CMS clearly did not expect as many practices to master the Merit-Based Incentive Payment System (MIPS) as quickly as they have. This is demonstrated by the 1.68% “incentive” payment received, funded by those who failed to master the program in this budget-neutral plan when a 2.05% incentive was projected for performance year 2018. Only 1.95% of qualified professionals fell below the performance threshold in 2018 and will be penalized the full 5% of their 2020 Medicare reimbursement. Beginning in 2020 with 9% of a providers’ 2022 Medicare income on the line, the proposed stakes have raised exponentially. The performance threshold to succeed is proposed to be raised an additional 15 points to 45 in 2020 and to 60 points in 2021. Historically, in 2017 the threshold was 3 points; 15 points in 2018 and 30 points for this reporting year, 2019. The performance category over which providers have the most control, quality, is being reduced from 45% to 40% of the total score, while the black-box category of cost is gaining that 5%. Other elements of the program are also changing to make it more difficult to succeed. Quality measures that have traditionally yielded the highest decile scores are being “topped out.” This means that they no longer offer the scoring potential they once did and will be phased out and unavailable to report. By 2021 it is proposed that all eligible clinicians report through a qualified registry or qualified clinical data registry (QCDR). This represents an additional practice expense for potentially little or no return. In fact, practices could end up paying to be penalized, if you don’t meet the ever-rising threshold point.

At what point does it make sense for your practice to consider the risk of an Accountable Care Organization (ACO)? Consider the time and money being spent on the current MIPS program and the potential incentive/penalty risk. Participants in Advanced Alternative Payment Models (APMs) are exempt from reporting MIPS. In 2019 participants in Advanced APMS must use certified electronic health record (EHR) technology, be part of a Medical Home model or bear significant financial risk. To qualify, participants must receive at least 50% of their Medicare Part B payments or see at least 35% of Medicare patients through an Advanced APM entity during one of the snapshot periods. Some of the benefits of participation include a 5% Medicare bonus, exclusion from reporting to the MIPS program and potential APM-specific rewards.

Each individual practice must decide which reporting method is right for them. Is it worth a 5% incentive payment guarantee for risking 50% of your Medicare income or risking 9% (plus costs) of all Medicare income for participating in MIPS? Factors such as payor mix and group size will surely need to be considered. What is the right reporting method for you? To learn more about reporting options, go to www.qpp.cms.gov.
Medicare’s new rules seek to expand price transparency. What this—and other regulatory proposals—mean for imaging
10:15 AM on August 20, 2019 by Catherine Kosse and Erin Lane. The Advisory Board Company is the owner and publisher of this article.

Recently, CMS released proposed rules governing hospital outpatient facility and provider payments for calendar year (CY) 2020. Unlike previous years, Medicare did not propose major changes specific to imaging payments, but did include a proposal to increase price transparency that affects radiology programs. To help you understand the potential new payment rates and regulatory updates, we read through more than 2,500 pages and identified four key takeaways below for imaging leaders and radiologists.

1. Medicare seeks to reveal private payer rates for outpatient services, focusing on radiology
   By far, the most buzz-worthy proposals center on increasing price transparency, which comes in response to President Trump’s executive order directing the HHS Secretary to accomplish this goal. The agency proposed outpatient price transparency requirements that greatly expand on the current requirement to post chargemaster prices online implemented in January 2019.
   The proposals are broken down into two major components:
   a. Post chargemaster and payer-specific negotiated charges for all items, services online.
   b. Post payer-specific negotiated charges for 300 "shoppable" services

   The first component requires hospitals to post both their chargemaster and all of their payer-specific negotiated charges in a machine-readable format (e.g. an Excel file).

   Second, hospitals must post payer-specific rates for 300 "shoppable" services in an online format that’s easily accessible and understandable to patients. CMS will define 70 of these services, while hospitals are able to define the other 230. Importantly, 13 of the 70 services proposed by the agency are imaging procedures such as CTs, MRIs, and mammograms. CMS also identified shoppable services from other service lines including evaluation & management codes, lab, and medicine and surgery. To enforce this rule, Medicare proposed a fine of $300 per day until organizations are in compliance or provide a corrective action plan. What this means for radiology: While CMS will likely make changes to this proposal, it’s clear that the agency seeks to drive greater price transparency by pulling back the curtain on hospital-payer negotiations. Expect to see widespread debate about the pros and cons of this proposal in the coming months. Regardless of the outcome, imaging leaders should consider moving on price transparency early as a market differentiator and potential to increase revenue capture. That said, it’s important to make the distinction between payment rates and individual payment price estimates. Simply posting a fee schedule provides individual patients limited insight into out-of-pocket expenses. Our research shows that providers are 20% more likely to collect full patient obligations if they provide a price estimate to patients. At the same time, imaging’s bad debt as a percentage of net patient revenue is over 11%, more than any other service line. Setting payment expectations upfront, asking for payment early, and providing realistic payment options improves the financial health of imaging programs. To learn more about how you can begin this process at your organization and hear about other organizations who’ve successfully implemented price estimation tools, register for an in-person or virtual Imaging Performance Partnership National Meeting session.

2. Overall hospital payments increase, but clinician payments remain flat...

(Continue the article here.)