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Making Sense of MACRA: A Guide for Diagnostic Radiologists

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A B S T R A C T

The Medicare Access and CHIP Reauthorization Act of 2015 was signed into law on April 16, 2015, fundamentally altering the way clinicians are reimbursed for the treatment of Medicare patients starting in 2017. Under this new pay-for-performance model, reimbursement will be tied to multiple metrics related to quality and cost of care. A scaled scoring system will require providers to compete for positive reimbursement adjustments, while also penalizing poor performers with negative adjustments. A firm understanding of this new system will be essential for all physicians looking to maximize their reimbursement, particularly diagnostic radiologists and members of other highly focused fields where special considerations lead to alterations in the scoring system.

Introduction

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015, fundamentally altering the way clinicians are reimbursed for the treatment of Medicare patients starting in 2017. MACRA shifts Medicare reimbursement from a traditional fee-for-service model to a modern pay-for-performance model, under which payments will be tied to quality of care. The law phases out the sustainable growth rate formula that has been in use since the Balanced Budget Act of 1997 to calculate annual changes in fees for medical services, replacing it with a Quality Payment Program (QPP) containing 2 separate payment systems—Alternative Payment Models (APM) and Merit-Based Incentive System (MIPS). These changes will affect over 600,000 clinicians,[1] including many radiologists, and adjust reimbursements both positively and negatively by up to 9%.[2] In this review, we aim to introduce MACRA to diagnostic radiologists and highlight specifically how MACRA will impact the practice and economics of radiology.

MACRA Eligibility and Payment Systems

To qualify for the QPP, a clinician must participate in an APM designated as "advanced" or bill Medicare Part B at least $30,000 and care for at least 100 Medicare patients annually. The APM system includes groups such as Accountable Care Organizations and Medical Home Models, as well as bundled payments under otherwise traditional systems for Centers for Medicare and Medicaid Services (CMS) designated episode groups covering conditions and procedures such as hip fractures and cataract operations.[3] Most radiologists who meet QPP requirements will not qualify for APM, therefore our discussion will focus on MIPS.

MIPS uses 4 weighted performance categories to calculate an overall score (the Composite Performance Score, CPS) upon which payment will be based. The categories are "Quality," "Advancing Care Information," "Clinical Practice Improvement Activities," and "Resource Use." Once fully implemented in 2019, their respective weights will be 50%, 25%, 15%, and 10%. While these labels and their scoring criteria are new, physicians may be familiar with 3 existing programs that MIPS aims to incorporate and replace: The Physician Quality Reporting System (replaced by Quality), Value Modifier (replaced by Resource Use), and Meaningful Use (replaced by Advancing Care Information).

MIPS Performance Categories

Quality included 271 measures during 2017, ranging from "Acute Otitis Externa—Systemic Antimicrobial Therapy—Avoidance of Inappropriate Use" to "Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents."[4] These measures are categorized in multiple ways, including by specialty. A total of 14 of the original measures applied to diagnostic radiology. As of 2018, there are 18 measures recommended by the American College of Radiology (ACR) for use in diagnostic radiology.[5] Clinicians choose 6

Abbreviations: ACO, Accountable Care Organization; ACR, American College of Radiology; APM, Alternative Payment Models; CEHRT, certified Electronic Health Record technology; CMS, Centers for Medicare and Medicaid Services; CPIA, Clinical Practice Improvement activities; CPS, Composite Performance Score; DRG, diagnosis-related group; EHR, Electronic Health Record; ICE-T, Inpatient Cost Evaluation Tool; MACRA, Medicare Access and CHIP Reauthorization Act of 2015; MHM, Medical Home Model; MIPS, Merit-Based Incentive Payment System; PQRS, Physician Quality Reporting System; QPP, Quality Payment Program; R-SCAN, Radiology Support, Communications, and Alignment Network; SGR, sustainable growth rate

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measures reflective of their practice, one of which must be categorized as an "outcome measure" or "high-priority measure." Measures for which benchmarks exist receive scores from 3 to 10 based on how well the submitter's data compares to the national benchmark, provided that the volume (usually at least 20 cases) and completeness (at least 50% of applicable cases) of the data is sufficient. When no benchmark exists or data are insufficient, a minimum score of 3 is assigned for that measure.[6] Bonus points are awarded for using end-to-end electronic reporting and for including more than the required outcome or high-priority measures.

Advancing Care Information replaces the Medicare Electronic Health Record (EHR) Incentive Program, which was also known as Meaningful Use. The goal of this performance category, however, remains unchanged, promoting the use of certified EHR technology. Similar to Quality, Advancing Care Information requires the submission of multiple measures that are graded to calculate an overall category score. Three subscores contribute to the Advancing Care Information score—the Required Base score (50%), Performance score (up to 90%), and Bonus score (up to 15%). While the maximum possible total score is 155%, any score above 100% will be capped at 100%.[7] To achieve the Required Base score, clinicians must meet minimum requirements in the 5 base measures. If any of these requirements are not met, the Required Base score is 0. The remaining 9 measures each contributes 10 points to the Performance score and are graded based on performance rate. For example, if one of these measures is performed 75% of the time, 8 out of a maximum 10 points will be earned. Participating in specified data registries and improvement activities earns the 15% Bonus score.

Clinical Practice Improvement Activities are similar to practices employed in the Medical Home Models.[8] Currently, 93 activities exist[9] and are grouped into 8 subcategories and classified as either medium or high weight. To get maximum credit, clinicians must use any combination of medium- and high-weight activities from any subcategory to achieve 60 points. Medium-weight activities are worth 10 points, while high-weight activities are worth 20 points.[10]

Unlike the other 3 performance categories, the initiation of Resource Use was delayed until the start of 2018 (in 2017 Quality counted for 60% instead of the current 50%). This category is calculated automatically based on billing data, meaning there are no reporting requirements.[11] Similar to the Value Modifier program it replaces, Resource Use will continue to incorporate total per capita costs and Medicare Spending per Beneficiary. Unlike Value Modifier, Resource Use will track costs for up to 41 "episode based measures" instead of 4 "condition-specific groups." Another key difference is that attribution may now be either to group practices or to individuals, instead of just group practices. Improvement from year to year will also be calculated and used to calculate the final score.

MIPS Scoring

The CPS will range from 0 to 100, with nonparticipants automatically being assigned 0 points. In the 2017 performance period, for which adjustments will be applied in 2019, the performance threshold to avoid negative adjustment was 3 points. Participants with exactly this amount will receive no adjustment and those below it will receive negative adjustments. Scores of 4 points or higher will receive positive payment adjustments, scaled linearly so that higher performers receive higher adjustments. The actual adjustment amount will be calculated based on budget neutrality. Additional bonus positive adjustments will be awarded for scores over 70, also scaled linearly so that higher performers receive higher bonuses. The rates of this type of adjustment awarded will depend on the number of qualifiers.[6] The maximum adjustment increases from ±4% in 2019, the year adjustments are initiated, to ±5% in 2020 and ±7% in 2021 before stabilizing at ±9% in 2022 and onward. The MACRA law allows for increased upward adjustments, but per CMS this is unlikely to occur. In future years, the scoring system will likely be less friendly, with the lowest 25% of performers being penalized with the maximum negative adjustment and higher thresholds for neutral and bonus performance. Bonus positive adjustments will allow qualifiers to receive more than the maximum adjustment, but will be split nationally from a pool of up to $500 million annually from 2019 to 2024.[11]

Special Considerations for Radiologists

Many of the specific measures described above used to calculate MIPS performance category scores, and ultimately the CPS, are not applicable to consulting and highly focused fields such as radiology and pathology. Recognizing the inequities, this would lead to in reimbursement, CMS proposed the designation of "non-patient facing clinician" for providers who bill for 25 or fewer patient-facing encounters annually. Since the initial CMS proposal for this designation, Rosenkrantz et al have successfully argued that the limit of 25 patient-facing encounter was too low. Using Medicare data, they showed that this limit would include only 72.0% of diagnostic radiologists, convincing CMS to increase the limit to 100, which includes 98.8%.[12]

Nonpatient-facing clinicians are exempted from the Advancing Care Information performance category, which is reweighted to 0. An additional exemption is that these clinicians will only have to complete 2 Clinical Practice Improvement Activities for a maximum score in this performance category (each earning 50% of the 60 possible points).[10,13] Removing 1 category and increasing the ease of receiving maximum credit for another effectively increases the importance of the remaining 2 categories in determining the CPS. Due to the fact that Resource Use is the lowest weighted category and automatically calculated, nonpatient-facing clinicians will be best served by focusing their efforts on the Quality category.

There are already numerous radiology-specific guides and tools aimed at facilitating the transition to MACRA. A good starting point for all radiologists looking to learn more about MACRA and search for information specific to its effects on their practice is the ACR's "MACRA Toolkit."[14] This resource contains general background information about MACRA, a guide for radiologists transitioning to MACRA, ACR analyses, and statements on specific MACRA-related issues, and a selection of calculators and analytical tools. Some examples of useful information provided in this toolkit are dedicated information for small and rural practices, suggested improvement activities, a MIPS calculator, and assistance with forming an advanced APM. For those who prefer a more guided approach to learning about MACRA, recorded webinar videos are also posted here.

CMS has created a brief, customized MIPS guide for radiologists.[15] This document is less comprehensive than the ACR's MACRA Toolkit, but provides a succinct summary of MIPS scoring, including a review of the score reweighting that occurs when nonpatient-facing clinicians are exempted from the Advancing Care Information performance category. Another valuable resource within this guide is a short list of recommended quality measures for both diagnostic and interventional radiologists.

One option for earning Clinical Practice Improvement Activity credit provided by the ACR is the Radiology Support, Communications, and Alignment Network (R-SCAN) clinical decision support tool.[16] R-SCAN was designed to increase collaboration between radiologists and referrers and developed as part of the American Board of Internal Medicine's Choosing Wisely campaign to reduce unnecessary tests, treatments, and procedures. After deciding on a clinical improvement topic, the radiology team collects cases referred by participating clinicians and uses R-SCAN to evaluate the appropriateness of each order. Based on the results, R-SCAN provided educational activity guides can be used to assist with clinical and staff training. Examples from the current list include imaging for low back pain,

minor head trauma, and early prostate cancer staging. Practices may also define their own topic.

For the small percentage of radiologists participating in the QPP via an advanced APM, the Inpatient Cost Evaluation Tool is a free application developed by the ACR's Neiman Health Policy Institute to analyze bundled payments across diagnosis-related groups.[17] Using historical Medicare inpatient claims data (from 2008 to 2013), the app can be used to explore the expected reimbursement and variance of bundling payments, and strategically select which codes to bundle in order to maximize profit and/or minimize financial risk. Costs can be evaluated in total or for imaging alone, thus allowing radiology practices participating in inpatient care to take advantage of this service regardless of whether they bill separately from or in conjunction with other fields of medicine. Even for those not currently participating in an APM, this tool can be used when considering a switch to this payment model or when considering the financial implications of a potential merger with an APM organization.

Impacts of MACRA

For all participants in MACRA, the new law's greatest threat is likely the potential for negative reimbursement adjustments. Furthering this threat is the fact that unlike fee-for-service, under which reimbursements were independent, this new model forces clinicians to compete with their colleagues locally and nationally. This competition, along with new scoring measures, will pressure radiologists to provide added value to the delivery of patient care. The data collection and coding and/or billing process, already vital for optimizing reimbursement, will become increasingly consequential as rising reimbursement variation in the form of adjustments stresses strategic selection and accurate reporting of MIPS measure data.

For those who master this system, however, the potential positive adjustments and bonuses could greatly surpass recent sustainable growth rate increases and result in greater overall reimbursement under MACRA. As a technologically focused specialty, radiologists will benefit from the widespread adoption of modern, shared EHRs encouraged by MACRA. MACRA will also allow radiologists to improve patient outcomes by playing a greater role in the ordering of appropriate imaging, increasing cooperation among radiologists and other healthcare providers, and placing greater emphasis on standardization of technology.

Conclusion

As Medicare transitions from a fee-for-service to pay-for-performance reimbursement model, a firm understanding of how reimbursements are determined is more essential than ever for clinicians. Under the new MACRA system, an increasingly wide range of possible reimbursement rates (including negative adjustments) calculated on a scaled system comparing clinicians will reward not just quality of care, but also strategic reporting and billing. As “nonpatient-facing clinicians,” diagnostic radiologists will be scored on a narrowed and highly weighted subset of metrics, highlighting the importance of preparedness for MACRA.

Supplementary Materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1067/j.cpradiol.2018.05.005.

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