

# Alternative Payment Models in Radiology: The Legislative and Regulatory Roadmap for Reform

EC: Editor's Choice

SA-CME

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## Abstract

The Medicare Access and CHIP Reauthorization Act (MACRA) replaces the sustainable growth rate with a payment system based on the Merit-Based Incentive Payment System and incentives for alternative payment model participation. It is important that radiologists understand the statutory requirements of MACRA. This includes the nature of the Merit-Based Incentive Payment System composite performance score and its impact on payments. The timeline for MACRA implementation is fairly aggressive and includes a robust effort to define episode groups, which include radiologic services. A number of organizations, including the ACR, are commenting on the structure of MACRA-directed initiatives.

**Key Words:** Medicare Access and CHIP Reauthorization Act (MACRA), Merit-Based Incentive Payment System (MIPS), alternative payment models (APMs), Physician Quality Reporting System (PQRS), episode groups, Center for Medicare and Medicaid Innovation (CMMI), Health Care Payment and Action Network (HCPLAN), resource use, clinical practice quality improvement activities

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Recent increases in health care spending in the United States have prompted a variety of legislative, regulatory, and nonlegislative initiatives over the past decade. These have incrementally set the stage for a pathway for payment system reform directed toward increasingly incentivizing health care in a value-based (rather than volume-based) manner. The most recent legislative initiative in this regard was passed in 2015, the Medicare Access and CHIP Reauthorization Act (MACRA).

MACRA abolished the sustainable growth rate (SGR), a key component of determining physician

payments under fee-for-service (FFS). It replaces it with a new payment framework with stable fee schedule updates, a new Merit-Based Incentive Payment System (MIPS) and incentives for alternative payment model (APM) participation. In exchange for the stability in payments enabled by the replacement of the SGR, MACRA increases the focus of payment policy on value, efficiency, and lowered cost. MIPS and APMs are both novel and complex, never previously implemented on the scale proposed, and conceptually still incomplete in many respects. Nonetheless, both will have profound consequences on how physicians will be paid moving forward.

Many of the historic initiatives leading up to MACRA are described in the first segment of this two-part series ("Traditional Payment Models in Radiology: Historical Context for Ongoing Reform") [1]. MIPS and APMs, along with a variety of other MACRA-related initiatives and contributing organizations, will be the focus of this second segment.

## MACRA STRUCTURE

MACRA replaces the SGR with a system providing stable annual Medicare Physician Fee Schedule updates. Under

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MACRA, effective January 1, 2019 providers will soon be subject to payment adjustments on the basis of MIPS. MIPS includes four performance categories: quality, cost (initially referred to as resource use), advancing clinical information (initially referred to as meaningful use), and clinical practice quality improvement. On the basis of their performance in these four categories, MIPS-eligible providers will be assigned composite performance scores between 0 and 100. A breakdown of maximum potential points for each category in 2019 is illustrated in Figure 1. However, physicians deemed non-patient-facing, a category into which many radiologists may fall, are exempt from cost and advancing clinical information, so the points for these categories would be reweighted to the other categories of quality and clinical practice quality improvement. The maximum adjustment in 2019 is 4%, increasing to 9% by 2022.

Providers who are deemed eligible APM participants will be exempt from MIPS and receive incentive bonuses. To be recognized as an eligible APM participant, a defined percentage of either payments or patients will have to be through a qualified APM. In 2019 and 2020, 25% of Part B payments or 20% of patients must be through an eligible APM for a MIPS exemption. These numbers increase to 50% of payments and 35% of patients in 2021 and 2022 and 75% of payments and 50% of patients from 2023 onward. APM payments will be contingent on both quality measures and electronic health record technology adoption, and providers will be required to bear more than nominal financial risk. From 2019 to 2024, eligible APM participants will receive a 5% bonus from CMS each year they are deemed APM

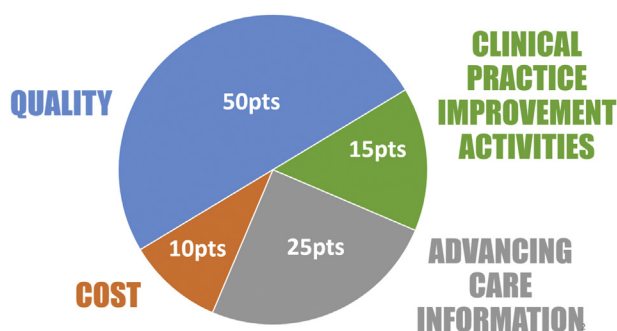


Fig 1. 2019 weighting of the four performance categories under Merit-Based Incentive Payment System. Non-patient-facing physicians are exempt from the cost and advancing care information categories, with those points reweighted to quality and clinical practice improvement activities. Source: Medicare Access and CHIP Reauthorization Act proposed rule [3].

eligible. In 2025, no bonus will be provided, but beginning in 2026, the conversion factor, a determinant of physician payment, will increase for APM participants by 0.75% per year (compared with only 0.25% per year for physicians paid under MIPS and FFS) [2]. The MACRA proposed rule, released in April of 2016, indicates that all physicians shall report under MIPS in year 1 and predicts that only a small percentage of physicians will be APM eligible in year 1 [3]. Accordingly, the vast majority of radiologists will be affected by the MIPS reporting criteria, but it is too early to determine the immediate financial implications of MIPS versus APM participation. However, as the greater conversion factor under APMs widens the payment gap between MIPS and APM participants, given its compounding nature, the incentive for APM participation will increase.

MACRA requires that the secretary of Health and Human Services define the specifics of MIPS and also the criteria for APMs, providing only a general framework and fairly aggressive timeline for the process. Since Congress passed MACRA, CMS has actively sought public and stakeholder input to inform the implementation of its provisions. Although not mandated by MACRA to act this early, CMS proactively solicited comment on MACRA provisions during the 2016 Medicare Physician Fee Schedule rule-making process. In late 2015, CMS released a 43-page request for information, which included a range of questions specific to MIPS and APMs. The recently released proposed rule on MACRA has an approximately 2-month public comment period. The final rule, which will include provisions relevant to the 2017 reporting period (for 2019 payment adjustments), will be released later in 2016 [3].

Two MIPS-related MACRA mandates are particularly relevant: episode groups and measure development. Regarding episode groups, MACRA requires that CMS “establish care episode groups and patient condition groups, and related classification codes, to measure resource use for the purposes including the MIPS and APMs.” Initially, these groups must account for “a target of an estimated one-half of expenditures under Part A and B,” potentially increasing over time. In the case of care episode groups, CMS must consider the patient’s clinical condition at the time items and services are furnished. Likewise, for patient condition groups, the “patient’s clinical history at the time of a medical visit” must be considered.

As part of the episode groups, CMS must also define classification codes “to identify patient relationship categories that define and distinguish the relationship and

responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or services.” One such patient relationship category is especially relevant to radiology because it could enable attribution of patients (and the resultant resource use) directly to radiologists: “Furnishes items and services only as ordered by another physician or provider.” Many radiologists will likely be classified under this “as ordered” classification, but some, such as interventional radiologists and breast imagers, could be considered consultative physicians under this scheme. Claims submitted after January 1, 2018, must include the applicable episode group and patient relationship codes [4].

To define the episode groups, the Patient Protection and Affordable Care Act requires that CMS develop an episode grouper, which is “software and logic that assign patient claims representing their utilization of health care services to clinically relevant episodes of care.” The grouper construction was informed by the National Quality Forum [5]. The first list of 46 episode groups was released for public comment in October 2015 and included episodes determined by two separate grouping methods. The individual episodes included specific trigger codes, relevant services and diagnosis codes, and the rules for “look back” and closing of episodes. The episodes represent a spectrum of body systems, such as breast, cardiovascular, gastrointestinal, genitourinary, and respiratory and vascular. Accordingly, there are numerous radiologic services found among the relevant services. For example, the hip replacement episode group includes radiography and CT of the hip, as well as MRI of the pelvis.

Regarding measures development, MACRA requires that CMS develop “a draft plan for the development of quality measures.” In late 2015, CMS released their measure development plan for public comment. The document serves “as a strategic framework for the future of clinician quality measure development to support MIPS and APMs.” CMS has proposed a strategic approach to address each of the following: multipayer applicability, coordination and sharing across measures developers, clinical practice guidelines, evidence base for nonendorsed measures, quality domains and profiles, gap analysis, applicability across health care settings, clinical practice improvement activities, consideration for electronic specifications, and challenges in quality measure development. The agency’s broader strategic vision strives to “produce a patient-centered measure portfolio that addresses critical measure gaps; facilitates alignment across federal, state and private programs; and promotes

efficient data collection.” More specifically, CMS proposes to develop measures that apply to multiple types of providers, “including clinical specialists, non-physician professionals, and non-patient-facing professionals.” CMS also pledges to incorporate the broader use of qualified clinical data registry reporting [6].

Regarding APMs, MACRA requires that the secretary establish the specific criteria for physician-focused payment models, including specialty-specific models by November 1, 2016. The MACRA proposed rule includes a list of models that would qualify as advanced APMs in year 1, such as the Medicare Shared Saving Program, Tracks 2 and 3, and the Next Generation ACO Model. MACRA requires that stakeholders submit APM proposals for review by the “Physician-Focused Payment Model Technical Advisory Committee,” which will then advise the secretary on those proposed models. The comptroller general has responsibility for appointing the committee’s 11 members, and its first group of members was announced on October 9, 2015 [7]. The first meeting of the Physician-Focused Payment Model Technical Advisory Committee took place on February 1, 2016. APM applications from providers will be accepted by CMS starting January 1, 2017.

## ACTIVE INITIATIVES TO DEFINE APMs

### Center for Medicare and Medicaid Innovation

The Patient Protection and Affordable Care Act of 2010 created the Center for Medicare and Medicaid Innovation (CMMI) for the purpose of testing “innovative payment and service-delivery models to reduce program expenditures while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program benefits [8]. The CMMI received \$10 billion in funding, and the Congressional Budget Office estimates a 13% return on that investment through 2019. Specific quality and cost criteria must be satisfied for a CMMI demonstration project to continue, such as evidence of quality improvements and cost reductions. If a model meets one of the stated criteria and other statutory prerequisites, the statute allows the secretary to expand its duration and scope through rule making [9]. MACRA states that demonstration projects meeting the criteria for expansion under the CMMI may be considered APMs. For example, the recently released MACRA proposed rule includes the Next Generation ACO Model as a qualified APM [3].

Innovation models are organized into the following seven categories: accountable care, episode-based payment initiatives, primary care transformation, initiatives focused on the Medicaid and Children’s Health Insurance Program population, initiatives focused on the Medicare and Medicaid enrollees, initiatives to accelerate the development of new payment and service delivery models, and initiatives to speed the adoption of best practices.

Two CMMI grants have specifically targeted radiologic services and may inform future APM criteria: (1) Imaging Advantage, LLC, received nearly \$6 million for its project “The Right Exam, at the Right Time, Read by the Right Radiologist,” and (2) the Altarum Institute received more than \$8 million for its project “Comprehensive Community-Based Approach to Reducing Inappropriate Imaging” [10].

The CMMI Transforming Clinical Practice Initiative recently provided a grant to the ACR to design the Radiology Support, Communication and Alignment Network. The purpose is “to support radiologists and ordering clinicians as they navigate the transition from volume- to value-based payment systems.” Although not specifically an APM, clinical decision support is highlighted within the four performance categories under MIPS, enhancing the potential benefit of participation in the Radiology Support, Communication and Alignment Network [11].

### Bundled Payment Initiatives

The Bundled Payment for Care Initiative (BPCI) is a CMMI initiative aimed at bundling payments for all providers engaged in a Medicare beneficiary’s episode of care. BPCI includes four models of care: model 1 involves acute inpatient care, models 2 (acute plus postacute) and 3 (postacute only) involve a retrospective bundled payment, and model 4 involves a single prospectively determined bundled payment. The episodes of care relate to specific Medicare severity diagnosis-related groups, such as gastrointestinal hemorrhage, renal failure, and stroke [12]. The four models under BPCI are summarized in Table 1. Radiologists have the potential to contribute to quality and efficiency under bundled payment models because these models include imaging across the spectrum of care. Participating radiologists have the potential to increase quality and efficiency through such initiatives as clinical decision support, structured reporting, and outcomes management. Furthermore, the BPCI may inform the structure of future eligible APMs under MACRA.

In late 2015, CMS finalized a specific bundled payment initiative, Comprehensive Care for Joint Replacement (CCJR), to

Table 1. BPCI Models of Care

Model	Care Setting	Payment	Affected MS-DRGs
1	Inpatient stay	prospective FFS	all MS-DRGs*
2	Inpatient plus post acute care	retrospective**	48 clinical episodes
3	Post-acute only	retrospective**	48 clinical episodes
4	Acute inpatient	prospective bundled	48 clinical episodes

\*MS-DRGs - Medical Severity Diagnosis Related Groups.

\*\*Medicare continues to make FFS payments: the total expenditures for the episode is later.

Reconciled against a bundled payment amount (the target price) determined by CMS.

test bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery. [13]

In broad terms, the CCJR initiative “proposes to hold hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries for hip and knee replacements from surgery through recovery.” This initiative may have considerable relevance for radiologists; although the per episode complexity of imaging in arthroplasty patients is low, almost all encounters do involve postoperative joint radiography. For this reason, this initiative offers radiologists opportunities to participate in high-visibility but low—financial risk pilot bundled payment initiatives [14].

The CCJR proposal has not been well received by multiple stakeholders. During the comment period for the initiative, both the American Academy of Orthopaedic Surgeons and the American Hospital Association have requested implementation delays from CMS [15]. The Center for Healthcare Quality and Payment Reform has stated that CCJR “fails to solve many of the problems with current payment systems and will likely create new problems for both patients and healthcare providers” [16]. After being finalized, the CCJR initiative went into effect January 2016 and affects approximately 800 hospitals in 67 geographic regions across the country [13]. Episodes of care begin with each patient’s admission to an acute care hospital for a lower extremity joint replacement. The bundles include the joint replacement procedure, the inpatient stay, and all related care covered under Medicare Parts A and B within 90 days after discharge.



The model involves five years of performance. Each year, comparison will be made between the actual spending for the episode and the Medicare target episode price for the responsible hospital. On the basis of this comparison and depending on the participant hospital's quality performance, the hospital may receive a bonus or be imposed a penalty. Of note, neither the general BPCI nor the CCJR initiative was recognized as a qualified APM in the recently released MACRA proposed rule.

### Health Care Payment Learning and Action Network Initiatives

Under the innovation category "Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models," CMMI created the Health Care Payment Learning and Action Network (HCPLAN). Its stated mission is "to accelerate the health system's transition to alternative payment models by combining the innovation, power and reach of the private and public sectors" [17]. One of the HCPLAN work groups, the Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group, recently published the "Alternative Payment Models (APM) Framework White Paper." The purpose of the APM framework is to "provide a road map to measure progress and to establish a common nomenclature and a common set of conventions, which can facilitate discussions between stakeholders and expedite the generation of evidence-based knowledge about the capabilities of APMs." The APM work group based its framework on the four-category framework published recently by CMS [18] but expanded the framework to include several new categories and subcategories, as well as delineated decision rules for specific APM placement by category. For example, payment models in category 1 (FFS with no link to quality) are paid under the FFS structure, with no adjustments made for performance on cost or quality metrics, whereas payment models in category 2 (FFS linked to quality and value) include services that include quality reporting tied to payment. Category 3 includes more advanced APMs, still built on the FFS architecture, and category 4 includes models related to population health. The HCPLAN document indicates that the document may be used "to track progress towards payment reform," implying that population-based APMs are an important goal [19].

### ACR ACTIVITIES

The rapidly changing health care payment landscape presents challenges for providers, facilities, and payers as they strive to maintain relevance and financial

sustainability. Those challenges also create opportunities for proactive individuals and organizations to help guide change in a manner that ensures the best patient access to necessary patient services. Many physician and other professional organizations have expressed interest in participating in this process. The ACR has taken an aggressive leadership stance and convened a MIPS work group to inform its actions, respond to the CMS request for information, provide rule-making comments, and provide for general communication among its various commission leaders and staff members. This work group informed the ACR's response to a number of the initiatives described in this report, such as the episode grouper effort and the CMS measure development effort. The mission of the ACR's MIPS work group is

to create meaningful opportunities for radiologists to participate in imminent value-based payment models that positively impact patient care at equal or lower costs. This effort includes the development of models and measures that improve and grow the profession to the benefit of patients (personal communication).

The MIPS work group prompted the creation of the MACRA Committee, an operational committee under the ACR Commission on Economics, tasked with evaluating the evolving MACRA-related regulations and providing ACR comments to policymakers regarding them. The Harvey L. Neiman Health Policy Institute has also taken a leadership role, developing tools to help radiology practices participate in APMs. The Neiman Institute's Inpatient Cost Examination Tool provides data, as well as detailed information and examples, for developing inpatient bundles with hospitals and other providers. They are also developing a mammographic screening model that could serve as either a stand-alone radiology-driven APM or as part of a larger breast cancer bundle. The ACR also maintains its long-standing commitment to develop meaningful metrics that may be applied to successful radiologist performance under MACRA.

### CONCLUSIONS

The recent passage of MACRA has accelerated the evolution of payment systems from those focusing on volume to those focusing on value and intended to support quality, care coordination, and lower costs. In this second part of a two-part series, we have described in detail the recent MACRA legislation, including its impacts on payment, the timeline involved and organizations,

including the ACR, helping shape its rules and regulations. This changing landscape creates challenges but also opportunities to ensure radiology's relevance and success as delivery systems change. This will require a high level of proactive engagement by radiologists, their practices, and their specialty societies. We hope that our two-part series will prompt the creation of a research agenda and also practical strategic guidance to inform new payment model discussions.

## TAKE-HOME POINTS

- MACRA replaces the SGR with a payment system based on the MIPS and incentives for APM participation.
- MIPS assigns physicians a composite performance score between 0 and 100 on the basis of four performance categories: quality, resource use, meaningful use, and clinical practice quality improvement activities.
- MACRA requires the establishment of the specific criteria for physician-focused APMs.
- A number of organizations are commenting on the structure of future payment models, including the CMMI and HCPLAN.
- The BPCI and the CCJR initiative are examples of potential APM structures, which are relevant to radiology.

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