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2018 predictions

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Part B News editors surveyed readers and interviewed experts to come up with 11 predictions of what will affect physician practices in 2018.

Prediction: Medicare Advantage (MA) participation will continue to grow. Numbers for MA have been increasing year by year (*PBN 5/23/16*). In fact, a majority of respondents from a December 2017 American Medical Group Association (AMGA) member survey say they expect Medicare Advantage revenues to equal Medicare fee-for-service payments by 2019.

*(see **Predictions**, p. 2)*

2017 predictions round-up

PBN's 2017 predictions: Right on QPP, CCM, fraud — and almost everything else

Part B News did well, if we do say so ourselves, in its predictions for health care in 2017, though it's too early to tell the results in some cases (*PBN 1/2/17*). Here's a round-up of how we did.

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

Unsure. For one thing: What ACA reform? The Trump administration has hobbled Obamacare somewhat with executive orders, but despite those changes, 2017's sign-ups

*(see **Round-up**, p. 7)*

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Predictions

(continued from p. 1)

That's not likely on a national level because traditional Medicare enrollment still outstrips "Medicare Advantage and other" enrollment 2 to 1 (67% to 33%), according to CMS' Medicare Enrollment Dashboard. But the respondents' enthusiasm says something about how widely accepted MA is.

Also, the death of the individual mandate will drive payers to look for new ways to get some of those government dollars, says Joel Ohman, founder of *MedicareInsurance.com*. Because Medicare Advantage and Medicare supplemental products "are immune from the political uncertainty that is part and parcel with the under-65 market in our post-ACA [Affordable Care Act] world," that's where those payers will go to get those dollars, he says.

Prediction: CMS will authorize total knee arthroscopy for ambulatory surgical centers (ASCs). "CMS has already asked for comments on allowing total knee replacements to be added to addendum AA, the list of surgeries that may be performed at ASCs," says Lyndean Brick, president and CEO of The Advis Group in Mokeno, Ill. "It is probable that CMS will include it on addendum AA when the 2019 OPPS proposed rule is released next year." The procedure already was included in the 2018 Hospital Outpatient Prospective Payment System rule for hospital outpatients.

That may not be the only ASC innovation in 2018, says Brick: "CMS is also asking for comments to not only remove total and partial hip replacement from the inpatient-only list, but also to allow them at ASCs. That means there is potential that by Jan. 1, 2019, the only patients who will be having knee and hip replacements in the hospital will be those with comorbidities."

Prediction: You'll face a highly competitive environment for merit-based incentive payment system (MIPS) bonuses. Most practices that are participating in the Quality Payment Program in 2018 will do so under the MIPS track, and the competition for bonus dollars is projected to be fierce, experts tell *Part B News*. All data indicators point to a more full-throttled approach in year two of MIPS, after CMS set the bar incredibly low for the 2017 transition year. In 2018, practices can avoid a penalty by accruing 15 performance points, up from just three points the year before — and those who reach the 70-point mark will be eligible for a payment bonus in 2020. If you're gunning for 70 points, chances are you're not alone.

"I think most large practices … that aren't part of an advanced APM [alternative payment model] will participate in MIPS and aim to get over 70 points to participate in the incentive funds," predicts Jeanne Chamberlin, practice management consultant with MSOC Health in Chapel Hill, N.C.

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Some experts think year two of the program will mark a ramp-up effort across the board. "I think everyone is going to bring it up one level [in 2018]," says Sandy Coffta, vice president of client services with revenue cycle management company Healthcare Administrative Partners in Danville, Pa.

In response to the *Part B News* 2018 Predictions Survey, medical practice personnel indicated that they would be approaching MIPS with more precision in 2018 than they did the year before. Roughly two-thirds (67%) of respondents to the survey said they would be participating in the MIPS track next year, and more than half of those (54%) said they would report as many measures as needed to gain a bonus (*see benchmark, p. 5*). That's a significant jump from a year ago, when just 22% of survey respondents said they would report as many measures as necessary to qualify for a payment bonus (*PBN 1/2/17*).

The days of scraping by may have been a short-lived phenomenon. "We continue to see growth in practices who try to do more than the minimum," reports Belinda Holmes, president of Healthcare Management Consulting in Sarasota, Fla. According to the *Part B News* survey, less than 9% of respondents said they would report enough measures to simply avoid a pay cut.

Increased sophistication in MIPS reporting may not be limited to large practices, either. Many small to mid-sized practices are getting on board as well, even if some are still playing catch up. "I think medium-sized practices are a mixed bag. Some will participate fully if they were doing PQRS [physician quality reporting system] and MU [meaningful use] for the past several years; some will do just enough to avoid the penalty," says Chamberlin. "I wouldn't expect very many to skip it entirely and accept a 5% penalty."

Coffta thinks smaller practices should get involved as soon as possible. "For groups with 10 or more docs, we're pushing them to submit everything they can to get the incentive," she says.

Prediction: Calls for widespread changes to the MIPS program will grow next year — but MIPS will persist in 2019. Recently, the Medicare Payment Advisory Commission (MedPAC) called for an overhaul of the MIPS program, and similar calls for reform are expected to increase in number and volume in 2018 (*PBN 12/18/17*). Coffta says she wouldn't be surprised if influential groups, such as the AMA, speak up about the MIPS program and its impact on physician practices, although she thinks they may do so "more gently" than MedPAC — i.e., "MIPS is flawed; here are some things we propose to make the program better."

However, some experts believe a component that's emerging in 2018 — the cost factor — may accelerate industry calls for reform. In 2018, the cost component will account for 10% of a clinician's MIPS score, and that number will rise to 30% in 2019. The speed at which that 30% is coming may create an irrevocable problem.

"Unless Congress acts to make a change to that requirement, CMS will be hard-pressed to come up with acceptable and transparent cost measures in time," says Chamberlin. Initial rule-making typically occurs around June, leaving about half a year for CMS to fine tune its cost approach. That timeline could sow unease among providers and their advocates.

"I think we will hear a clamor for the cost component to be delayed, removed or otherwise reconfigured," predicts Chamberlin. And should a wave of dissent foment? "It may be loud enough to cause the entire MIPS program to collapse or exclude so many providers as to become meaningless," Chamberlin adds.

"I would not be surprised to see some kind of change to [the cost scoring] in the 11th hour," says Coffta.

While nearly anything is on the table as far as the future of MIPS, *Part B News* will stick with its prediction that providers will be facing a MIPS reporting year — however changed — in 2019.

Prediction: Mergers and acquisitions among medical practices will be strong in 2018. After his spot-on prediction for 2017, Leslie J. Levinson, partner at Robinson + Cole in New York City, remains bullish on M&A (*see 2017 predictions round-up story, p. 1*). "M&A activity in this sector for 2018 should continue to be active," he says.

Some large medical organizations will spin off acquisitions that don't prove profitable. "That trend, particularly with private equity investors, should continue in the coming year," says Levinson.

But other players are likely to pick them up. "Whether it's payers merging with retailers or health systems combining to super-size, consolidation will continue as providers work to strengthen and protect their brand and market position," says Lyndean Brick.

If you're looking to sell out, now may be a good time, but "I wouldn't say it's a total seller's market because buyers are likely to be picky," says Brick. "Synergies and new market penetration are key considerations in the fit" — that is, do you offer services they need in areas they want to move into?

Also watch for medical organizations branching out into new ancillary businesses — such as midwestern health system Community Healthcare's "SpaPointe and Hair Studio," which offers patients "a professional and educational atmosphere for the enhancement of self-renewal, stress management and overall well-being."

"Providers have slowly entered non-traditional [markets] in recent years with hospital-owned ambulance companies, pharmacies, fitness facilities, gourmet carryout, alternative health boutiques, insurance companies and even spas and beauty facilities," says Brick. "Your local hospital may soon be operating your neighborhood funeral home or institutional catering company."

Prediction: HHS' Office for Civil Rights (OCR) will go hunting for HIPAA failures — and the fines could be large. Roger Severino, head of OCR, said in March he was looking for a "big, juicy, egregious" HIPAA settlement to show practices and hospitals that he was serious about enforcement.

"I think with cuts across departments [in the federal government], you have to question whether breach enforcement might be a way to help pay for additional privacy and security audits and monitoring," says Kathy Downing, director of practice excellence at the American Health Information Management Association (AHIMA) in Chicago.

And don't think if you're not a major hospital system this can't apply to you: Severino also said, "just because you are small doesn't mean we're not looking and that you are safe if you are violating the law. You won't be."

Providers have plenty of opportunities to fall afoul of OCR, says Matt Fisher, partner and chair of the health law group at Mirick O'Connell in Worcester, Mass. First, there's providers' traditionally sloppy attitude toward HIPAA (*PBN 2/28/13*). Second, new cybersecurity exploits, including ransomware, are expected to be more aggressive in 2018 — and it's already been established that a ransomware attack can be considered a HIPAA breach (*PBN 5/22/17, 8/8/16*).

"Ransomware is definitely vulnerable to a front-door exploit via phishing," says Fisher, "and also to back-door exploits via medical devices or other internet-connected devices that are not adequately secured."

To protect yourself, in addition to doing everything you can to keep bad guys out, make sure you have a Plan B for when intruders get in, says Fisher. "Do you have good backups? A good disaster recovery process? There are ways to cut off the exposure and recover data." OCR may take that into account when calculating your settlement.

Most importantly, get "good IT staff and advisers," says Fisher. "When it comes to this, you need people with the technical knowledge to install and assist with appropriate measures."

Prediction: The government will stay aggressive on overpayments and fraud. A big development last year was the tendency of prosecutors to turn what once might have been mere overpayment takebacks into False Claims Act prosecutions (*PBN 4/17/17*). That will continue, predicts Mark J. Silberman, a partner in the health care and life sciences practice group at Benesch, Friedlander, Coplan & Aronoff in Chicago.

"The government's enforcement efforts are going to continue unabated into 2018," says Silberman. "Over the last year, they have realized the ability to use technology in the form of analytics to drive their health care fraud enforcement efforts. It is likely that they will continue to utilize technology as an anchor for future efforts, including their aggressive use of audits."

The motivation is largely financial, says Silberman. "The government is still at a point where they are looking for low-hanging fruit, anything that will yield a substantial return, especially those circumstances in which the government can use its extrapolation methodology to take a limited universe of alleged violations and turn them into substantial recoupment amounts or civil monetary penalties," he says. "The advantage to these instances is that the potential consequences if a judge, jury or administrative law judge concludes that the government is right can literally end the continued existence of a business, which bullies many providers into negotiated settlements."

Prediction: New codes — for prolonged preventive care and behavioral health care — will see a slow adoption rate. More than 50% of respondents to the *Part B News* predictions survey reported that they were "not at all likely" to use either of two types of codes, which cover prolonged preventive care (**G0513**, **G0514**) and a range of behavioral health services, including cognitive assessment (**99483**) and behavioral health care management (**99484**).

"It's going to be the practices that are really paying attention that are even going to be aware of these," says Holmes.

(continued on p. 6)

Benchmark of the week

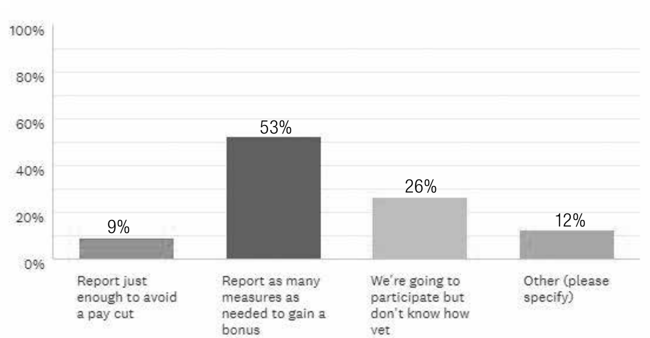
Survey says: *Part B News* readers going for the gold in MIPS 2018

CMS will allow merit-based incentive payment system (MIPS) participants to turn in a minimum amount of data to avoid penalties, but *Part B News'* 2018 Predictions Survey shows practices are far more likely to go for a positive payment adjustment. And a surprising number appear to be involved in value-based care models.

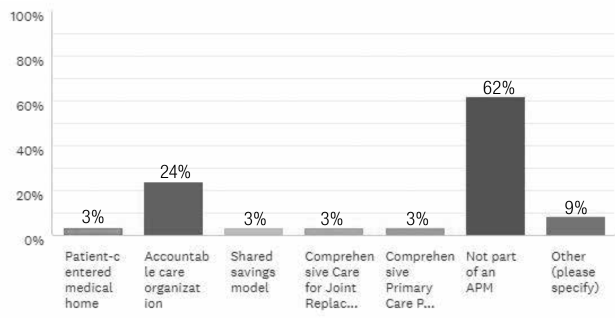
In the survey, taken online by 58 respondents in December, said they'd report as many measures as needed to gain a bonus versus just 9% who said they'd report just enough to avoid a pay cut. However, 26% said they "don't know how" they will participate in 2018, though it was less than a month away. As you might expect, the majority — 66% — of respondents were doing MIPS instead of the Quality Payment Program's (QPP's) advanced alternative payment model (APM) option, in which a mere 3% were planning to be involved. But far more than 3% of respondents are in APMs and other quality-based organizations. For example, 24% said they were in an accountable care organization, though not all ACOs qualify as advanced APMs under QPP. About 74% of respondents said they had no plans to become accountable care organizations in 2018.

Other highlights from the survey:

- By a 62%-to-38% margin, more respondents expect to see more uninsured patients at their practices in 2018.
- A whopping 57% of respondents said their practice planned to add more providers in 2018, and 26% said they'd add more support staff such as billers, coders, medical assistants and front desk staff.
- Most respondents said they were "not at all likely" to report CMS' new prolonged preventive service codes (**G0513**, **G0514**) and cognitive assessment (**99483**) and behavioral health care management services (**99484**) codes (*PBN 12/4/17*). — *Roy Edroso (redroso@ decisionhealth.com)*



Are you part of an alternative payment model (APM)? If so, which one? (Check all that apply.)



Source: Part B News' *2018 Predictions Survey*

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Practices may want to assess their previous billing patterns related to preventive care codes, such as the annual wellness visit (AWV) or Welcome to Medicare visit, advises Sandy Coffta. "What proportion of Medicare patients did I bill a second E/M on the same day as a preventive service?" she asks.

For practices that billed two E/Ms on the same day, you may find G0513 and G0514 serving as "a better avenue to get paid," says Coffta. As a reminder, the prolonged preventive service codes can be attached to any of the 18 Medicare-covered preventive services that CMS pays for (*PBN 11/13/17*). The add-on codes cover additional time, starting in 30-minute allotments, that you spend with a patient during a preventive care episode and pay an extra $65.

But pay attention to the fine print on the codes, which require that you report the preventive care services as time-based services, notes Valerie Rock, senior manager with consultancy PYA in Atlanta. The new add-on codes "are not likely to be used or used correctly because the use of them will be difficult to implement," says Rock.

CMS listed typical times in the final 2018 Medicare physician fee schedule for each of the 18 covered preventive care codes to which you can append the add-on codes, but that may be lost on many practices. "If the provider is unaware that the typical times are referenced in the final rule, he or she will either be applying incorrect assumptions to code for the service or will be unable to use the codes," says Rock.

More practices expect to bill the prolonged preventive service codes in 2018 than the behavioral health codes, according to the *Part B News* survey. About 30% of practices said they were "somewhat likely" to report the new preventive add-on codes once eligible, and about 20% are "likely" to report them. Just about 2% of respondents said they were "highly likely" to put them to use.

"I think we'll see a build," says Holmes. "I don't think it's going to be something that will jump the first year."

Prediction: More providers will migrate to risk-based models, including accountable care organizations (ACOs). AMGA found something interesting in its December 2017 member survey: 60% of AMGA members "stated they would be ready to take downside risk within two years." That is, they were willing to enter models that put some of their earnings at risk if their performance did not meet certain standards — presumably with the possibility of making more money if their performance met or exceeded those standards.

A major risk model is the ACO — including ones managed by Medicare that the Trump administration and CMS Administrator Seema Verma haven't meddled with in their first year. "HHS hasn't pulled back support on ACOs [and related performance-based programs]," says Rosemarie Day, president of Day Health Strategies in Somerville, Mass., and a former deputy director of the Massachusetts Health Connector. "Maybe it's because it doesn't have the Obama label on it." Indeed, Trump's nominee for HHS secretary, Alex Azar, praised Medicare ACOs in his committee hearings (*PBN 12/11/17*).

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PAS 2018

Beyond Medicare, the market also will provide incentives to accept risk. "Payers will continue to expand risk contracts in 2017 that reward providers for improving health outcomes, an objective far easier to meet with technology that enables a current view of patient health," predicts Koorosh Yasami, founder and chief strategy officer of HealthBI in Socttsdale, Ariz. Add the incentive the Quality Payment Program gives providers to avoid MIPS by enrolling in advanced APMs, which require a certain amount of risk, and 2018 should see significant movement to risk models.

Prediction: HHS will push for better interoperability. Sure, you've heard it before; interoperability is the holy grail of health IT — long sought, never seen (*PBN 2/21/17*). But the Trump administration recently signaled that it's serious about it with a high-level electronic medical records interoperability meeting at the White House including representatives of projects like the Sequoia Project and the CommonWell Health Alliance, who did working sessions with Verma, Acting HHS Secretary Eric Hargan and the president's son-in-law, Jared Kushner. "I suspect the meeting means they're trying to find a policy that defines interoperability," says Fisher.

Prediction: End of the ACA individual mandate would mean higher premiums and maybe cuts to Medicare and Medicaid — but some states may step up. It's no shock that the possible end of the ACA's individual mandate — which Congress passed in its December tax bill and Trump is expected to sign, though he hadn't as of press time — would cause healthy citizens no longer worried about tax penalties to leave the ACA insurance market, causing a sicker pool and, as a result, higher premiums from insurers (*PBN 10/23/17*).

"The repeal of the individual mandate to purchase health insurance that's contained in the tax bill is a problem, and we know that from our experience in Massachusetts, from having had reform without the mandate, that the healthier people didn't purchase insurance until the mandate kicked in, even if they qualified for subsidies," says Day. "So it does matter. It's been proven."

Day also expects the Republicans will come after Medicare and Medicaid as part of their "entitlement reform" plan soon. After the tax bill, "there'll be 'not enough money' for Medicare and Medicaid," she predicts. "So, they'll ask, how do we tighten up the programs?"

While states can't do much with Medicare, they can do something about their own insurance markets — in fact, some Californians have proposed that the state put in its own mandate, as Massachusetts did in the days of Romneycare. "I've had some states ask me about that behind the scenes," says Day. "I think a state with a state-based exchange that has the infrastructure and a critical mass of people in the government who understand enough to work with the insurance commissioner on it could create a potential nexus of advocacy to support the legitimacy of a state-based individual mandate."

And while Medicaid cuts will be painful, the added state flexibility of waivers and vouchers that Republicans often tout as the upside of reform could be used by more progressive states to improve care for some of its most needful citizens. "Something we're working on here in Massachusetts is ACOs for Medicaid — an idea that has only gained a modest foothold in this country," says Day. "Massachusetts is committed to making the model work for its harder-to-serve population." — *Roy Edroso (redroso@decisionhealth.com) and Richard Scott (rscott@decisionhealth.com)*

Resource:

- AMGA paper, "Taking Risk, 3.0: Medical Groups Are Moving to Risk … Is Anyone Else? AMGA's Third Annual Survey on Taking Risk": *www.amga.org/wcm/PI/Risk/MA/EI/wpTakingRisk3.pdf*

Round-up

(continued from p. 1)

exceeded 1 million (*PBN 1/30/17*). The real damage to Obamacare is expected to come in 2018, when a tax bill that would kill the individual mandate is expected to kick in (*see predictions story, p. 1*).

But *Part B News*' 2018 Predictions Survey suggests it was right to suspect more cash payments. By a nearly 2-to-1 margin, 62%-38%, respondents say they expect to see more uninsured patients at their practices in 2018. Even with the current, lowered uninsured population — which is expected to grow when the mandate ends — plenty of cash also will be paid for *insured* patients' care, points out Ron Harman King, CEO of health care consultancy Vanguard Communications in Denver. A 2017 Kaiser Family Foundation analysis finds that the average deductible for people with employer-provided health coverage rose from $303 in 2006 to $1,505 in 2017. "Eventually, rising costs always trickle down to consumers, who will continue paying more both out of pocket and also in elevated insurance premiums," King says.

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

True. Former CMS Acting Administrator Andy Slavitt, no fan of Trump, said right after the 2016 election that the Trump administration wouldn't touch QPP, and he appears to have been right (*PBN 11/15/16*). The final rule for QPP year two shows none of the signs of drastic alteration visible in the administration's Obamacare actions. And MACRA itself remains law.

Prediction: Providers will meet QPP requirements faster than they did with prior performance programs.

Unsure. Some stakeholders have shown signs of discontent with QPP — MedPAC, for example, has denounced the merit-based incentive payment system (MIPS) in particular and called for it to be abolished (*PBN 12/18/17*). And the HHS Office of Inspector General (OIG) put out a Dec. 14 report saying that CMS "still needs to clearly designate leadership responsibility for QPP program integrity and develop a plan to prevent and address fraud and improper payments."

But the *Part B News* 2018 Predictions Survey suggests that providers are getting with QPP — only 7% of respondents said they weren't participating at all and half of those said they were exempt; 3% said they would participate in advanced alternative payment models (APMs); and a whopping 66% said they'd participate in MIPS (*see benchmark, p. 5*).

Prediction: The advancing care information (ACI) category in MIPS will be a sticking point for some practices.

Unsure. Numbers from year one of the Quality Payment Program's MIPS compliance are not available, but it's significant that CMS went out of its way to keep ACI as simple as possible in its final rule for the program's second year. The reporting window is still 90 days while quality went to a full year, and CMS added opportunities to score bonus points (*PBN 11/13/17*).

Prediction: Changes to CCM services won't attract huge crowds to the service, but claims will top 1 million unique patients.

True. While chronic care management didn't set the woods on fire, the latest data shows that claims on the **99490** Medicare-payable code more than doubled to 2.5 million in 2016 from 1.1 million in its initial payment year (*PBN 12/4/17*). That's "still a relatively low number, considering an estimated 35 million Medicare beneficiaries are treated for multiple chronic conditions," Linda King, client success specialist at DocsInk in Wrightsville Beach, N.C., told *Part B News* this year (*PBN blog 11/30/17*).

Unfortunately, CMS did not release updated figures in the 2018 fee schedule, stating only that "we expect that utilization of care coordination services will continue to increase as more health care practices … implement these services." However, *Part B News* is comfortable projecting that any decrease in the percentage of unique patients would be outweighed by the increasing number of total services reported in 2017, giving us a clear lane to 1 million unique patients (*PBN 11/14/16*).

Prediction: Expect a split decision on behavioral health integration (BHI) codes — CoCM will lag but general BHI and cognitive assessment codes will charge ahead.

True and false. As expected, the Collaborative Care Management (CoCM) services haven't garnered much attention, but, to our surprise, neither did the behavioral health integration or cognitive-assessment services that debuted in 2017, sources tell *Part B News* anecdotally. Firm numbers are not available yet, but insider knowledge draws a bleak portrait. "I don't know of any practices that are using the behavioral integration codes," says Betsy Nicoletti, president of Medical Practice Consulting in Northampton, Mass. "Too complex," she says. Perhaps the switch from HCPCS codes to CPT codes in 2018 will raise some interest (*PBN 12/4/17*). *— Roy Edroso (redroso@decisionhealth.com) and Richard Scott (rscott@decisionhealth.com)*

***Editor's note:** For a complete rundown of the 2017 predictions, read more at www.partbnews.com.*

Resources:

- U.S. Health Care Industry Cybersecurity Task Force Report, June 2017: *www.phe.gov/preparedness/planning/cybertf/documents/report2017.pdf*
- AHIMA cybersecurity guidelines: *http://journal.ahima.org/wp-content/uploads/2017/12/AHIMA-Guidelines-Cybersecurity-Plan.pdf*
- OCR Cyber Awareness Newsletters: *www.hhs.gov/hipaa/for-professionals/security/guidance/cybersecurity/index.html*
- McAfee Labs Threat Report Q3, December 2017: *www.mcafee.com/us/resources/reports/rp-quarterly-threats-dec-2017.pdf*

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