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 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.

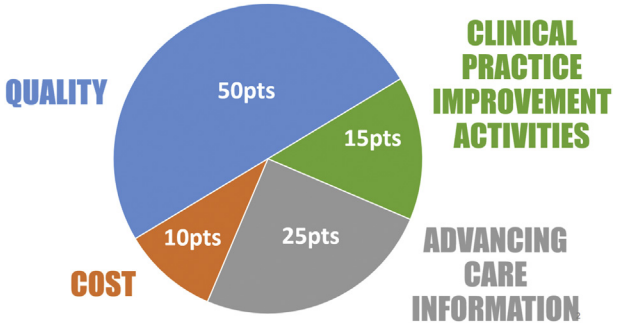

Fig 1. 2019 weighting of the four performance categories under Merit-Based Incentive Payment System. Non-patient-facing physicians are exempt from the cost and advancing care information categories, with those points reweighted to quality and clinical practice improvement activities. Source: Medicare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

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