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MEDICARE RULES

CMS unveils 2017 physician fee schedule proposed rule

Primary care physicians will be the biggest beneficiaries of the 2017 Medicare Physician Fee Schedule (PFS), according to an analysis of the PFS proposed rule by *The Business of Medicine*. Specialty practices can still look forward to better reimbursement for prolonged services, chronic care management, and also imaging services thanks to a proposal to boost RVUs to account for digital image processing.

Overall payments will remain stable – the proposed rule sets the 2017 conversion factor at $35.7751, which is down from the current 2016 conversion factor of $35.8043. This change, which essentially keeps Part B payments flat, is mandated by the budget neutrality requirements in the Medicare Access and CHIP Reauthorization Act (MACRA), the law that repealed the longstanding Medicare payment formula known as the Sustainable Growth Rate (SGR).

MACRA requires CMS to establish positive or flat payment updates from 2016 through 2019, at which point the Merit-Based Incentive Program (MIPS) will begin to adjust payments based on provider performance.

Now let's take a look at the highlights of the 856-page proposed rule, which CMS released on July 7.

- **Flat payment update.** As mentioned above, the 2017 conversion factor is projected to be $35.7751, which is essentially flat and continues the series of minor payment updates CMS is required to establish as part of MACRA.

- **Global surgical data-gathering.** CMS was committed to turning all codes that currently have 10-day and 90-day global periods into 0-day global codes, a change finalized in the 2015 PFS. However, the MACRA law required CMS to first gather data on post-surgical visits so the agency could accurately value these codes. Thus for the 2017 PFS, CMS is proposing to collect data via claims along with a representative survey of 5,000 randomly sampled providers. All providers that currently perform

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services with 10-day and 90-day global periods will be required to report additional information on those claims about all services rendered during the global periods. This will be mandatory and while CMS won't withhold payments from providers who fail to participate, the agency warns it is authorized to withhold up to 5% of Medicare payments and could implement this in a future rule if participation rates aren't high enough.

- **Primary care payment increase.** CMS aims to increase payment for primary care services in several different ways with the proposed rule. Overall, CMS wants to increase how much primary care physicians are paid for their bread-and-butter E/M services, and the agency is asking for feedback on RVU increases in the proposed rule.

- **Chronic care management boost.** One leg of CMS' push to increase primary care pay is a proposal to pay more for the existing chronic care management (CCM) codes, as well as add two new CCM codes for complex cases where patients require extra management. Specialists are eligible to report CCM codes and would benefit from this proposal if they specifically treat chronic conditions relevant to their clinical focus, though the codes are only reportable once per month per beneficiary.

- **Prolonged services.** Related to the above bullet, CMS proposes increasing payment for existing prolonged service E/M codes (CPT **99354-99357**) and also adding new prolonged service codes for *non-face-to-face* evaluation and management.

- **Mobility-related disability code.** CMS wants to create a new HCPCS code, **GDDD1**, that can be billed for E/M encounters where the patient has a mobility-related disability that increases the amount of time the physician must spend with the patient (e.g. moving the patient over stairs or other obstacles). This code would have roughly the same RVUs and payment as a level established patient visit (99212). Though again aimed at primary care providers, specialists such as orthopedists and wound care physicians could benefit from this code since they are also likely to see patients with mobility issues.

- **Expansion of diabetes prevention services.** In a potentially significant change for many patients and providers, CMS wants to expand its Diabetes Prevention Program (DPP) to all states. The program, which is only currently operational in eight states, provides counseling, education, and support services to pre-diabetic patients and those at increased risk of becoming diabetic. Providers who participate receive additional payments for these services.

- **Increased RVUs for imaging.** CMS wants to rework practice expense relative value units (RVUs) for imaging services (CPT codes in the **70000** range) to account for the cost of a picture archiving computer workstation, as well as the time associated with reviewing and scanning images. A total of 426 codes would have their practice expense RVUs modified under the proposed rule, though the actual RVU and payment changes are not specified and CMS is asking for feedback on the "standard time" it takes to scan and review images on workstations.

- **New Medicare Advantage enrollment rules.** CMS wants to require all providers who participate with Medicare Advantage plans to be subject to its enrollment and revalidation process. This would affect only those providers who are currently non-par with Medicare but do participate with private-payer Medicare Advantage (Part C) plans.

Final rule expected this fall

You have until Sept. 6 to submit any comments to Regulations.gov during the public comment period for the proposed 2017 PFS. Typically CMS releases the PFS final rule at the end of October or during the first week of November.

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MEDICARE RULES

Proposed OPPS/ASC rule offers 90-day EHR reporting

You would only have to report meaningful use measures from your electronic health record (EHR) for 90 days in 2016 instead of the full year if CMS' proposed Outpatient Prospective Payment System and Ambulatory Surgical Center (OPPS/ASC) rule for 2017 is finalized.

The meaningful use proposal would apply to all eligible providers, including critical access hospitals (CAHs), and means any contiguous 90-day period between Jan. 1, 2016 and Dec. 31, 2016, could be used for reporting. "We believe it would continue to assist healthcare providers by

increasing flexibility in the program," CMS stated in a fact sheet accompanying the proposed rule, which dropped July 6.

This provision is the biggest in an otherwise uneventful proposed rule for most physician practices. Below is a bullet-point list of other highlights from the 2017 proposed rule.

- **OPPS and ASC payment rates.** CMS proposes to update OPPS payments by 1.55%, and the agency estimates an overall 1.6% payment increase for hospitals paid under OPPS in 2017. For ASCs, the payments are updated annually based on increases to the Consumer Price Index for urban consumers. In 2017, CMS is projecting an overall 1.2% increase in ASC payments.

- **90-day meaningful use reporting period.** As mentioned earlier, the reporting period for 2016 is proposed to be any 90-day contiguous period for eligible providers. Additionally, CMS admits in the proposed rule that it would not be "technically feasible" for those eligible providers that have not successfully demonstrated meaningful use yet (i.e. new participants) to attest to the Stage 3 objectives and measures. CMS proposes that these providers attest to modified stage 2 objectives and measures by Oct. 1, 2017.

- **EHR hardship exceptions.** For new providers – again those who have not yet attested to meaningful use – CMS is proposing a new hardship exception that would allow them to be exempt from the 2018 payment adjustment. These providers would be required to transition to meaningful use reporting under the Merit-Based Incentive Payment System (MIPS) in 2017, under the MACRA proposed rule.

- **New ASC quality measures.** The existing Ambulatory Surgical Center Quality Reporting Program (ASCQR) would get seven new quality measures under the 2017 OPPS/ASC proposed rule. There is a new measure for anesthesia and one for cataract surgery. The remaining five have to do with patient satisfaction and experience.

The OPPS/ASC final rule is typically released around the beginning of November.

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PRACTICE MANAGEMENT

Cyber security insurance: Do you need it?

The term cyber liability refers to the risk and responsibility that a business carries when it stores data. In today's world, most data is stored on a computer network; however, the liability extends to information stored on paper records as well. Medical practice records are rich with data, including sensitive patient health information, social security numbers and possibly credit card information. As the owner of this data, you are responsible for its safekeeping, which means you must protect it against cyber-based criminals. You must also protect data such as paper records, patient IDs and photos from "human error," which includes any of these being posted publicly. Since there are no guarantees when it comes to network protection, a cyber liability insurance policy can offset the costs and reduce the time to remedy a cyber breach.

Cyber and privacy insurance policies provide coverage for the liability a business might incur in the event of a data breach. Whether someone gains access to your electronic network

or computers or if paper files go missing, a cyber liability insurance policy can help you address the repercussions more quickly than if you have to go it alone. While other insurance policies may cover the loss of computer hardware, many practices mistakenly think that these policies cover the data, unfortunately, they usually don't. Cyber liability insurance has become its own specialized insurance policy. Every cyber policy is different and new types of coverage are added daily to keep up with changes in technology.

What motivates cyber criminals?

It might help to understand the motives of cyber criminals. Data is valuable and even in small-time cases cyber perpetrators can make a quick buck on social security numbers or credit card numbers. Healthcare organizations are often targets of cyber attacks because of the extent of data they possess, and patient records are a jackpot for cyber criminals. Patient records can be sold off on the black market for as much as $6.40 per record.* In more elaborate cyber attacks, like ransomware, an entire healthcare network is held hostage until a financial demand is met. In the case of Hollywood Presbyterian, hackers shut down the hospital's entire network for over a week and demanded $3.7 million dollars in exchange for its release.

The types of policies and the coverage they offer vary quite a bit. In addition to cyber security insurance policies, there are also cybercrime policies to cover things like wire transfers and social engineering where an employee is manipulated into performing acts or divulging information such as responding to an email requesting that a bookkeeper change company bank information. Once that money is transferred, no coverage exists under a standard crime or cyber liability insurance policy.

The risk of saying "pass" on cyber liability protection

The risk of not having it or not having appropriate coverage is simply the amount of time and money you will have to spend to pay for and manage the following:

- Legal Fees
- Regulatory Fines and Penalties
- Forensics Expense
- Immediately reaching out to all patients via mail and/or phone
- Arrange for monitoring of patients' credit profiles for up to one year
- 24-hour call center expense
- Business interruption income loss
- Business extra expense loss

Be sure to talk with a cyber liability expert

While lots of insurance companies offer bits and pieces of coverage, it is still somewhat unchartered territory. The coverage language is often not very broad and the coverage amounts are usually too small. It is imperative to talk with a specialized insurance agent about cyber liability and cybercrime insurance. Inappropriate coverage may be no better than no coverage at all. A qualified insurance agent with the background and knowledge of how cyber liability policies work can help you navigate this ever-changing aspect of today's technology-driven world.

Key questions to ask your cyber liability insurance provider

- Does my current cyber liability policy cover me for first-party coverages? First-party coverage includes things like costs to regain access, or restore data, if recoverable, business interruption for loss of income, and reputation loss. If so, how much policy coverage exists?
- How much regulatory coverage exists? Does this cover HIPAA fines and penalties?
- Does your current policy cover PCI fines and costs?
- Is notification expense covered? Does this include mailers and call centers? How does notification work?
- Do you need a cybercrime policy? Are you covered for social engineering coverage?
- What happens if a claim occurs? It depends on the company from which you purchased your policy. Some companies have specialized claims teams that only deal with cyber liability, some don't have dedicated claims people.

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BREAKING NEWS:

CMS may delay MACRA, MIPS start date

You might get some extra time to prepare your providers for Medicare's sweeping new Merit-Based Incentive Payment System (MIPS). MIPS is currently scheduled to begin modifying your 2019 Medicare payments based on performance data from 2017, which means that you have less than six months to get ready. But now CMS is hinting that a delay is possible, though the information is based on statements from the agency's acting administrator.

"There has been significant feedback received here, and we remain open to options including alternative start dates, looking at shorter [reporting] periods used, and other ways physicians could get help and experience before the program hits them," CMS Acting Administrator Andy Slavitt said during a July 13 televised Senate Finance Committee hearing on MIPS, which is a key component of the Medicare Access and CHIP Reauthorization Act (MACRA), passed last year.

Slavitt said that CMS will take steps to ensure that MIPS "begins on the right foot, so every physician in the country feels that they are set up for success."

Slavitt made these remarks under questioning from several skeptical members of the Committee, including Sens. Orrin Hatch (R-Utah), Ron Wyden (D-Ore.), and Robert Menendez (D-N.J.), all of whom referenced the volume of legislative changes providers and practices are facing as a result of the Affordable Care Act, the ICD-10 transition, and the switch to electronic health records.

As it stands, the MACRA proposed rule (released April 27) sets Jan. 1, 2017 as the date on which CMS begins data collection for 2019, the first MIPS payment year. The MACRA final rule is expected in early November, which would give you even less time to prepare for any changes made in the final rule that don't appear in the proposed rule.

REVENUE CYCLE MANAGEMENT

FRANK COHEN

JASON STEPHENS

Revenue growth: Efficiency in healthcare

Note: This is the second of a four-part series on improving your practice processes and workflow to boost revenue. The first article ran in the June 2016 issue of *The Business of Medicine*.

Negotiating better contracts would certainly be beneficial, but many practices, suffering from the "Eeyore syndrome" (named for the gloomy, anhedonic donkey in the *Winnie-the-Pooh* books), are unlikely to pursue this process because they haven't assembled or reviewed the data to support their position and don't want to spend time arguing with carriers for scraps. For example, conducting a cost analysis would allow a practice to see which procedures have a higher cost-to-collection ratio, enabling it to potentially negotiate carve-outs for those procedures. Bottom line? Increasing revenues using traditional methods often costs too much time and resources to make any net gain.

Key points

Efficiency suggests the ability to do something well or reach a specified goal without wasting resources.

- Lean Six Sigma has emerged as the "horse and carriage" of process improvement for medical practices.
- Efficiency is key in healthcare

The idea of profitability being tied to linear algebra actually is quite archaic and is not very applicable in a complex system, of which healthcare fully qualifies. See, in a linear system, a one-to-one relationship exists between the components, and it's usually pretty easy to manage. In a complex system, we see a many-to-many relationship, and the idea of complexity itself is tied to these interrelationships between players.

Yet even with all of the complexities on the nonclinical side of practicing medicine, there remains a beacon of light. And the word of the day (or decade) that describes this beacon is *efficiency*. It's a word that all of us know and probably use routinely, but far fewer of us actually recognize the power of this weapon in the battle against declining profitability and even fewer know how to wield it effectively. For our purposes, *efficiency* is the ability to do something well or reach a specified goal using the least amount of resources possible. It's also the ability to achieve the same results with less resources or achieve more or better results with the same amount of resources.

Here's a real-life example. A subclinical staff member escorts a patient to the exam room where, *inter alia*, she spends three minutes verifying questions the patient completed on your questionnaire while in the waiting room. Once completed, the physician enters and repeats the same process, spending another three minutes verifying the same questions already reviewed by the subclinical staff.

We asked the physician about the redundancy of the process, and he said that a speaker at a conference told him that this process would result in fewer errors with regard to the answers provided by the patient – a noble rationale that speaks to the heart of quality of care and, on the surface, seems like sound advice. In subsequent questioning, however, we discovered that the practice never measured the error rate before engaging in this redundant step, nor did it measure the error rate during this redundant step. So while the goal (reduce errors on intake forms) was commendable, the practice didn't know whether a problem existed in the first place and had no way to know whether this additional step improved either the safety or quality of patient care.

We conducted a test on this process and couldn't find a single occurrence in which a patient answered the questions differently for the physician than for the subclinical staff member. We did, however, find instances in which the patient responded to the subclinical staff member differently than they had on the questionnaire they completed in the waiting room (a finding we attributed primarily to patients misinterpreting questions on the questionnaire that were later clarified by the subclinical staff). As a result, we advised the physician that, by eliminating the step in which he repeated the questioning, the practice could save three minutes per visit without negatively affecting the quality of care.

The physician replied, "My problems here go way beyond three minutes a visit." This statement is true if you only see

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Oct. 4	**NAMAS Webinar, "2017 ICD-10 Updates for the Auditor,"** 2pm to 3pm ET
Oct. 18	**AHIMA 2016 Convention & Exhibit, Baltimore, MD** – Shannon DeConda
Oct. 27-28	**AMBA 16th Annual National Medical Billing Conference,** Las Vegas
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Nov. 22	**NAMAS Webinar, "The 2017 OIG Target List Update,"** 2pm to 3pm ET

a few patients a day, but this practice saw 80 patients a day, which translates to 240 minutes (or four hours) of wasted time per day. In an ideal scenario, we could easily convert those four hours into value, but in our real world, because a base set of constraints exists in any process, we would likely only be able to convert around 25%, or one hour, of that time. So if this practice sees about four patients per hour, with an average revenue of $116 per visit, this results in an additional $92,800 in revenue per year. And that's just from one modification to one process. Think about the revenue opportunities you might be missing out on simply because of a few obscure steps in your work flow.

Next issue: We'll look at key concepts and models for efficiency and process improvement, including Six Sigma and Lean.

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MEDICARE RULES

MIPS: Why alternative payment models matter

You now know that Medicare will be consolidating all of its existing major incentive programs into a single entity called the Merit-Based Incentive Program (MIPS), but you may not know that there's a way to avoid participating in MIPS entirely. The same law that created MIPS also establishes a second path to pay-for-performance called Alternative Payment Models (APMs), and participating in the right APM means you don't need to worry about MIPS.

Previous issues of *The Business of Medicine* have discussed in detail how quality reporting and meaningful use will change under MIPS, as well as how the overall MIPS program works on a point system to determine positive or negative final payment adjustments. This article addresses APMs, which operate in tandem with MIPS but have gotten far less publicity. Part of the reason is that APMs are described in the MIPS proposed rule, but in less detail than the MIPS program itself. Another reason is that APMs describe a wide variety of both existing payment models, such as Medicare's Bundled Payments for Care Improvement (BPCI) program and a variety of Accountable Care Organizations (ACOs).

What are APMs?

APMs refer to payment models that are pay-for-performance as opposed to fee-for-service model that has long been the basis for Medicare payments. CMS defines two types of APMs: "advanced APMs," which are considered eligible for complete exemption from MIPS, and "intermediate APMs," which includes all other APMs that don't meet the advanced criteria and thus do not allow providers to be exempt from MIPS.

Providers who are not participating in advanced APMs, but are participating in other APMs, do receive some credit toward the MIPS program under one of the four MIPS components, *clinical practice improvement activities*. **Remember:** The MIPS components are **quality**, which replaces the Physician Quality Reporting System (PQRS), **advancing care information**, which replaces the meaningful use program, **cost**, which replaces the value-based payment modifier, and **clinical practice improvement activities**, which replaces the similarly-named clinical practice improvement initiatives. It's not a huge boost, since the clinical practice improvement category can only account for 15% of the overall MIPS composite score that determines payment.

Participation in an advanced APM is far more beneficial, and the payment bonuses are significant while the administrative burden is reduced since MIPS participation goes away. **Providers in an advanced APM receive a positive 5% Medicare physician fee schedule update from 2019 through 2024**. For years 2026 and beyond, these providers are guaranteed to receive higher fee schedule updates than other non-participating providers. During all of these years, they do not have to participate in MIPS.

In the MACRA proposed rule, CMS identifies six existing APMs as advanced and 18 others as not advanced. The six **approved advanced APMs** are:

- Comprehensive End-Stage Renal Disease (ESRD) Care
- Comprehensive Primary Care Plus
- Medicare Shared Savings Program, Track 2
- Medicare Shared Savings Program, Track 3

- Next-generation Accountable Care Organization (ACO) Model
- Oncology Care Model, two-sided risk arrangement

Many other existing APMs, such as BPCI and another Medicare program, the Comprehensive Joint Replacement (CJR) model, are on this list from the proposed rule. As a result, specialty groups are pushing hard for their models to be included as advanced APMs, and CMS has signaled an openness to change. This represents the greatest hope for many practices who want to take the APM path rather than be continually subject to performance monitoring via MIPS.

CMS: It's still early and we want to help

While there's no guarantee that CMS will reclassify BPCI or CJR models as "advanced" APMs for MACRA purposes, the agency has publically stressed its openness to feedback and change. "We are on the beginning of a journey to move toward a new set of models that ... give [providers] the flexibility to get reward for quality," CMS Acting Director Andy Slavitt said during a Senate Finance Committee hearing on July 13. Slavitt emphasized that the current crop of APMs is open to change based on feedback, especially in the first few years of MACRA, and said the agency wants APMs that deliver better outcomes at lower cost while running "in the background" of the physician-patient interaction.

The full text of the MIPS proposed rule is available here. The public comment period officially ended on June 27 and the final rule is expected at the end of October or beginning of November.

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ENT group, LA	Credentialing
Family practice, LA	Credentialing
Cardiology practice, LA	Credentialing
Lab group, CO	Credentialing
Family practice, GA	Review and edit of employment letter
Dermatology/skin cancer group, TN	Employee handbook
Pediatric group, FL	DM University CMPM program
Optometry practice, GA	HR reference manual
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