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Health Care Reform and Its Impact on Radiology Practice

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CMS is testing a range of payment policy options, including pay for performance, bundled payments, and shared savings through accountable care organizations. Radiologists can anticipate that the basis for how they are paid by Medicare will change and that they will need to play a greater role than has been required of them in the traditional fee-for-service payment system to demonstrate that imaging studies are used safely and efficiently.

Key Words: Affordable Care Act, payment policy, Medicare

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The Patient Protection and Affordable Care Act (PPACA) is a federal law that is not only increasing the number of Americans with health insurance but is also catalyzing significant changes in how physicians are paid. Over time, it is anticipated that there will be a decline in the use of pure fee-for-service reimbursement, which rewards service volume, and an increase in the use of payment approaches that are tied to performance and value: higher quality for lower cost. Although these strategies will be tailored to match different clinical circumstances, the changes are expected to affect all specialties, including radiology.

PPACA includes resources for CMS to test new payment models in the Medicare and Medicaid programs to develop an evidence base for determining which payment approach or combination of approaches yields the highest health care quality at the lowest cost [1]. The strategies being tested all incentivize performance to a greater degree than does the fee-for-service system, but they vary in the size of the available financial reward and risk providers face in providing care. The greater the financial risk a physician is willing to accept for the cost of care, the greater the opportunity to be financially rewarded if care is demonstrated to be of high quality.

The most basic approach ties payments to specific quality metrics in a clinical domain. This strategy, sometimes referred to as pay for performance, uses financial bonuses or penalties in an attempt to incentivize high-quality care. For example, as a part of PPACA, hospitals are subject to mandatory financial penalties from CMS on the basis of their Medicare population

rates of hospital-acquired infections and hospital readmission. CMS's physician-oriented pay-for-performance scheme, called the Physician Quality Reporting System, is currently voluntary and provides a 1% Medicare payment bonus tied to reporting on health care quality [2]. It is anticipated that over time, the program will incorporate penalties for those who do not participate and that the bonus payment will be tied to actual performance, not just reporting. One component of the incentive payment is for participation in a quality improvement program, which radiologists could meet by reporting data to a registry, such as one that captures radiation doses associated with imaging studies.

Another CMS payment approach is testing bundled payments for discrete episodes of care, such as for the performance of elective procedures. The bundled payment covers the physician, hospital, and post-acute care costs, including any laboratory and imaging studies. The involved clinicians are paid a fixed amount, which is based on an average payment for the care that includes the historical average costs associated with complications from the procedure. Clinical teams that are able to provide the care with lower than average complication rates can expect to enjoy financial windfalls, whereas those that have higher than average complication rates are at financial risk for providing additional care without the availability of additional resources. The allocation of the bundled payment is at the discretion of the entity that contracts with Medicare for the bundled payment. Clinical teams that receive bundled payments will be looking to limit unnecessary costs, and thus radiologists will need to be prepared to demonstrate the value of imaging in providing services.

While CMS is testing bundled payments for subsets of patients with narrowly defined clinical problems, it is

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pursuing accountable care organizations (ACOs) as a payment model for a broad population of Medicare beneficiaries with a variety of clinical needs. ACOs are provider networks, hospitals, and doctors that take responsibility for defined populations of patients. These organizations are held accountable for all of the costs associated with delivering care to their target populations and for the quality of care these populations receive. ACOs take on financial risk, but in return, they have an opportunity to share in cost savings with CMS. ACOs have a financial incentive to identify clinical problems at an earlier, less costly stage of disease. There will be opportunities in these organizational arrangements for radiologists to demonstrate that increased use of imaging, such as the use of CT scanning of tobacco smokers to identify early lung cancer, can contribute to cost-effective screening and prevention programs that build on the successes in breast cancer to include other clinical conditions.

There are 2 major types of Medicare ACO demonstrations: the Medicare Shared Savings Program (MSSP) and the Pioneer program. The MSSP requires ACOs to care for a minimum of 5,000 Medicare beneficiaries determined on the basis of where the beneficiaries receive the majority of their primary care. For each ACO, CMS determines on an annual basis the projected expenditure for all qualifying Medicare beneficiaries under the care of the ACO on the basis of their average annual expenditures in Medicare Part A and B during the previous 3 years, which is then adjusted for future years on the basis of the annual national growth in Medicare Part A and B. In this way, the health status of an ACO's patient population is accounted for by the historical cost for these patients, but the rate of future growth spending is held constant across ACOs. If in a given year, the actual amount of spending for the population in an ACO is less than what is projected, the ACO, provided it has met the predetermined quality targets, can share in a portion of those savings that exceed a minimum savings rate (approximately 2% below projected).

There are currently 33 quality metrics an ACO must pass to capture potential shared savings. None of these are currently specific to radiology. There are 7 on the patient experience, 6 on care coordination and patient safety, 8 on preventive care measures, 6 on diabetes care, 1 on hypertension care, 2 on ischemic vascular disease care, 1 on heart failure care, and 2 on coronary artery disease care.

The amount of savings an ACO in the MSSP can share with CMS depends on whether the ACO accepted risk for costs that exceed its projected budget. ACOs can elect to be protected from the risk of expenditures that exceed their projected budgets, but then the amount these ACOs can potentially earn from shared savings is

more limited. In calculating the actual cost, an ACO is held accountable for not only the care it provides but for all Medicare Part A and Part B expenditures its beneficiaries have with all providers. Thus, it becomes important as a strategy for an ACO to be able to attract its members to seek care within the ACO where the ACO has the ability to provide cost-efficient services. Redundant imaging studies, which are incentivized under a fee-for-service system, will be problematic for an ACO held accountable for the total cost of care for its assigned patients regardless of whether the service is delivered inside or outside of the ACO. Although radiologists do not directly order imaging studies, the way they communicate with their clinical colleagues about the role of imaging studies in different clinical circumstances, as well findings from studies and recommendations for follow-up studies, could influence ACOs' rates of testing and their ability to provide cost-efficient care.

The Medicare Pioneer ACO program is for organizations that are further along in their development and are thereby prepared to take on greater risk, with the potential for greater shared savings. CMS uses the same methodology for projecting costs and judging quality as is used in the MSSP. However, Pioneer ACOs must have a minimum of 15,000 Medicare beneficiaries and be able within the first 2 years of operation to transition from a fee-for-service to a capitation payment with CMS. A Pioneer ACO must also demonstrate that it has entered into a similar reimbursement arrangement as it has for Medicare with at least one other payer.

CMS is testing a range of payment policy options. How fast and how far ranging these changes ultimately will be is not predetermined. However, radiologists can anticipate that the basis for how they are paid will change and that they will need to play a greater role than has been required of them in the traditional fee-for-service payment system to demonstrate that imaging studies are used safely and efficiently. CMS is already developing a reporting system for quality that is poised to incorporate measures of radiation dose in its Medicare pay-for-performance program. Although these measures do not yet appear as part of the Medicare ACO quality metrics, one can easily imagine these measures being incorporated as the elements of care that ACOs are held accountable for grows over time.

Providers and managers collaborating as a part of an ACO have a shared interest in achieving cost savings by reducing unnecessary tests and procedures. Radiologists in these organizations may serve their own and their organizations' interests by developing new roles as consultants within the ACO to increase the appropriate use of imaging studies, to eliminate unnecessary studies, and to ensure that the studies

that are performed are done with as little radiation exposure as is possible. CMS is testing some of these new roles through demonstration projects looking at the cost-effectiveness of paying radiologists for immediate clinical decision support to help clinicians determine whether imaging is indicated in a specific clinical situation and, if so, the most appropriate test to order.

TAKE-HOME POINTS

- PPACA includes resources for CMS to test new payment models in the Medicare and Medicaid programs.
- The strategies being tested, including pay for performance, bundled payments, and shared savings

through ACOs, all incentivize performance to a greater degree than does the fee-for-service system.

- Radiologists can anticipate that the basis for how they are paid will change and that they will need to play a greater role than has been required of them in the traditional fee-for-service payment system to demonstrate that imaging studies are used safely and efficiently.

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