

# Radiology Trends

## ***Did You Know?***

Extracolonic findings are relatively uncommon in CT colonography screening, but the few that require follow-up tend to be highly significant to the patient's health.

## **CMS Proposes Changes To ACO Benchmarks**

CMS is proposing changes to the way it evaluates whether accountable care organizations in the Medicare Shared Savings Program actually save money. They want to move away from assessing ACO benchmarks based on historical spending and instead analyze trends in regional fee-for-service costs.

"Medicare payments are an important catalyst to improving care delivery, spending our resources smarter and keeping people healthy," Andy Slavitt, acting administrator for CMS said. "This proposal allows ACOs in all parts of the country to be successful by recognizing their achievements and improvements in how they provide care." He added that he hopes the proposed changes will grow the numbers of ACOs and their model of coordinated care. According to CMS, these proposed changes would result in \$120 million in net federal savings between 2017-2019. Comments on the proposal are due by April 3rd.

## **Proposed CMS Rule Encourages Analysis And Sharing Of Claims Data**

Medical data miners may soon be allowed to share and sell Medicare and private-sector medical claim data, as well as the analysis of that data. The CMS news comes from a 86 page proposed rule stating that quality improvement organizations and other 'qualified entities' would be granted permission to perform data analytics work and share or sell it to others. "Increasing access to

analyses and data that includes Medicare data will make it easier for stakeholders throughout the healthcare system to make smarter and more informed healthcare decisions" said CMS Acting Administrator Andy Slavitt. "This is going to allow us to get down to the nitty gritty of best practices, who is doing what, and what works and doesn't

work," said Dr. John Toussaint, CEO of the ThedaCare Center for Healthcare Value in Appleton, WI. "I think that's a pretty big change," he added. Several states already have commercial claims in their databases, and the addition of Medicare claims will give them a view of "most of the episodes of treatment that physicians deliver," Toussaint said.

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## Meaningful Use Program Is Ending, Says CMS Chief

Centers for Medicare and Medicaid Services (CMS) is planning to end the Meaningful Use program. "The Meaningful Use program as it existed will now effectively be over and be replaced with something better," CMS acting administrator Andy Slavitt said at a recent healthcare investors conference. The details of the program will be revealed in the next few months. "Now that we effectively have technology in virtually every place care is provided, we are now in the process of ending Meaningful Use and moving to a new regime culminating with the MACRA implementation," he added. Slavitt is referring to the Medicare Access and CHIP Reauthorization Act, the law that repealed the Sustainable Growth Rate reimbursement formula.

CMS also wants to increase the number of Medicare accountable care organizations (ACOs). "In 2016 we will not only have more ACOs, we will have better ACOs," Slavitt said, referring to the 21 healthcare organizations registered to participate in the agency's new Next Generation ACO model. The new design for ACOs requires provider groups to be fully financially responsible for patient care and allows physicians to conduct home visits, use telemedicine, and employ direct-to-consumer incentives. To enable coverage for consumers with preexisting conditions as well as stabilize risk pools, CMS also will offer early estimates of health plan-specific risk plans calculations, Slavitt added.

## Coding and Compliance Tips by Lori Shore, CPC, RCC

### Changing The Rules In The Middle Of The Game?

Just when you thought Medicare "incentive" programs couldn't get any more confusing, now they are changing the rules in the middle of the game. Enter the Merit-Based Incentive Payment System (MIPS) slated to begin in January, 2017. MIPS will now roll Meaningful Use, PQRS and the value-based modifier programs all into one! This program will be based on points in each of four categories; Meaningful Use, PQRS/VBM quality, Value-based modifier cost or resource use and clinical practice improvement. Each year providers can earn up to 100 MIPS points which will be compared to a CMS determined performance threshold. A maximum of 30 MIPS points can be earned from PQRS/VBM and another 30 points from the VBM cost or resource use. There are 25 available Meaningful Use MIPS points to earn and 15 from clinical practice improvements. Those at the threshold will receive no adjustment. Those above the threshold will earn a financial incentive funded by those below the threshold. The program will be phased in through 2021 with positive or negative payment adjustments beginning at 4% in 2019; 5% in 2020; 7% in 2021 and 9% thereafter. CMS will also publish the MIPS scores on the CMS Physician Compare website. The MIPS legislation, passed as part of the Medicare Access and CHIP Reauthorization Act (MACRA) in April 2015, will likely have its details finalized just two months prior to implementation, giving us all little time to prepare. To learn more about MIPS go to: <https://www.cms.gov/site-search/search-results.html?q=Merit%20Based%20Incentive%20Payment%20System>