webpage on the ACR website at www.acr.org and the RBMA website www.rbma.org for conferences and forums to begin your dialog on getting started today!

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