ORIGINAL ARTICLE

Traditional Payment Models in Radiology: Historical Context for Ongoing Reform

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Abstract

The passage of the Medicare Access and CHIP Reauthorization Act (MACRA) replaces the sustainable growth rate with a payment system based on quality and alternative payment model participation. The general structure of payment under MACRA is included in the statute, but the rules and regulations defining its implementation are yet to be formalized. It is imperative that the radiology profession inform policymakers on their role in health care under MACRA. This will require a detailed understanding of prior legislative and nonlegislative actions that helped shape MACRA. To that end, the authors provide a detailed historical context for payment reform, focusing on the payment quality initiatives and alternative payment model demonstrations that helped provide the foundation of future MACRA-driven payment reform.

Key Words: Affordable Care Act (ACA), Merit-Based Incentive Payment System (MIPS), alternative payment models, Medicare Access and CHIP Reauthorization Act (MACRA), Physician Quality Reporting System (PQRS)

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Health care spending in the United States is, by many accounts, on an unsustainable trajectory. The country's population is increasing, and aging as well, with higher rates of chronic disease, all driving the demand for health care services. The Medicare population is estimated to increase from its current 54 million beneficiaries to more than 80 million by 2030, at which time the Congressional Budget Office estimates that federal Medicare spending will surpass $1 trillion, amplifying the call for more effective care at lower cost [1]. To that end, the US Department of Health and Human Services (HHS) recently announced a number of ambitious goals for the Medicare program. CMS is pledging that by the end of 2016, 30% of all Medicare payments will be through some form of alternative payment model (APM), and 85% will be tied to quality. By 2018, those figures will increase to 50% and 90%, respectively [2].

Shortly after that HHS announcement, the Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law. MACRA replaces the often-criticized sustainable growth rate (SGR) formula as a determinant of Medicare physician payment. The SGR was criticized largely for failing to directly address volume-driven growth in Medicare spending while mandating across-the-board payment reductions that disincentivize efforts to control costs at the physician level [3]. The SGR is now replaced with a system involving two separate, but related, pathways for physician payment: (1) the Merit-Based Incentive Payment System (MIPS) and (2) APM participation. The passage of MACRA legislatively solidifies a commitment by CMS to shift from payments based on fee for service (FFS) (often referred to as "volume"-driven care) to payments based on quality and APMs (often referred to as "value"-driven care). MACRA provides a general framework for APMs, but it provides little guidance on the structure of these new payment systems. MACRA does, however, mandate a

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fairly aggressive time frame for implementation. Therefore, it behooves the radiology profession to contribute meaningfully to MIPS and APM discussions during this period of rapid transition. Effective participation requires historical, legislative, and regulatory context as well as an understanding of this important recent legislation.

To satisfy this calling, we have prepared a two-part series addressing current and future payment models and how they specifically impact medical imaging. In this first part, we provide the relevant historical context for ongoing value-driven payment reform including a summary of historical highlights (Table 1) and a listing of relevant acronyms and abbreviations (Table 2). In the second part, we focus on what MACRA means for radiology practices so as to prepare the profession for future payments under MIPS and APMs.

FFS AND PHYSICIAN PAYMENT

Since Medicare's inception, physician payments through the program have occurred on an FFS basis. Initially, the payment amounts were based on reasonable and customary charges and later the Resource-Based Relative Value System [4]. Under pure FFS, physicians are paid for each individual service provided to beneficiaries, regardless of the appropriateness or quality of those services. This has resulted in numerous cases of egregious abuse, including a case recently of a nonphysician billing for imaging interpretations [5].

Such examples notwithstanding, though, FFS has been the subject of considerable criticism for increasing expenditures without commensurate improvements in quality or care coordination [6].

STATUTORY QUALITY AND BUNDLING INITIATIVES

The evolution from FFS to APMs will initially leverage a variety of existing and proposed quality initiatives. Because incentives to reduce cost must also show that quality is not being reduced, robust and meaningful quality metrics will be necessary for APMs to succeed. Many radiology practices are already participating in quality programs [7] and will continue to need to expand that engagement to optimally prepare themselves for full APM participation.

Bundling refers to single payments made for multiple services, often to multiple providers, rather than to individual providers for individual services. It is a key component of APMs and will only become more commonplace under MACRA. A single payment made to an acute care hospital and its treating physicians for a single clinical condition would be an example of bundling.

Table 1. Historical highlights

Year	Initiative	Relevance
1982	Inpatient Prospective Payment System	Bundles hospital inpatient care for acute inpatient services under Medicare Part A
1989	Agency for Healthcare Research and Quality	Agency among first focused on enhancing the quality of health care delivery systems
2001	Institute of Medicine publication of *Crossing the Quality Chasm: A New Health System for the 21st Century*	Provided a comprehensive strategy for health care system reform
2003	Medicare Modernization Act of 2003	Mandated demonstration projects for quality and efficient care
2006	Tax Relief and Health Care Act of 2006	PQRI established
2006	Massachusetts Health Care Act ("Romneycare")	Provided early experience on which PPACA was later based
2008	Medicare Improvement for Patients and Providers Act of 2008	Extended the PQRI and created the Physician Compare website
2008	Baucus white paper	Provided early blueprint for PPACA to follow
2009	HITECH Act	Established meaningful use program
2010	PPACA	Broad health care reform package
2012	American Taxpayer Relief Act	Required development of additional PQRS reporting options
2014	Protecting Access to Medicare Act of 2014	Mandated clinical decision support for the ordering of advanced diagnostic imaging
2015	Medicare Access and CHIP Reauthorization Act	Replaces the sustainable growth rate as a determinant of physician payment

Note: HITECH = Health Information Technology and Clinical Health; PPACA = Patient Protection and Affordable Care Act; PQRI = Physician Quality Reporting Initiative; PQRS = Physician Quality Reporting System.