Time for radiology to get ready for MACRA and MIPS

Mary Beth Massat

By signing into law the Medicare Accessibility and CHIP Reauthorization Act (MACRA) in 2015, President Barack Obama replaced the Sustainable Growth Rate formula with a method that incentivizes value and quality over volume.

Under the Quality Payment Program (QPP), the Centers for Medicare and Medicaid Services (CMS) has two payment tracks: the Merit-based Incentive Payment System (MIPS) or the Alternative Payment Models (APMs). MIPS has absorbed three existing quality improvement programs: Physician Quality Reporting Systems (PQRS), Value-Based Payment Modifier and Medicare EHR Incentive Program.

Ezequiel Silva III, MD, Chair of the ACR Economics Commission, says that most radiology practices will be judged under the MIPS payment pathway. "The good news is CMS says the first two years of the program are transitional years. The potential for downside risk is fairly low, so groups don't have to do a whole lot to be neutral, and not a lot more to get that bonus."

If they haven't already, radiology managers should become acquainted with the new scoring system and criteria, and understand that radiologists and radiology groups are being scored against other physicians. There are four performance categories: Quality (60%); Advancing Care Information (25%); Improvement Activities (15%); and Cost (0%). CMS has exempted the cost category from the performance criteria in 2017.

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The first step is to determine whether or not the radiologist and/or group is patient facing or non-patient facing. Dr. Silva points out that non-patient facing radiologists will have fewer requirements and measures to report and therefore have a higher chance of fulfilling those requirements.

"From a purely risk-averse perspective of avoiding penalties, it is better to be non-patient facing," says Dr. Silva, who understands and agrees with the movement within radiology to be more involved in patient care and a visible contributor to a patient's health. However, from a reporting and billing perspective, patient-facing radiologists and groups will have more requirements.

For example, non-patient-facing radiologists are likely to be automatically reweighted to zero for the Advancing Care Information category; non-patient-facing, hospital-based eligible clinicians may have to apply for this exemption. Within Improvement Activities, most clinicians are required to complete up to four improvement activities; yet, non-patient-facing MIPS clinicians must meet half that requirement.

Another piece of good news for radiology is that the 2017 MACRA Final Rule stated that physicians would need more than 100 patient-facing encounters in order to be designated as patient-facing, which includes additional performance criteria.

Danny R. Hughes, PhD, Senior Director, Health Policy Research, and Senior Research Fellow at the Harvey L. Neiman Health Policy Institute (HPI); Judy Burleson, ACR Senior Director for Quality Management Programs,

and HPI's Wenyi Wang, MS, research associate, explored the impact of the patient-facing designation on radiologists.

In a Jan. 5, 2017, blog post, Dr. Hughes wrote, "10 percent of all radiologists and 9 percent of diagnostic radiologists would receive the patient facing designation under CMS' definition." The three also evaluated the publicly available Physician and Other Supplier Data from CMS to see if this percentage has been consistent over the last three years of available data. While there has been a slight increase in patient-facing radiologists from 2012 to 2014, Dr. Hughes expects this number to remain fairly consistent.

Dr. Hughes further noted that even if an individual radiologist is patient facing, "Under the group reporting option, if 75 percent of a group's clinicians meet the non-patient-facing criteria, then the group does as well."

Radiology groups have a few options for reporting in 2017, explains Lea Halim, Senior Consultant, Research, at Advisory Board. In theory, groups that report on the required MIPS measures across all categories for at least 90 days will be eligible for some positive payment.

"One option for all physicians who are not prepared to fully report on all the criteria is they can report on a smaller set of measures—at least one MIPS metric in each category—for 90 days," Halim says. "Or, minimally to avoid a MIPS penalty, they can report one metric in one of the categories for any period of time."

While groups will be better off if they can report the full metrics, Halim says, "If you haven't done anything, figure out one metric to report this year for 90 days."

Erin Lane, Senior Analyst, Research, at Advisory Board, adds that because there are options for reporting and the possibility to reduce the number of reported metrics, groups can use this transition year to put the systems and infrastructure in place for the following year.

Registries

Practices that have been participating in PQRS and Meaningful Use will be well suited for MACRA, Dr. Silva adds. "They will have the operational procedures in place to do well in this new paradigm, so practices that tackle this now are well positioned to thrive."

A challenge for some radiology groups is that they have outsourced their PQRS to their billing company, explains Halim. Now with the more complete metrics and performance measures closely tied to reimbursement payment and penalties, practices may want to explore either bringing that function back inside or working more closely with the billing company.

Another issue is that some groups and billing companies have deduced PQRS through billing claims. "The challenge with MIPS is that claims-based reporting is not an option for all categories," Halim adds. "Groups may need to rethink their reporting and invest in a different method, such as using a registry."

The ACR's PQRS Qualified Clinical Data Registry (QCDR) is an example of a robust reporting option that radiologists can utilize. It has been approved for the CMS PQRS for 2016 and became fully functional for 2017 MIPS reporting as of March 31, 2017. And, with 60 percent to 85 percent of a radiologists' or groups' score based on quality performance, depending on patient-facing or non-patient-facing designation, the registry can help groups to benchmark outcomes and process-of-care measures as well as develop quality improvement programs.

"With claims-based reporting, reaching the required six MIPS measures is challenging. However, with the ACR QCDR, we have a list of registry-based measures that we can report," says Dr. Silva. "It is not plug and play and is fairly involved—it's not easy but doable. In my opinion a good business manager can put the processes into place to get six measures for all their radiologists."

Some facilities may already be participating in a registry, such as the ACR Lung Cancer Screening Registry. Dr. Silva explains that when CMS began to cover lung cancer screening services, one of the requirements was participation in a registry.

"It is possible for practices to translate their experience with one registry to other registries," Dr. Silva adds. "The Dose Index Registry is a good registry to start with as most practices can manage it effectively. They may also want to look at the National Mammography Database and the CT Colonography Registry."

There is another advantage to participation in the registries. Advisory Board's Lane says, "Through the QCDR, practices can see what they are doing best in and adjust their reporting based on their performance for MIPS. So the ability to track, select and adjust will be key."

Lane adds that it is also important to note that the trend toward evidence-based medicine began before MACRA and MIPS. Utilizing

registries and solutions such as clinical decision support solutions can help practices adapt to value-based reimbursement models and help improve quality.

Image sharing

Another area that is also appropriate and sensible to pursue is image sharing—not just for MIPS but for interoperability. However, Dr. Silva cautions while it is not a significant component of the quality program, it should not be overlooked because image sharing has the potential to lower costs by helping to avoid duplicate or inappropriate exams.

As a specialty, Dr. Silva encourages radiology groups to expand their use of certified EHR systems. "We had an exemption from Meaningful Use for five years, and the consequence of that exemption is that many radiology groups didn't participate. The secondary consequence is that vendors didn't take the steps through ONC to become certified."

Why does this matter now? Because, Dr. Silva says, the Advancing Care Information category and the quality measures behind it are evolving; while these measures may not be dependent upon the use of certified EHR systems, their use can enhance them.

"As the landscape changes and hospital or multi-specialty groups embrace new payment models tied to quality improvements, there is no question radiology has to be a part of that," says Dr. Silva. "These changes are more than scoring and protecting payments … . Practice and industry leaders need to prepare radiologists and groups to implement the quality payment program and to understand the processes that impact payments. The practices that want to do well in the next chapter will have to do well now, or the opportunity may pass them by."