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Predictions round-up

2016 predictions: Use of ACP codes lags, docs struggle with quality reporting and more

Part B News asked several industry sources to predict 2016 trends on a variety of topics. Prepare your practice for the new year with these insights.

Advance care planning

Prediction: Providers will be slow to use the codes. The new advance care planning codes represent a billing opportunity, especially for offices with non-physician practitioners (NPPs) who can provide it cost-effectively (*PBN 11/9/15*). But providers face impediments to getting it done. Physicians

*(see **2016 predictions**, p. 3)*

Predictions: How we did

Our 2015 predictions: SGR was a shock, ICD-10 a breeze; the rest PBN called

By and large, our predictions for 2015 came true (*PBN 1/1/15*). Granted, we were surprised by the relatively smooth ICD-10 premiere and the end of SGR, but then so was everyone else. Read more about how *Part B News* fared with its 2015 predictions.

*(see **How we did**, p. 7)*

Preserve post-op block pay with best practices

For the second year in a row, CPT® has introduced new post-op pain block codes. With the new codes come new revenue opportunities, but coding these services is a challenge. Avoid denials with tips from the webinar **Post-op blocks 2016 — Learn to report new blocks, use best practices to preserve your post-op block pay** on Jan. 21. For more information, visit *www.decisionhealth.com/conferences/A2649*.

Predictions: Mergers and acquisitions

M&A outlook: More big deals; insurers, private equity stepping in

Mergers-and-acquisition experts predict that the recent buying spree in the health care industry will continue and perhaps accelerate in 2016, with some new players joining the hunt and specialties getting fresh attention.

A predicted slowdown in the 2015 health care M&A market as buyers paused to digest years of heavy deal-making didn't materialize (*PBN 1/5/15*). Business remains brisk, especially at the top of the food chain. And *Part B News* experts expect it to stay that way in 2016.

"The general trend in the health care industry has for years been consolidation — health systems rolling up hospitals, hospitals rolling up practices," says Marc Mertz, vice president, GE Healthcare/Camden Group.

Health systems are being pushed by payers and the government "to deliver low-cost, highly effective and well-coordinated care," and that requires the efficiencies of scale that come with consolidation, says Jimmy Burnett, managing director of Navigant Healthcare in Chicago. CMS' push to switch from fee-for-service to performance-based payment also enforces a big-is-better approach. "The transition from 'volume to value' continues to gain steam in both the commercial and governmental markets," says William H. Thompson at Hall Render Killian Heath & Lyman in Indianapolis. "As more reimbursement becomes contingent on performance and outcomes, hospitals and physicians have to have access to technology and infrastructure that will enable them to manage care to the payment metrics," he says. "That's an expensive proposition, and one that few small community hospitals or independent physician practices can fund on their own. That will drive them into partnerships or systems with the inevitable forfeiture of some degree of autonomy."

Also, it's a buyer's market as practices find themselves running short of cash after years of keeping up with expensive government mandates and other business demands. "Many small independent groups don't have access to capital, and rising operating costs and the investments required to retain and attract patients in today's market make it hard to compete," says Nick A. Fabrizio, principal, Medical Group Management Association (MGMA) Health Care Consulting Group, Baldwinsville, N.Y.

Insurers step up

Other players besides practices and hospitals have been getting in the game — like payers. For a few years, insurance companies have been partnering with providers — see "integrated care" companies like Kaiser Permanente and Vivity and recent mergers like Highmark-West Penn Allegheny in Pittsburgh. Now insurers are turning into super-insurers, as seen in the proposed multibillion-dollar Aetna-Humana and Anthem-Cigna

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mergers. “Four of the largest payers becoming two could have a profound impact on the market,” says Mertz.

In an era of managed care and accountable care organizations (ACOs), when patient demographic data is especially important, insurer-provider unions seem a natural evolution. “In 2016, I think we’ll see increased activity in payers acquiring providers,” says Thompson. “The payers have the data; they just need a dedicated provider network to leverage that data. I believe we’ll also see more contracting networks develop (e.g., ACOs, CINs [clinical integration networks]) that provide the population health management tools that physicians and hospitals need in order to participate in shared-savings programs and assume some degree of performance risk.”

Private equity firms are moving in on anesthesia, cardiology and “other specialty practices with a view towards consolidation and scalability” of their health care portfolios, notes Leslie J. Levinson of Robinson & Cole in New York City. And deals such as physician services company TeamHealth’s recent $1.6 billion purchase of IPC Healthcare, a hospitalist and post-acute provider organization, suggest that other companies outside the normal practice/hospital paradigm are looking to consolidate.

Government steps in

If anything can stem this tide of consolidation, it won’t be economics but government intervention, says Matthew R. Fisher, attorney with the Mirick O’Connell law firm in Worcester, Mass. “The level of scrutiny and skepticism about such deals by both state and federal regulators will increase,” he predicts. “Many reports show that consolidation does not result in better prices or reduced cost, which is often cited as a reason to support a proposed merger or acquisition.” This gives some government bodies a reason to step in — for example, the feds can stymie a deal citing antitrust laws.

And states can get in on this too: Fisher notes that his own state, Massachusetts, recently created the Health Policy Commission, a state agency that can review proposed mergers and, if it has major concerns, report the deal to the state attorney general for further review or action.

Another expected development

Big hospitals will partner with little hospitals. “We see more hospitals forming relationships with other small community hospitals,” says Fabrizio. “They become ‘sister’ hospitals; everything bigger or more complex [that the smaller hospitals get] they refer to the larger partner or tertiary hospital. You see this arrangement with Geisinger in Pennsylvania and even with the Cleveland Clinic member hospitals. Member hospitals retain their independence but they get the benefit of the bigger hospitals’ resources such as tech, IT, management services and greater efficiencies” — as will the physicians who work with the smaller hospitals. — *Roy Edroso (redroso@decisionhealth.com)*

Part B News brief

- **Congress eases way for providers to obtain meaningful use hardship exception.** The House and the Senate have passed the Patient Access and Medicare Protection Act, which would create a blanket hardship exception for providers who will not be able to meet the requirements of the Medicare meaningful use program for the 2015 reporting period. As of press time, the bill was headed to President Barack Obama for his signature. Many stakeholders had urged that the hardship exception be expanded for 2015 because the rule changing the reporting requirements for that year was not issued until October. Providers who obtain the hardship exception would not incur a Medicare payment penalty in 2017. This hardship exception is not automatic; physicians would need to apply for it by March 15, 2016. To learn more, visit *https://www.congress.gov/bill/114th-congress/senate-bill/2425/text?q={%22search%22%3A[%22\%22s2425\%22%22]}&resultIndex=1*.

2016 predictions

(continued from p. 1)

may “feel ill prepared to manage the complicated emotions which might arise from a conversation about end-of-life issues,” says Monica Williams-Murphy, M.D., emergency physician and medical director for advance care planning at Huntsville (Ala.) Hospital and author of *It’s OK to Die*.

“Let’s be real — why don’t they do [ACP] now?” says Meg Doherty, CEO of Norwell VNA and Hospice in Norwell, Mass. “Some physicians say they don’t have the time but in reality, a lot of them don’t have the ability or inclination to approach the subject.”

Training would help, but "since there aren't national coverage determinations, it will be up to each MAC [Medicare administrative contractor] to set up their own requirements, and this will likely make it more difficult for specialty associations to provide advice and training on how to bill," says Jeanne Chamberlin, practice management consultant, MSOC Health in Chapel Hill, N.C. So unless they're affiliated with a health system that can afford to train them, many providers will have to get training themselves.

Prediction: Outsourcing companies will not rush to handle ACP. Outsourcing companies quickly developed to handle chronic care management (CCM) chores for practices once CMS established codes to bill for that service (*PBN 10/26/15*). But Williams-Murphy doesn't see it happening for ACP. "The CCM codes reimburse for non-face-to-face encounters, and the ACP funding is for face to face only at the present time," she says. "That could change, but for now I think CMS wants to more closely tie the patient with their health care providers in these very intimate conversations."

Quality reporting

Prediction: Most practices will struggle with the value-based modifier (VBM) in 2016. While this prediction may be hard to quantify, the indicators of physician competence with VBM are not promising, Chamberlin reports.

Here's the skinny on the VBM: Providers stand to gain — or lose — up to 4% on their Medicare reimbursement rates in 2018 based on their VBM scores for reporting period 2016 (*PBN 11/9/15*). The VBM, of course, is tied to the physician quality reporting system (PQRS), which providers have struggled with in the past. When factoring in potential PQRS penalties, practices can lose up to 6% in 2018.

Yet the penetration of VBM into the working orders of many practices is limited at best. "Practices are not well-informed about this program," says Chamberlin.

Ultimately, the 2018 cuts may feel as if they come from left field. "Small and mid-sized independent practices will be surprised when they get penalties," predicts Chamberlin. "Their administrators don't have the luxury of focusing just on these programs but have to fit it into an already full schedule of activities."

If you're not up to speed on the VBM, you should take heed, warn experts. While the pay cut is steep, the ramifications are farther reaching. "Commercial payers are likely to use negative quality scores — or the fact that none are reported — as one of the key ways they determine which will be invited into their narrow network products," explains Chamberlin.

That means poor participation in the VBM program could result in a double whammy of less revenue and fewer options to delve into value-based payment systems with your payers.

Prediction: The merit-based incentive payment system (MIPS) will not veer far from current quality-reporting programs. First, know the timeline: You can expect further MIPS regulations in 2016, with proposals in the 2017 proposed fee schedule and revisions in the final fee schedule. That's a compressed timeframe for a program that's set to debut in 2019.

"Because this doesn't provide a lot of time for practices to adapt, the program will not be very different than the current modified stage 2 [meaningful use] and VBM programs," explains Chamberlin.

However, Chamberlin and her colleagues at MSOC Health see a heavier focus on quality metrics under the coming MIPS reporting structure — which is an outgrowth of the VBM program that many providers are not yet prepared for (*see above*). Eventually, Chamberlin believes physicians might have to formalize quality-improvement initiatives with a recognition or certification program from a national accreditation body or specialty board. Yet for 2016, at least, the MIPS apple won't fall far from the quality-reporting tree.

Meaningful use, EHR

Prediction: Meaningful use will see an uptick in attestation. It's worth asking whether the imminent debut of MIPS, scheduled to replace meaningful use in 2019, might depress participation in 2016 by providers who've had trouble meeting the requirement and just want to forget meaningful use ever happened. But eligible professionals (EPs) will instead try in increasing numbers to attest, predicts Jeff Short, attorney with Hall, Render, Killian, Heath & Lyman in Indianapolis. The payment adjustment for sub-par 2015 performance will be 3% in 2017, and in 2016 it will be 3% or 4% for 2018. "That's not inconsequential in this environment," says Short. He expects a 10% to 20% lift.

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Benchmark of the week

Modifier 25 denial rates hold steady for most heavy hitters

You're losing out on big money if your notes supporting the use of modifier **25** (Significant, separately identifiable E/M services) are not up to snuff.

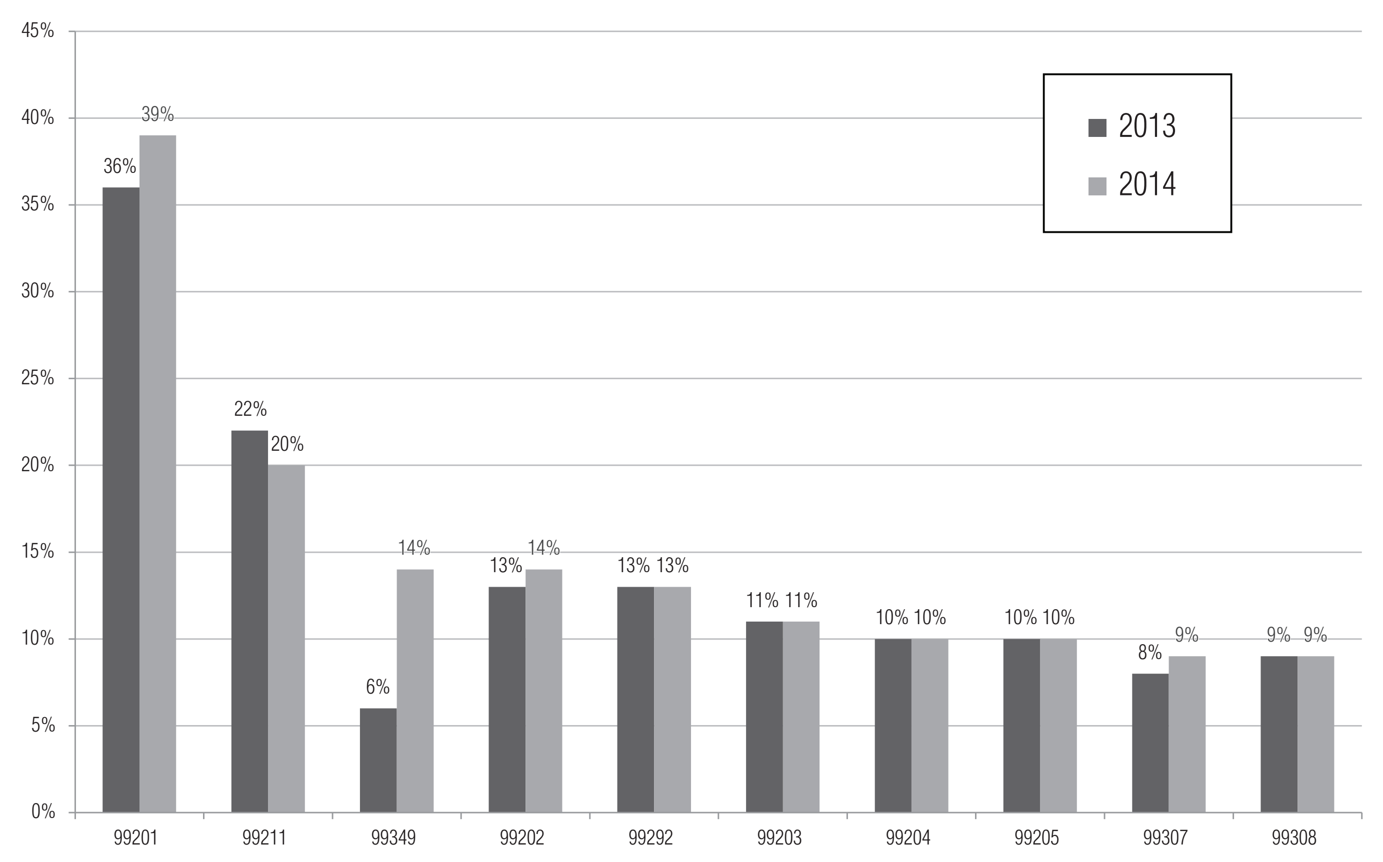
The 10 most frequently used codes with the modifier, reflected in the chart below, saw more than $215 million in denied claims in 2014, according to Medicare claims data from that year, the most recent available. The same 10 codes saw $189 million in denied claims the previous year.

In 2014, providers billed the codes detailed in the chart below with modifier 25 about 10.5 million times — and saw 1.4 million denials on those claims. That's up from 10.1 million claims and 1.3 million denials in 2013.

Physicians fared worse in 2014 than the previous year on the most frequently denied E/M service billed with modifier 25 (**99201**), achieving a dubious 39% denial rate, up three percentage points from a 36% mark the previous year. Providers also saw a big increase in denial rates for modifier 25 with E/M code **99349** (Home visit for the evaluation and management of an established patient), which shot up to 14% from the previous year's 6%.

Otherwise, many of the E/M services held steady on year-over-year denial rates. Providers performed slightly better on **99211**, which saw denial rates decrease by 2%. Five other codes in the top 10 saw flat performance year to year, while two others (**99202**, **99307**) each increased by 1%. — *Richard Scott* (*rscott@decisionhealth.com*)

Denial rates of most-billed E/M services with modifier 25, 2013 vs. 2014



Source: Part B News *analysis of 2013 and 2014 Medicare claims data*

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Prediction: Providers will file more hardship exception applications. At this writing, Congress has sent the president a bill that would extend the meaningful use hardship exception application deadline for 2015, which is now closed, to March 15, 2016. If that happens, look for a flood of applicants, says Short; in any case, the next hardship exception process will see a lot of entries as well.

Prediction: Stage 3 goes away. "If CMS doesn't act to do it themselves, I can see Congress stepping in to scrap it or delay it," says Short. The general feeling that CMS has done a poor job of developing stage 3, which was finalized later than expected in October, will help doom it (*PBN 10/12/15*). "Why make it so hard when the government itself couldn't get the regs out in sufficient time?"

Prediction: Electronic health records (EHRs) get new powers. The big EHR innovations in 2016 will have less to do with government mandates than with vendors' struggle for share of market, experts say. "Provider dissatisfaction with EHRs will increase," but unlike CMS, which can ignore it, vendors will respond, "driving new innovations to solve the challenges facing EHR users," says Derek Gordon, general manager of health care risk adjustment and analytics company Talix in San Francisco. The changes will range from simple fixes to common EHR problems to "new capabilities such as NLP [neuro-linguistic programming]" so practices can run sophisticated analytic reports to better understand their own data.

Alternative payment models

Prediction: More providers will move to — and struggle with — alternative payment models (APMs). Providers have tangible incentives to transition to an APM, including a 5% Medicare reimbursement incentive starting in 2019 and a way to avoid being involved in MIPS (*PBN 4/27/15*).

The most popular APM in the new year will be the accountable care organization (ACO), predicts Donald Skinner, M.D., medical director of the McFarland Clinic in Ames, Iowa, who sees ACOs' "increasing momentum" as a reason for growth in 2016.

CMS' effort to realign payment modalities is another big driver, explains Daphne Saneholtz, attorney with Brennan, Manna and Diamond, Columbus, Ohio. Wide-scale payment reform "was punctuated earlier this year with CMS announcing that 30%, or about $113 billion, of Medicare's traditional spending will be made through value-based reimbursement mechanisms by the end of 2016," she says.

Yet the stairway to an APM is not glittered in gold, experts caution. "MACRA legislation is designed to reward providers who are willing to take on financial risk," says Chamberlin.

For those without the financial savvy or infrastructural support, the risk may outrun the reward. The ACO

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PAS 2016

models themselves are still works in motion, experts tell *Part B News*.

"In the short-term, we'll see an increase in participants in alternative payment models but many of these will not have the expertise to manage the financial risk and will not be able to influence patient behavior sufficiently to be successful long-term," predicts Chamberlin.

You can take steps to prepare your practice for a turn to APMs that will last, such as defining the size and structure of your group and creating operational bulwarks that can support a quality-intensive program model (*PBN 12/21/15*). For sustained success, our experts caution that you should enter a new payment arrangement slowly and thoughtfully.

New revenue

Prediction: Physicians will jump into value-based contracting to counteract diminished revenue. While the repeal of the sustainable growth rate (SGR) augured cost certainty for providers, with Medicare promising 0.5% payment increases annually through 2019, the actual returns on the post-SGR era are currently mixed (*PBN 4/20/15*). When the final 2016 Medicare physician fee schedule appeared in November, providers saw the conversion factor take a hit, resulting in reduced payments for a number of services in 2016 (*PBN 11/9/15*).

With the incremental payment increase locked in for the next four years followed by a flat payment adjustment (0.0%) for years 2020 to 2025, the current fee-for-service payment environment will barely change over the next decade. So what will providers do to put their finances on solid footing? "Value-based contracting," predicts Skinner. "Other revenue streams, such as ancillary services, are being severely curtailed by insurers, including Medicare."

By entering a value-based contract, such as an ACO or patient-centered medical home (PCMH), physicians can remap their payment model and gain potentially lucrative dollars by meeting quality benchmarks and, essentially, better managing the full course of patients' care.

That should move the needle at least somewhat, opines Chamberlin. "There will be movement of some practices to ACOs and other alternative payment models," she says. "But not momentous [movement]."

Medicare offers sizable upfront payments to physicians that enter an ACO model (*PBN 7/13/15*), and so do some private payers (*PBN 11/23/15*). Keep an eye out for further guidance from CMS in 2016 that will shed light on what requirements you'll need to meet to become an APM.

Bonus prediction for 2017: CMS will unveil at least four new E/M codes to capture physician's work. It's no secret that CMS is working to better recompense physicians for the behind-the-scenes work involved in patient care. Both the proposed and final 2016 Medicare physician fee schedules called for feedback on how to reimburse for physicians' "cognitive work," as CMS terms it.

The early signals say that CMS will go radical — relatively speaking — and introduce multiple new E/M codes that reflect the agency's stated intent to shift from strictly fee-for-service payments. Medicare says it wants to pay physicians for their work "in planning and thinking critically about the individual chronic care needs of particular subsets of Medicare beneficiaries," according to the proposed 2016 fee schedule (*PBN 7/20/15*). CMS also stated the new E/M codes would be similar in nature to transitional care management (TCM) and chronic care management (CCM) services.

"Hopefully it will reward the thought processes and decision-making that historically has been undervalued," says Skinner. There's plenty of room for correcting historical abnormalities — with at least four E/M codes, that is. — *Roy Edroso (redroso@decisionhealth.com) and Richard Scott (rscott@decisionhealth.com)*

How we did

(continued from p. 1)

Prediction: Oct. 1, 2015, will mark the beginning of the ICD-10 era, and the start will be shaky.

True and false. While ICD-10 did go into effect Oct. 1, the start was not as shaky as predicted. Everyone was nervous about the Oct. 1 launch — even when it came to the deadline. When we made our 2015 predictions last January, Robert Tennant, senior policy adviser for the Medical Group Management Association (MGMA) in Washington, D.C., was able to give *Part B News* only a "qualified 'maybe'" that CMS wouldn't delay ICD-10 yet again. But CMS kept to the deadline. ICD-10 has slowed practices down a little but claims are getting through fine (*PBN 12/21/15*). Providers have seen some hiccups on the contractor end with LCDs (*PBN 11/2/15*).

Prediction: More practices will attest for stage 2 meaningful use, yet not enough to avoid further delays or exceptions.

Mostly true. More practices have attested: In October 2014, CMS reported 3,655 eligible professionals (EPs) were in stage 2; a year later, the number was 58,547 EPs. On the other hand, far more EPs are in stage 1 — 652,928 — than in stage 2, CMS reported in October 2015. And CMS keeps hedging on the program. In the 2016 meaningful use final rule, CMS scaled back stage 2 requirements from 18 objectives a year to 10, which suggests the federal agency knows that providers are having a hard time with them (*PBN 10/5/15*).

Prediction: Providers will wait for worse penalties to comply with the physician quality reporting system (PQRS).

True. They're waiting for something, anyway. It's impossible to tell how many are currently sitting on their hands, but an ominous sign came in April when CMS reported that 469,755 eligible professionals were subject to a PQRS negative payment adjustment in 2015 based on their 2013 performances and "of those professionals subject to the adjustment, 98% did not attempt to participate in PQRS."

Prediction: Health IT vendors will improve options for PQRS reporting.

False. Technology has been an impediment to quality reporting for providers, says Jackie Coult, owner of Complete Healthcare Business Consulting in Salt Lake City. Providers are able to meet requirements, she says — "it's the system they're having the problems with. So they say 'forget it' and throw up their hands. … The system doesn't capture what they're doing, so they do the work but don't get the credit. … If technology advances to make it easier, they'll adhere. But right now, I see 50% hanging in and 50% opting out."

Prediction: Providers will be slow to adopt billing for chronic care management (CCM).

True. Only 22% of respondents to a recent survey had CCM programs and only half of those had successfully submitted a CCM claim, according to the survey from PYA of Overland Park, Kan. (*PBN 10/26/15*). Lack of time and resources are among the reasons providers have given for not doing CCM, though the low $40.39 nationalized charge might have something to do with it.

Prediction: Health IT companies will come up with CCM-related products.

True. Companies of all kinds got into the CCM outsourcing business (*PBN 10/26/15*). Health IT vendors such as Allscripts, population health companies such as Kryptiq and provider enhancement services such as Hello Health rushed to market with suites of products to take some or even all CCM tasks off the providers' hands; other companies, such as SmartCCM, were created for that purpose.

Prediction: A temporary "doc fix" will avoid large Medicare cuts but a permanent fix will elude providers again.

False. *Part B News* editors weren't the only ones surprised when Congress suddenly got serious and shoved aside the years-long tradition of evading the sustainable growth rate with an occasional doc fix (*PBN 4/23/15*). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law April 16, replaced the threat of double-digit percentage cuts to physician payments with a series of small rate hikes with a new emphasis on performance-based payment to make up the difference (*PBN 4/20/15*). The law also overhauls meaningful use and the physician quality reporting system (PQRS) into the merit-based incentive payment system (MIPS) starting in 2019.

Prediction: Practices will suffer the financial repercussions of not understanding incentive and quality reporting programs or coding rules.

True. Compliance with federal programs evades many providers, and contractors, the Office of Inspector General (OIG), CMS and the Department of Justice continue to claw back money, either in overpayment returns, fines or audits. Also providers are advised to be careful as CMS' failure to finalize its long-proposed rule on overpayments leaves practices vulnerable to having their overpayments turn into false claims — and thus subject to triple damages (*PBN 3/2/15*).

Prediction: Physicians will delve into preventive care, other office-based services to offset reimbursement cuts.

True. "Absolutely," says David Zetter, president of *Zetter Healthcare Management Consultants* in Mechanicsburg, Pa. "Most of my clients are taking advantage of a lot of this, including PT [physical therapy], in some cases." — *Roy Edroso (redroso@decisionhealth.com)*

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