2017 predictions: Increased cash payments, no changes to MACRA and more

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Predictions round-up

The new year has the possibility of being a time of unprecedented change in health care. Here's how *Part B News* expects physician practices to be affected.

Prediction: Affordable Care Act (ACA) reform will have some patients switching to cash payments.

Most observers believe the new administration will, to paraphrase an old expression, try to have its ACA and repeal it too: "A lot of repeal on mandates, not much repeal on protections against rating individuals lower who have pre-existing conditions," says attorney Bryan Rotella, founder, CEO and general counsel of Rotella Legal Group in Tampa, Fla. (*PBN 12/5/16*).

ACA plans aren't dropping off the face of the earth yet. "ACA provisions that have expanded coverage, such as guaranteed issue and Medicaid expansion, will still be in effect at the end of 2017," says David M. Kaufman, a partner at Freeborn & Peters in Chicago. "Open enrollment for 2017 exchange plans continues until Jan. 31, 2017, so individuals will be able to purchase coverage" for that year.

But over time many such plans, deprived of their mandates and premium supports, will raise their premiums beyond customers' reach or leave the marketplace. And with affordable plans exiting, more patients who need care will pay cash.

"ACA had meant fewer patients coming in on a cash basis, which helps with participation and collection," says Sanjay Seth, M.D., executive vice president and chief operating officer of HealthEC in Piscataway, N.J. "But the premiums are going up. … If the exchanges lose that population, that will be felt in the office — a drop in office visits by a few percentage points."

The impact to you will depend on how many such patients you're seeing. "When I ask practices, how many ACA patients do you have? They often say, 'We're not really sure,'" says Pamela Ballou-Nelson, RN, senior consultant with MGMA Health Care Consulting Group, Englewood, Colo.

One feature of discussions around ACA repeal is the substitution of health savings accounts (HSAs) for the mandates and premium supports. With many Republicans supporting programs such as the Direct Primary Care model — described by advocacy group Direct Primary Care Coalition as a system where "fee-for-service incentives are replaced with a simple flat monthly fee" — "it is more likely than ever that this model of practice will be encouraged and expanded," says Christine Tremblay, director of product strategy for electronic health records (EHR) company Amazing Charts in Boston. In that case, prepare for more cash transactions and collections activity.

Prediction: The Trump administration won't make changes to the Medicare Access and CHIP Reauthorization Act (MACRA) that created the Quality Payment Program (QPP).

While nominee for HHS Secretary Tom Price is conservative, "he's in favor of value-based care," says Justin Barnes, partner and chief growth officer at iHealth in Atlanta. "He voted for MACRA, and he supports moving from fee-for-service. And because he's got 30-plus years as an orthopedic surgeon, you'll see a focus on lessening the burden for care providers, which helps everybody."

Besides, MACRA has had bipartisan support up and down the line, says Seth. "If even parts of MACRA were repealed, CMS might have to revisit the CPT codes they'd introduced to meet it, such as CCM [chronic care management] and TCM [transitional care management] and accountable care programs," says Seth.

Prediction: Providers will meet QPP requirements faster than they did with prior performance programs. With QPP's easy-entry first year, some observers have a concern that providers will do what they've done in previous programs — ignore it until they're forced to participate and then do badly. Barnes doesn't see it that way. "The first bar is very low, extremely flexible and customized to specialties," he says. He thinks advanced providers with time and resources to go for positive adjustments will clean up. "I'm out there on a daily basis and people are telling me, 'I want to go for a 2%, 3%, 4% increase in payment,'" he says.

"For the big practices, it's a no-brainer," says Ballou-Nelson. "This opens the door for them to get their extra 10% bonus under MIPS or be considered an advanced APM."

"I don't think we'll see [many problems] with MIPS because of what doctors have already gotten used to doing with PQRS," says Seth. "The new stuff may pose problems — like the improvement activities that have to do with beneficiary engagement, for example, which is something doctors are not typically paying attention to."

With "fewer and more customizable reporting categories, on its face it should be easier to comply with than previous reporting regimes," adds Michael Strazzella, attorney with Buchanan, Ingersoll & Rooney, Washington, D.C.

Prediction: ACI will be a sticking point for some practices. "I question the ability of small independent practices to actually make good on the technical piece, advancing care information [ACI]," says Ballou-Nelson. "Even the ones with EHRs, many of them don't have the ability to track numerators and denominators. They also have difficulty extracting data for reporting even using a CMS-approved registry."

These providers may get some relief in MIPS' "virtual groups," promised for 2018, whereby they could pool money for EHR expenses without running afoul of the Stark law, says Ballou-Nelson. But for 2017, they're stuck with what they have, and it could be rocky.

Prediction: Changes to CCM services won't attract huge crowds to the service, but claims will top 1 million unique patients. The 2017 reporting year brings eased reporting requirements for CCM code **99490** and the addition of two complex CCM codes that Medicare will cover — **99487** and **99489** (*PBN 11/14/16*). While the total number of claims related to the three codes is on pace to rise in the new year, don't expect a sudden reporting frenzy.

Nearly half (46%) of the respondents to *Part B News'* 2017 Predictions Survey said they don't currently report CCM services and they have no intention of starting. The codes are "still too complex and difficult to report," sighs Betsy Nicoletti, president of Medical Practice Consulting in Northampton, Mass.

"If the hassle factor is the same, we will likely not be involved," reports Donald Skinner, M.D., medical director at McFarland Clinic in Ames, Iowa.

But some signs augur a more promising future for CCM services. The larger payment attached to the complex CCM codes — 99487 will pay about $94 for 60 minutes, and add-on code 99489 will pay $47 for each additional 30 minutes — may have more providers looking at these codes, predicts Manny Oliverez, CEO of Capture Billing and Consulting, South Riding, Va. Given the higher pay, more providers may think "it is now worth taking the time for the extra documentation," he says.

The combination of enhanced payment and a slightly easier time reporting 99490, while likely not enough to push CCM services into the top tier of frequently billed codes, should move the needle past 1 million unique claims.

To date, since 99490 debuted in 2015, providers have billed about 560,000 unique claims, according to data contained in the final 2017 Medicare physician fee schedule. With 25% of survey respondents saying that, out of all fee schedule updates, a reconfigured CCM landscape will have the biggest impact on their practices in 2017, expect the upward climb to continue — perhaps not rapidly, but at a steady pace.

Prediction: Expect a split decision on behavioral health integration (BHI) codes — CoCM will lag but general BHI and cognitive assessment codes will charge ahead. Few providers will be ready to bill three of the BHI codes debuting this year — **G0502**, **G0503** and **G0504**. All three codes require that providers are up and running with a Collaborative Care Model (CoCM), which demands investments in staffing and technology (*PBN 11/14/16*).

Few respondents to *Part B News'* 2017 Predictions Survey — under 11% — reported that the introduction of BHI codes would have a significant impact on their practice in 2017.

By and large, practices "don't have behavioral health managers or consulting psychiatrists," notes Nicoletti — and that will preclude them from reporting the trio of CoCM codes.

"I do not believe [the CoCM codes] will be used by practitioners," adds Maxine Lewis, president of Medical Coding & Reimbursement in Cincinnati.

Yet not all BHI codes will wallow in a sea of disuse, and two codes in particular — general BHI code **G0507** and cognitive assessment code **G0505** — will see significant mileage. We'll see "more use of G0507 because it doesn't have such high requirements," projects Nicoletti.

Specifically, G0507 requires only 20 minutes of non-face-to-face behavioral health care management that can be performed by clinical staff and doesn't demand electronic plan sharing and other arduous reporting elements. The stated policy of the general BHI code is to be inclusive of various models of care that practices are engaged in, and that should encourage buy-in (*PBN 12/5/16*).

For cognitive-assessment code G0505, you can expect the dollar signs to attract some glances. "It has a high payment, and that gets everyone's attention," says Nicoletti. In 2017, G0505 will pay about $238 per claim, according to data contained in the final 2017 Medicare physician fee schedule.

Although projecting numbers is perilous business, we'll go out on a limb and set a dividing line at 250,000 claims — providers will stay under the dividing line for the CoCM codes and will exceed it for each of the G0505 and G0507 services.

Prediction: ICD-10 again will be all smoke and no fire. The dire warnings — and subsequent flame-out — of the transition to ICD-10 in 2015 are not so distant that they'll skew our experts' predictions this year as the CMS-backed flexibilities rule has come and gone (*PBN 9/15/16*). Should we expect massive turmoil in coding and billing departments across the country as the grace period is out the window?

The quick prediction: No. "None of my clients are having difficulties," reports Nicoletti. "No disruption," adds Skinner.

Lewis is also witnessing a general state of calm. While she doesn't predict upheaval, Lewis does note that efficiency may take a slight hit. "It is going to take more time to select the proper ICD-10 codes, but it pays off in the long run," she says.

Most practices — about 53% — admit that they used the flexibility year to get up to speed on ICD-10 coding and will now need to be more specific on their claims, the *Part B News* survey shows. However, being more specific and seeing widespread claims rejections are two separate things — so, while we may witness a few bumps along the way, the post-flexibilities period will be another case of all bark and no bite.

Prediction: Practice consolidation will accelerate. Practice acquisition remained active in 2016, "particularly in the specialty practice areas with dermatology, ophthalmology and anesthesia remaining strong, along with a continuing consolidation of dental practices by practice management companies," says Leslie J. Levinson, partner in Robinson + Cole, New York City. "Interest still continues in cardiology and primary care as well."

Consolidation "will speed up as hospitals try to position themselves as dominant in their respective geographic area," says Kristen Valdes, founder and CEO of health IT company b.well in Baltimore. "There are too many hospitals, and those that consolidate and have integrated practices with outpatient, primary care and specialty will be in a stronger position to survive. I believe hospitals will continue to buy physician and specialty practices in addition to urgent care centers."

Prediction: More practices will have to get serious about cybersecurity. The wave of hacks on health care providers in recent years is well known (*PBN 8/29/16*). Smaller providers will be more exposed, particularly if they adopt EHRs with Web-based tools, which have become popular in recent years, suggests Seth.

"A lot of Web-based EHR tools require static IPs," says Seth. "Static means consistently available. Previously, smaller vendors and practices got away with using temporary IP addresses. Those are harder to hack. … But once you're static, it becomes an issue."

Also, the increase in interconnectivity that CMS and the Office of the National Coordinator of Health IT are pushing will, ironically, make practices even more vulnerable. "Getting data from mutual sources into an EHR product is potentially hazardous," says Seth. "So tech advances can open up the EHR to a lot of people." — *Roy Edroso (redroso@decisionhealth.com) and Richard Scott (rscott@decisionhealth.com)*

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