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2015 predictions: ICD-10 will start, meaningful use will stall, PQRS won't stick

Here are *Part B News*' predictions for the new year, with input from industry experts and more than 110 readers.

ICD-10

Prediction: Oct. 1, 2015, will mark the beginning of the ICD-10 era, and the start will be shaky. Questions remain about the health care system's readiness to tackle the expansive ICD-10 code set, but perhaps the more important question is this: Will Congress act to postpone the oft-delayed go-live date yet again? The signals are cloudy but trending to the negative.

*(see **2015 Predictions**, p. 4)*

Predictions

2014 predictions: Too early on ICD-10; right about HIE, permanent SGR fix

Part B News hit the target on some predictions but missed on others. Here are the results from the forecasts we made in 2014.

Prediction: ICD-10 switch will disrupt cash flow at many practices.

Too early to tell. The most recent one-year delay that pushes ICD-10 implementation to Oct. 1, 2015, gives practices

*(see **2014 Predictions**, p. 7)*

Predictions

Practice-buying will slow in 2015 — but some markets will keep booming

Acquisition experts agreed a slight downturn in buying activity will occur in the new year, though regional markets may vary, new kinds of buyers will emerge and certain types of practices — for example, primary care practices — have great chances for getting picked up.

"A lot of large systems are pausing to digest what they've purchased and to get the management of those assets right," says Mark Rust, office managing partner, Barnes & Thornburg LLP, Chicago. Also, they want to take stock of the unresolved issues before the states and the Supreme Court, such as the future of Medicaid expansion and the subsidies at issue in *King v. Burwell*.

Acquisition "may not be at the rapid pace it has been for the last few years in all markets," says Mary Witt, senior vice president with The Camden Group, Los Angeles. "Hospitals often lose money on their physician enterprise and may feel they cannot continue to sustain huge losses."

Buying history, region matter

After several busy years, there are "fewer attractive practices left to buy," says Roger Strode, a partner and health care business lawyer with Foley & Lardner LLP, Chicago. "There is also greater competition left for those that are attractive acquisition candidates."

Some markets are fished out, but others are not, says Strode. In northern Illinois, for example, one large independent practice is left while the rest of the independent physicians are in small practices, leaving few opportunities for investment. However, in other markets such as the southeast coast of Florida or the Phoenix and Scottsdale markets in Arizona, more fragmentation exists, says Strode.

Buyers want to make sure their investments are good bets and are requiring that practices agree to more stringent performance targets in their contracts with them, notes managing director, Ron L. Vance, Navigant, Suwanee, Ga.

What's selling: PCP, ancillaries

Primary care providers are higher on shoppers' lists than they've been in a while because of the trend toward care coordination, says Marc Halley, chairman and CEO of Halley Consulting in Westerville, Ohio.

But instead of buying one-doctor and two-doctor practices as they have in the past, buyers are looking for bigger groups, says Adam Higman of Soyring Consulting in St. Petersburg, Fla. "They want to acquire those referral networks."

If you don't want to sell everything, think about pieces you're willing to give up. Buyers are looking for ancillary services that they can take over; for example, they may

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not want to buy your ortho practice, but they may want the physical therapy unit that's part of it, says Strode.

"I see hospitals interested in practices that have robust ancillary services — such as ambulatory surgery, imaging, labs — because those are services that were taken out of the hospitals years ago and this is their chance to get them back," says Strode. If they don't have to buy the whole practice to get these services, they won't. They'll buy your imaging service, for instance, and let the practice "ride shotgun" — that is, maintain their business and continue to make referrals to the ancillary they no longer own.

The equipment helps them "eliminate, to the degree possible, competition from others in all areas of revenue generation," Rust says.

This may be a good deal for owners who plan to get out of the game soon because buyers have been known to pay top dollar on ancillaries in anticipation of long-term profits. But if the owner wants to hang in, he or she may prefer to hold off on selling, says Strode.

Private equity companies look to buy

Other players besides hospitals and health systems may get busier in 2015. Private equity companies, for example, such as New Enterprise Associates (NEA) and Audax Group are creating acquisition "platforms" by forming physician practice management companies that manage practice groups and hospitals, says Strode. They're well-financed and looking to buy.

Good news for specialists: Those groups are looking for you. Dermatology "is hot for these investors because there's a lot of cash and private-pay revenue," says Strode. "Also radiology and anesthesiology because they're hospital-based and if they own them, they become relevant to payers. If you can say to UnitedHealthCare, we control 5,000 radiologists or 1,500 anesthesiologists, they can use that to bargain for better rates [for their physicians]."

Also, says Strode, look for companies with more exotic combinations of buyers to come shopping in the near future — such as Vivity, the new company run by Anthem Blue Cross in California that's partnering with local health systems. "I think you'll see more payer-provider relationships," says Strode. "Payers are becoming interested in being health care owners. … You'll see more Vivitys."

Doctors have a say

But be careful: Your physician partners might not be as eager for a change as you are. Word's getting around that some of those hospital contracts aren't so hot, and doctors are becoming resistant, says Maxine Lewis, president, Medical Coding and Reimbursement in Cincinnati.

"Doctors are looking harder at those contracts," says Lewis. "I've done RVU [relative value unit] calculations for some doctors who have hospital contracts and want to know if they're being cheated."

If their contracts give them to room to do so — and often they do — your fellow physicians might resist a deal (*PBN 3/11/13*). Lewis thinks it's more likely now than it was in the past.

"I've seen some doctors go with one hospital, and the others say 'no' and go with another," says Lewis. "I've seen it in three practices where they split up. And I hadn't seen that before — usually they all go together."

"We will see more providers leaving hospital employment as they become frustrated with hospital administration, bureaucracy and unkept promises and going back into private practice," agrees David Zetter, president of Zetter Healthcare Management Consultants, Mechanicsburg, Pa.

Tips for would-be sellers

Think like a buyer. "If you're looking at prospects, put yourself in the place of your potential acquirers, and ask what benefits you offer," says Higman. That may not necessarily mean billings — it could also mean a patient mix that suits the shopper's strategy. Look at what the local players have been doing and see whether you have something to offer.

Have a "succession plan" — basically, a written operational plan that makes sure younger doctors are on their way in as the older doctors are on their way out, says Todd Brower, head of the health law practice at McCarter & English in Newark, N.J. The contract issue is well-known to buyers, and "hospitals have become too savvy to buy 'air,' which translates roughly to older physicians looking to retire while on the job and get bought out," he says.

Increase efficiencies. Understand how the practice compares with external benchmarks, says Vance. Demonstrating that the practice is efficient relative to overhead costs — "including support staff, building and

supply costs, as well as financial management of billing and collections processes — will enhance the profile of the practice."

Also, be aware you're by judged by the same kind of quality reporting metrics that CMS increasingly favors in its programs — for example, patient satisfaction, clinical quality and overall cost efficiency metrics, says Vance.

Engage and work with advisors — legal, clinical and financial — to help prepare for buyer inquiries, says Les Levinson, co-head of the transactional healthcare practice at Robinson+Cole in New York City. When it comes time to pitch, "the practice will shine and questions that are likely to be asked on diligence will be thought through as best as possible and addressed in advance."

Determine whether you're interested in leasing. Brower says a growing number of hospitals and systems are pursuing the "enterprise model where hospitals lease practices for a fixed amount of time but don't buy them. It's a good way to try out a hospital partnership without actually partnering. But don't get too comfortable: "Those hospitals that leased physician practices five or so years ago are looking at the deals now as they come up for renewal, and they're being choosier as to which ones they'll renew," says Brower. — *Roy Edroso (redroso@decisionhealth.com)*

2015 Predictions

(continued from p. 1)

"I'll give a qualified 'maybe,'" hedges Robert Tennant, senior policy adviser, Medical Group Management Association (MGMA), Washington, D.C. "Unless there's a clear signal from the administration or Congress that a delay is imminent, I would proceed under the belief that it will be Oct. 1."

The results of Medicare's first end-to-end testing period for ICD-10, for which volunteer providers will submit claims between Jan. 26 to 30 may provide the earliest signal of ICD-10's fate in the new year, says Tennant. Until then, many practices are planning for the transition with continued training.

About 70% of practices will continue the training they started before the last delay, according to respondents to a *Part B News* predictions survey. "It's time to get this done and move on," says David Zetter, president of Zetter Healthcare Management Consultants, Mechanicsburg, Pa. "It cost many practices more when the feds decided to postpone implementation."

Among providers, however, confidence in the transition occurring on the appointed date appears fickle. While 43% of respondents believe ICD-10 will go live Oct. 1, nearly one-third (31%) disagree and more than a quarter (26%) simply shrug their shoulders. If this prediction hits the mark, it may be a calamitous time for providers. "Even if Congress does not take action to institute another delay, that doesn't mean that everything is going to go swimmingly" in October, warns Tennant.

Meaningful use

Prediction: More practices will attest for stage 2 meaningful use, yet not enough to avoid further delays or exceptions. The cost of not moving ahead with meaningful use — a projected 5% penalty per provider by 2019, up from 1% in 2015 — will be enough incentive to keep practices slogging ahead toward attestation, says Zetter.

Initial feedback from the *Part B News* survey shows promising movement: Nearly one-third (32%) of practices reported that they will attest to stage 2 for 2014 and achieve stage 2 in 2015. Overall, approximately two in five practices (39%) are currently working on stage 2, according to the survey.

Yet those numbers might not be enough to meet the "reasonable expectation," which CMS conveyed in the original HITECH legislation, of three-quarters of practices reaching stage 2 by the attestation deadline (Feb. 28, 2015), says Tennant, and thus forestall further delays or exceptions. Adds Tennant: "ONC is hopeful of a huge spike in participation. I'm not that confident."

Slow attestation numbers may force lawmakers to intervene, says William Maruca, attorney with Fox Rothschild in Pittsburgh. "I think there may be more delays. The administration wants this program to work and will try to be responsive to the issues that are delaying implementation." On Maruca's side is language within the 2015 Medicare physician fee schedule granting the federal agency greater latitude in setting its hardship filing deadline "to July 1 of the year preceding the payment adjustment year or a later date specified by CMS."

Keep an eye on further details in early March.

PQRS

Prediction: Providers will wait for worse penalties to comply with PQRS. Almost every Medicare provider will have skin in the quality-reporting game in 2015 and will be liable for physician quality reporting system (PQRS) and, in some cases, value-modifier penalties (*PBN 11/10/14*). But you can see harbingers of non-compliance: Barely 30% of practices said "we are capable of reporting the required number of measures and will have no problem avoiding the penalties," according to *Part B News*' recent survey.

Practices already are getting penalized and for many of them, "the penalty is not as bad as the cost of doing it, what with the extra time for documentation," says Maxine Lewis, president, Medical Coding and Reimbursement in Cincinnati. A significant number are confused and frustrated by their counterintuitive reporting responsibilities. "I did an audit for a dermatologist. He asked about smoking cessation and flu shots," says Lewis. "How is that contributing to his quality of care?"

"There are many providers and practices out there that are not aware that they should have been report-

Benchmark of the week

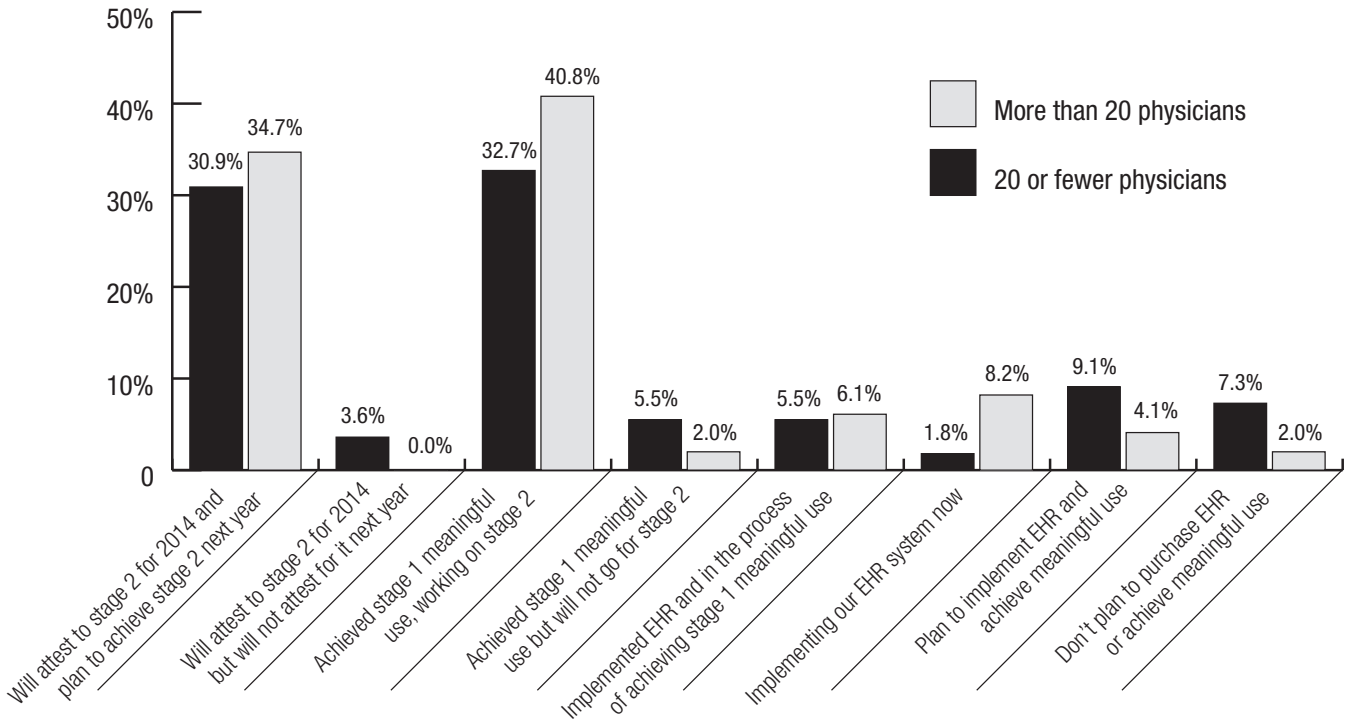
More large practices working on stage 2 meaningful use; some shirk EHR program

Almost 35% of practices with more than 20 physicians will attest to stage 2 meaningful use for 2014 and plan to achieve the same requirements in the new year. That number is lower — 30.9% — for practices with 20 or fewer physicians, according to 114 respondents to Part B News' 2015 predictions survey.

Another 40.8% of larger practices achieved stage 1 meaningful use and are working on stage 2. That number is just 32.7% for practices with 20 or fewer physicians.

On the other end of the spectrum, more practices with fewer physicians don't plan to buy electronic health record (EHR) systems or achieve meaningful use. About 7.3% of those practices won't participate in meaningful use while that number is 2.0% for the practices with more than 20 physicians. Notably, a small percentage of small practices (3.6%) will attest for stage 2 meaningful use in 2014 but abandon the program for 2015, the survey shows.

Meaningful use adoption and plans by practice size



Source: Part B News' *2015 predictions survey*

ing PQRS in 2013 — and there are plenty that are not prepared to report for 2014 either," says Zetter.

But as the negative payment adjustments increase, they'll "get to be too much and providers will be forced to comply," Zetter says.

Pain will be the most effective teacher, when the negative adjustments for PQRS non-compliance begin to add up next year, says Seth Flam, D.O., CEO and director of EHR company HealthFusion in Solana Beach, Calif. Providers face a 2% penalty for not complying with PQRS, and that penalty is amplified by an additional 2% penalty related to the value-based modifier. But they won't see that until after the year is over, so during 2015 itself, expect a lot of non-compliance.

Prediction: Health IT vendors will improve options for PQRS reporting. Expect EHR companies and registries to improve their offerings for reporting. "Since the penalties for poor performance are so onerous, we expect software vendors to be under pressure by their users to make compliance simpler, and therefore we hope to see an increase in compliance," says Flam.

Lindsey Bates, market segment manager for PQRS at Wellcentive in Atlanta, believes "other vendors will, as we do, upgrade their solutions and resources to ensure that eligible providers are given the latest education and tools that best accommodate their needs with the most appropriate reporting option."

CCM

Prediction: Providers will be slow to adopt billing for chronic care management (CCM). The announcement of the new CCM code and payment in the final 2015 Medicare physician fee schedule in November buoyed many practices' spirits (*PBN 11/10/14*). After all, it's $40.39 for work they do for patients with multiple chronic conditions, and it takes much of the burden of that work off the M.D.'s shoulders.

But experts think some issues will slow adoption.

"Providers will take a wait-and-see attitude," Lewis says. "The documentation requirement is significant, even for 20 minutes of work. And you need a specific worker to follow the case. This is work doctors normally do, and it's complicated for an office to follow these. Forty dollars isn't enough."

Provider reaction to transitional care management (TCM) codes is an indication of what could happen with CCM billing, notes Martie Ross, a principal at consultancy PYA in Kansas City, Mo. When CMS introduced reimbursement for TCM, another non-face-to-face care management service with a 30-day service period, the agency anticipated paying more than $500 million per year in TCM claims. But in 2013, CMS paid about $44.1 million, according to the latest Medicare data available.

Among the reasons for the low TCM adoption: Lack of awareness that the service is billable, providers who are "unwilling to invest the time and resources necessary

to develop a workflow process needed to furnish TCM," perception that TCM rules are ambiguous or confusing and belief that the compliance risk outweighs potential revenue, Ross says.

CCM could suffer from the same issues. CMS also is releasing billing details in pieces, which is likely to make providers nervous (*PBN 11/24/14*). "There are several points CMS needs to clarify, especially the rules regarding who is eligible to receive the service," says Ross. This approach to provider education has not been successful in the past, as shown by high denial rates recently revealed for TCM, which was rolled out in a similarly piecemeal fashion (*PBN 11/3/14, 12/9/13*).

For all these reasons, "initial adoption of CCM is likely to be underwhelming," says Ross.

Prediction: Health IT companies will come up with CCM-related products. CCM requires a provider "to develop an electronic care plan as a basis for providing CCM," Ross says. "However, there's no technology product on the market of which I'm aware that supports care plan development. The EHR certification requirements for meaningful use do not include care plans, and thus EHR vendors have not focused on this to date."

Some health IT vendors are already at work on CCM-related products. PracticeFusion "has designed a special module that assists providers with CCM billing," Flam says, while other companies such as eQHealth Solutions in Baton Rouge, La., are working on developing CCM products.

Permanent SGR fix

Prediction: A temporary "doc fix" will avoid large Medicare cuts but a permanent fix will elude providers again. Despite the annual angst surrounding Medicare cuts, a rosy outlook about a permanent solution to the sustainable growth rate is hard to find. "I'm not too optimistic about a permanent fix or anything else cooperative coming out of Congress in the next two years," offers Maruca. Without a wholesale solution, considerable pressure from the industry should at least ensure a temporary patch to avoid "catastrophic" Medicare cuts, adds Tennant.

In the event that lightning strikes Congress twice and a permanent solution arises, it will almost certainly be tied to additional regulations. "We do not know what those may possibly be," says Zetter, although he posits they could be additional bundled payment programs. Watch SGR-related legislation for additional requirements you may need to meet in 2015 and beyond.

Audits

Prediction: Practices will suffer the financial repercussions of not understanding incentive and quality reporting programs or coding rules. Jennifer Searfoss, CEO of SCG Health, Ashburn, Va., is already seeing "a significant uptick" in the number of her clients that are getting audited for meaningful use, "including those who are just simply writing a check [to pay back their incentive money] because they didn't dot their Is and cross their Ts." She expects "audits on meaningful use will go through the roof" and many providers will have to pay back the incentive money.

The same will be true for code utilization and PQRS, "which all will return monumental amounts of money to the feds since many practices do not have knowledgeable staff or vendors assisting them with these programs," Zetter says. The big triggers for the coding audits will be, as usual, E/M and incident-to — and also the new CCM codes, he adds.

New revenue

Prediction: Physicians will delve into preventive care, other office-based services to offset reimbursement cuts. "I see PCPs [primary care providers] expanding into physical therapy and other services, such as expanded preventive care in their practice, including smoking cessation [and] weight loss counseling," predicts Zetter. Other service areas that physicians might wade into to sustain finances? "Alternative/complimentary medicine is one area," adds Maruca. "Physician dispensing of medications is another one." — *Roy Edroso (redroso@decisionhealth.com) and Richard Scott (rscott@decisionhealth.com)*

2014 Predictions

(continued from p. 1)

more time to prepare. That was welcome news to 13.6% of the respondents to an April *Part B News* survey who said their practices would not have been ready to switch code sets in 2014 (*PBN 4/7/14*).

But more time may not overcome challenges that survey respondents cited, such as poor documentation (22.1%), scarce resources (14.4%) and software that vendors haven't updated (8.5%).

Don't expect to have CMS to blame if your ICD-10

claims don't get paid in October. CMS officials stated that the agency was ready to start ICD-10 in 2014 and will be ready for the new go live date (*PBN 4/28/14*).

Prediction: Health insurance exchanges (HIEs) will make collection problems at practices worse.

True. More than 90% of practices *Part B News* surveyed said they had patients with exchange plans, though those people made up less than 10% of the patient base (*PBN 6/9/14*). And three-quarters of the respondents said they had verification or other problems with the patients' exchange plan paperwork.

Practices also had trouble with patients' understanding of their plans. For example, one Dallas nephrology practice had trouble determining deductibles because of inconsistency between what the patient says and what the insurance verification says.

Along with typical collections troubles, practices struggled with an unfavorable provision in the Affordable Care Act that left them on the hook if a patient with an exchange plan didn't pay his premium during the 90-day grace period (*PBN 2/10/14*). The insurer covers services performed in the first 30 days, but services provided for the rest of the grace period, during which the patient is considered enrolled, become the patient's and likely the practice's responsibility.

Prediction: Increased PQRS requirements will tax practices' resources.

False. CMS tripled to three the number of measures practices had to report in 2014 to avoid PQRS penalties in 2016. And the federal agency is moving away from claims-based reporting, making reporting through registries and electronic health records (EHR) more advantageous, though they are pricier (*PBN 9/22/14*).

But practices didn't seem to feel the PQRS pinch in 2014. About 11.5% of practices said in a *Part B News* survey at the end of 2013 that they were capable of reporting nine measures to avoid penalties; that number jumped to almost 30% in a *Part B News* survey at the end of 2014.

And fewer practices said they would be at risk for incurring penalties in 2015 (17.1%) than in 2014 (21.2%), according to the surveys.

But in future years, as more practices are subject to value modifier penalties based on their PQRS participation, the result of this prediction may change.

Prediction: The stage 2 meaningful use requirement that more than 5% of patients view, download or transmit to a third party their health information will be one of the toughest to meet.

Too early to tell. CMS and the Office of the National Coordinator for Health Information Technology (ONC) allowed eligible professionals who were supposed to start stage 2 in 2014 to attest to stage 1 objectives if their systems made achieving the newer standards impossible (*PBN 9/15/14*). Despite that, 32.4% of practices completing *Part B News*' recent survey plan to attest to stage 2 meaningful use for 2014 and achieve the same requirements in 2015. Another 38.9% achieved stage 1 meaningful use and were working on stage 2.

One EHR vendor, athenahealth, shows its customers' performance on its website and noted in December that the patient electronic access measure has a 93% success rate.

Prediction: Meaningful use audits will increase.

True. Recent reports found that more than 10,000 audits of eligible professionals who have attested to demonstrating meaningful use in the Medicare electronic health record (EHR) incentive program have been initiated and 8,000 completed. More than one-fifth (21.9%) of the professionals have failed the audits. In addition, the OIG announced in October that the meaningful use program is a top priority and the agency will conduct its own investigations (*PBN 11/17/14*).

Prediction: The permanent sustainable growth rate (SGR) fix won't happen this year.

True. A temporary "doc fix" signed into law April 1 killed the hope of a permanent replacement of the sustainable growth rate (SGR) formula determining physician payments in 2014. Before the doc fix, legislation to permanently repeal the SGR looked promising as it enjoyed bipartisan support. But the way to pay for it eluded legislators (*PBN 3/31/14*). With the temporary patch in place, talk of the permanent fix faded. — *Karen Long (klong@decisionhealth.com) and Marla Durben Hirsch (pbnfeedback@decisionhealth.com)*

Correction

A story in the Dec. 22, 2014, issue of *Part B News* erroneously reported who can report transitional care management (TCM) and chronic care management (CCM) codes. The codes can be billed by any specialty.

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