WHITE PAPER

Getting Paid in 2019

What Independent Medical Practices Need to Know

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Table of **Contents**

PART ONE

Quality Payment Program Changes and MIPS Expansion 2

PART TWO

ACA Changes and the Impact on Independent Practices 5

PART THREE

CMS Changes That Benefit Independent Practices 7

PART FOUR

Maximize Your Revenue in 2019 9

PART FIVE

Getting the Jump on Patient Collections 12

Introduction

We know that doctors and patients prefer the independent practice setting over hospital care. But, it's also true that between July 2015 and July 2016 alone, hospitals acquired more than 5000 practices and increased the number of employed physicians by 14,000, according to a study by the Physicians Advocacy Institute. So what's happening there? Far too often, those same physicians find themselves regretting their decision to give up their autonomy and independence. They didn't think they had a choice.

We're here to let you know that with a little planning, forward thinking and willingness to embrace new tools and technologies, the future of independent medical practices has the potential to be brighter than ever. It's possible to navigate the regulatory and industry challenges and retain control of your practice, while still providing a more personal level of care. There are even signs that independent practices are getting a little help from a few regulatory changes coming down the road.

PART ONE

Quality Payment Program Changes and MIPS Expansion

CMS recently released some encouraging statistics regarding the participation levels and success rates of the 2017 MIPS program year. Approximately 93% of the eligible clinicians participating in 2017 earned a positive payment adjustment, according to Seema Verma, the CMS Administrator. Another 2% received a neutral adjustment, and 5% received a negative adjustment.

PQRS and Meaningful Use Phased Out

While the positive payment adjustments are somewhat modest, for some practices who previously had received penalties under the Meaningful Use and PQRS programs, the net effect on their revenue will be more significant. As the penalties for PQRS and Meaningful Use phased out at the end of 2018, many of those practices who found it too cumbersome to fully participate in those programs will no longer see those dreaded CO-237 adjustments on their Medicare EOBs.

Because of the "pick your pace" approach to MIPS in 2017, many of those practices were able to avoid the penalty and even obtain a slight positive adjustment. While it remains to be seen whether those practices will continue to be successful in avoiding penalties in year two and beyond, the slower pace of implementing MIPS along with the commitment from CMS to reduce the administrative burden on physicians just may be enough to allow more providers to be successful in avoiding negative adjustments. This is all good news for smaller, independent practices.

> MIPS Results: Approx. **93% of participating** clinicians earned a positive payment adjustment

As we approach the third year of the QPP MIPS program, there are a few key changes to the program worth noting.

Increased Point Requirement to Avoid Penalty

CMS increased the minimum number of points required to avoid penalties in 2019. The new threshold to ensure an eligible provider achieves a neutral adjustment will be 30 points, up from 15 in 2018. For those providers who hope to obtain the exceptional performance bonus, they will need a minimum of 75 points, a five point increase from 2018.

MIPS Expands Eligible Clinician Types

An expanded definition of MIPS eligible clinicians now includes the following clinician types:

- Physical therapists
- Occupational Therapists
- Qualified speech-language pathologists
- Qualified audiologists
- Clinical psychologists
- Registered dietitian or nutrition professionals

More Help for Small Practices

The final rule for the 2019 QPP contains several items specifically targeted toward helping small practices. Those include:

- Increased small practice bonus to 6 points and including it as part of the Quality performance category
- Continuing to award 3 points for submitted quality measures that don't meet data completeness requirements
- Offering continued support for small and rural practices through the Small, Underserved, and Rural Support (SURS) technical assistance initiative.

Help for Small, Underserved and Rural Areas

The Small, Underserved, and Rural Support initiative that was funded by MACRA is a five year program that provides free, customized technical assistance to clinicians in small practices of 15 providers or less. The QPP website provides a link to locate selected providers of these services by state. These organizations provide both program level support and practice level support in the form of helping providers understand the general requirements of the QPP, determining if they are considered a MIPS eligible clinician, choosing appropriate measures and activities for a practice, and assistance with submitting their data. They can also perform practice readiness assessments and assist in developing strategies for implementing Certified Electronic Health Record Technology (CEHRT).

> **Physical Therapists** and **Clinical Psychologists** are among the clinician types now eligible for MIPS.

2015 Certified EHR Now Required

Beginning in 2019, only the 2015 certification will qualify for the QPP. If you have not participated in previous MIPS reporting periods, it's not too late to get started. The thresholds for participation are still relatively low in 2019, so it's a good time to become familiar with exactly what is required to, at a minimum, avoid a penalty in your 2021 payments.

> **2019 QPP increases** small practice bonus points for the Quality category.

For a complete list of the 2019 QPP changes, review the executive summary published by CMS.

Contact Kareo to assess your software and reporting readiness for MIPS 2019.

PART TWO

ACA Changes and the Impact on Independent Practices

Elimination of the Individual Mandate Penalty

While attempts to "repeal and replace" the Affordable Care Act have not been successful and are unlikely to continue, with the change in control of the House of Representatives, there have been other legislative changes that will have a significant impact in the enforcement of parts of the ACA, particularly as it relates to individual healthcare coverage. The most significant change for 2019 is the elimination of the penalty for the individual mandate. As part of the 2017 tax reform bill, individuals will no longer be penalized for failing to obtain healthcare coverage that meets the requirements of the ACA. The Congressional Budget Office issued a report titled, Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028. One of the most relevant takeaways from that report for providers in 2019 is the fact that between 2018 and 2019, the number of individuals enrolled in non-group plans is expected to decline by 3 million, largely due to the elimination of the individual mandate penalty.

There is some uncertainty as to how much of an impact this will have on the number of insured individuals long term, with estimates ranging from 3 million to 13 million fewer insured. However, there are steps you can take to make sure that your practice is prepared for the possible changes you will see in your patient population with regard to individual coverage.

Update Your Policies

The most important thing you can do is to make sure that you have a policy in place of verifying your patient's insurance coverage prior to every

No more penalty for individual coverage → **Estimated 3 million fewer people insured as a result** → **Means increased patient financial responsibility**

visit. With improvements in technology and the integration of eligibility verification tools offered by some billing and EHR software, there is no excuse for losing money as a result of incorrect eligibility information.

You will also need to make sure that your staff is familiar with your self-pay policies and are prepared to collect from patients who are newly without insurance and may not be aware of their financial responsibility. It's a good idea to use the beginning of each new year to review your financial policy and make any updates necessary so that your patients are aware of their responsibilities. Also, you should require patients to not only update their demographic information during their first visit of a new year, but also ask them to review and sign the practice financial policy again.

"New" Plan Options

The elimination of the individual mandate penalty also opens up the option for individuals to purchase Short-term Health Plans that don't meet the requirements of the ACA. These plans can rage in term from 3 months to 364 days and can be renewed for up to 36 months under the new regulations. While some states are already pushing back on these plans—either not allowing them to be sold or limiting the duration and renewability—for those practices in states where these plans are allowed to be sold to the full extent of the new regulation, it may mean some challenges trying to keep up with all of the changes.

A few key points about short-term health plans:

- Not required to meet the "essential coverage" requirements of ACA
- Allowed to charge more for pre-existing conditions
- Attractive to younger, healthier individuals with incomes above the limits for receiving federal subsidies
- Cost approximately 50% of what ACA compliant plans do
- Have higher deductibles than ACA plans
- May contain exclusions for coverage which payers are required to disclose

It will be critical for providers and their staff to be aware of the limitations and exclusions of these types of plans before providing services to patients who have purchased them. These types of plans rarely cover preventative care and are primarily designed for unexpected injury or illness. They are effectively "catastrophic coverage" and these plans will likely appeal to younger, healthier individuals.

Association Health Plans

While Association Health Plans (AHPs) are not a new concept, the ACA had previously eliminated these plans. An executive order in 2018 has revived this option as a way for smaller employers to band together and recognize savings on their health coverage. These plans will still be required to meet most of the requirements of the ACA. In many cases, AHPs will be provided by some of the same payers as other individual and group plans, so again, it will be important to conduct regular eligibility and benefits verification to ensure coverage for patients with these plans.

PART THREE

CMS Changes That Benefit Independent Practices

Changes to E/M Documentation Requirements

Another very real threat to independent physicians is burnout. Burnout is often brought on as a result of the increasing administrative burden physicians and their staff face due to documentation requirements that were put in place decades ago and no longer reflect the way that care is delivered. In a letter to doctors from CMS Administrator Seema Verma, she cites a Medscape survey in which 42 percent of the 15,000 physicians surveyed reported burnout. Administrator Veema when on to state that CMS is committed to turning the tide and to allow physicians to focus more on patients and less on paperwork.

One of the proposed ways to reduce administrative burden for physicians caused quite a stir in the industry in it's initial iteration.

> 42% of the 15,000 physicians surveyed reported burnout.

CMS proposed a change to the way that E/M office/outpatient visits would be paid. The initial proposal called for collapsing the current visit levels into a single code each for new and established patient in the 2019 fee schedule. After a bit of pushback from the industry, the final rule will collapse levels 2 through 4 into one payment level for each new and established visit and leave level 1 and level 5 codes as separate payments.

This would eliminate multiple documentation requirements with the goal of reducing the administrative burden on providers. The changes to coding and payment structures will not take place until 2021, however, CMS plans to implement policies for the 2019 calendar year that will reduce some of the documentation burden while maintaining the existing payment levels.

Documentation changes expected to be implemented in 2019:

- Elimination of requirement to document medical necessity of a home visit versus an office visit

- Allowing providers to focus documentation on what has changed since the last visit rather than having to re-document information already contained in the medical record, provided that there is evidence that the provider reviewed the information
- Clarifying that providers do not need to re-enter information on chief complaint and history that has been entered by staff or the patient; the provider must indicate that the information was reviewed

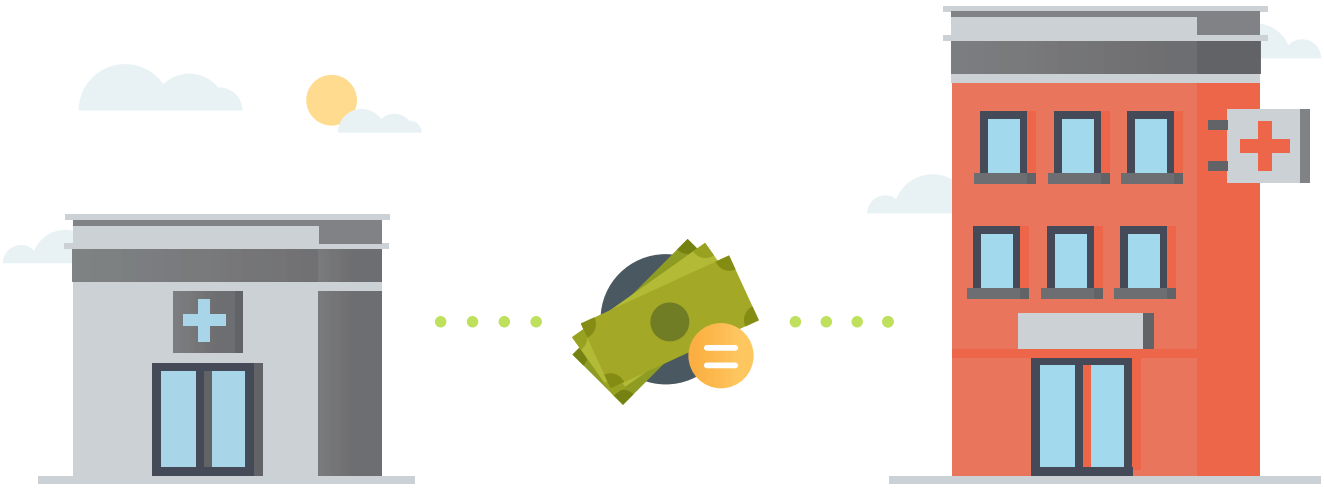
Further changes to documentation requirements will be implemented in 2021, including allowing providers to choose to document E/M office/outpatient visits using either medical decision making or time rather than the current 1995 or 1997 guidelines. For a complete overview of the final policy changes, see the CMS Fact Sheet.

Site Neutral Payments

Perhaps one of the most positive developments for independent practices announced by CMS is the site-neutral payment policy rule which was included in the 2019 Outpatient Prospective Payment System (OPPS). Prior to this change, outpatient services provided at a hospital-owned off-campus clinic were paid at a higher level than the same service provided at an independent provider office.

Under the new policy, the payment rate will be the same whether a patient is seen at an off-campus hospital clinic or a private practice. The policy is expected to reduce coinsurance amounts for beneficiaries and generate savings to the Medicare program of approximately $380 million in 2019 alone. For independent practices, this means that your services will be reimbursed at the same level as those of hospital employed outpatient practices.

> Starting in 2019, CMS will pay independent practices at the same level as hospital-employed outpatient clinics.



PART FOUR

Maximize Your Revenue in 2019

One of the greatest challenges for independent practices is maximizing revenue while keeping costs down. It's easy to get wrapped up in the day to day activities of a busy practice. Before you know it, revenues are stagnant or declining and costs are rising. Even in practices that follow best practices when it comes to keeping rejection and denial rates down and patient collections up, it is not uncommon to find that negotiation of payer contracts and updating fee schedules has fallen by the wayside. This can lead to significant revenue loss over time.

It is important that you review your fee schedule at least annually to ensure that you are being adequately reimbursed by payers with which you are contracted. Regular review of payer EOBs can alert you to underpayments which payers are notorious for. Too many practices sign payer contracts when they first become credentialed and then never bother to renegotiate their fees.

Plan Ahead

It's important to review your payer contracts and know when they are due for review. The best way to manage this is by creating a spreadsheet that tracks the following:

- Payer name
- Payer address
- Original effective date of contract
- Anniversary date of contract
- Termination notice requirement days
- Contract information for payer representative

Pulling together this information may take some time, especially if it has been several years or if there have been multiple changes in staff within the practice since the contracts were originally signed. Once you have gathered this information, it is time to determine which payers to tackle first.

Download Kareo's sample Payer Contract Tracking Form.

Review Current Fee Schedules

If you don't have a current copy of your fee schedule for each payer, you can create a simple report that provides a CPT Breakdown by Payer. Your billing software should include reports that can provide you with the average charge of each CPT code by payer.

Here's the information you should include in your report:

- Payer name
- CPT Code
- Average charge
- Average payment
- Medicare allowed amount

You don't need to compile this data for every CPT code that you bill. Begin with the top 20-30 CPT codes billed in the last 12 months. This will give you a better understanding of who your best and worst payers are. The results may surprise you.

Identify Contract Improvements Needed

Once you have reviewed your current fee schedule you can use that information to identify which payer contracts need some improvement. Remember that it's not just the financial aspects of payer contracts that impact contract negotiation. Review your contracts for carve outs, timely payment and filing requirements, and what notice you are required to provide when requesting contract amendments or termination.

Determine What You Have to Offer

Before you begin the negotiation process, identify what leverage you may have that makes you more valuable to the payer. Be prepared to provide the payer with data showing that your practice provides a higher quality of care and better outcomes that ends up saving them money through reduced hospitalizations and lower chronic care costs.

Renegotiate

When the time comes to renegotiate be sure to have some specific goals. It's always a good idea to have a list of "wants" and "must haves" clearly defined. It is important to be ready to walk away from a payer if they are unwilling to meet your bottom line requirements. Of course, this becomes much more difficult to do if a payer represents a significant

portion of your practice revenue. Make sure you know what percentage of your total revenue comes from a payer before you get into a contract negotiation.

Tips for Successful Negotiation

- Set your bottom line
- Know what data the payer may request and be ready to provide it
- Be the first to set the contract offer and make counter proposals incrementally
- Start with an easy win for each party
- Be informed and confident in your negotiations
- Know when to close and push for a quick effective date

Don't Let "Accelerated Payments" Cut Into Your Bottom Line

Payers seem to find new ways to cut into the already small margins that independent practices make on their services. One of the most commonly overlooked losses of revenue occurs when providers receive an explanation of benefits from a payer and rather than having a check attached, there is a "virtual credit card" number. This practice has become more common in recent years and too many providers simply accept these payments as if they don't have a choice.

By accepting these "accelerated payments," providers are losing 2-3% of their reimbursement from the payer due to merchant services fees. By law, the issuer of these virtual payments is required to provide information on how to opt out of receiving virtual payments and request that all future payments be made via check or EFT. It may not seem like a big deal, but every little bit of your revenue that doesn't end up in your bank account adds up.

PART FIVE

Getting the Jump on Patient Collections

Patient deductibles are at their highest levels in history with the average deductible for employer based plans reaching $1,500 in 2018. The average deductible for individual ACA Bronze plans was more than $5,800 in 2018.

Maximizing collections at the time of service is critical to staying on top of patient collections, especially as we head into a new year when deductibles reset and most patients effectively become "self-pay." Independent practices need to focus their patient collections efforts on the most effective tactics to maximize time of service collections and reduce bad debt write offs. Practices can no longer simply send out statements and expect to receive a check in the mail a few days later.

> In 2018
>
> **$1,500** Avg. deductible for employer-based plans
>
> **$5,800** Avg. deductible for individual ACA Bronze plans

Eligibility Verification Is Critical

With the changes to the ACA in 2019 regarding the individual mandate penalty and less comprehensive insurance plans being available, patient responsibility is likely to continue to increase in 2019. It is more likely that coverage for routine or preventative services either may not be covered under some of the new short-term health plans, or that the patient may have let their coverage lapse, hoping it wouldn't be noticed until after they had received services. This is why it is critical to make eligibility and benefits verification mandatory at every patient visit. Once a patient receives services and leaves the practice without paying, the time it takes to collect increases while the likelihood of collecting the full patient responsible amount decreases.

Changes in Bad Debt Classification

You may have noticed that there has been a change in how patients respond to statements and letters attempting to collect on past due balances. One factor that many practices are not aware of is that the credit scoring agencies changed the weight that medical debt has on an individual's credit score.

While medical debt does still show on a credit report, the impact that it has on the overall credit score has been reduced. Patient's are often told to ignore or pay as little as possible on their medical bills by "debt consolidation counselors" because it won't have as great of an impact as other forms of debt such as credit cards and mortgages.

> Patients aren't afraid of medical debt anymore.

Capitalize on Technology

Traditional methods of collecting from patients are no longer as effective as they once were. For a practice to be effective in patient collections, there need to be multiple methods of communication with patients based on their preferred communication channel. If a patient is used to receiving all of their bills for their utilities, insurance, mortgage and credit cards electronically and paying either online or through automatic withdrawal, they will likely expect the same convenience when presented with a bill from their medical provider.

> If your bill is the most difficult one to pay, you can expect that it will be the last one paid, if at all.

Take advantage of technology to allow for multiple avenues of payment for your patients. It is easier than ever to send money to an individual or business using only an email address or cell phone number. Make sure that you are using every option available to you. It may be hard to believe, but there are still practices that don't accept credit or debit cards because they don't want to lose a portion of their revenue to merchant services fees. The amount that will likely be written off to bad debt due to making it more difficult for patients to pay will far exceed any cost associated with payment technologies.

Educating and Empowering Staff

Every point of patient contact becomes a potential opportunity for collecting balances due. The job of collecting from patients is no longer the sole responsibility of the billing office. As much as providers and their staff may dislike this new reality, it is not going away and it is more important than ever to stay ahead of the patient collections game.

You need to make sure your staff is prepared to ask for payment in a way that doesn't allow the patient to deflect or make excuses. Instead of asking, "Would you like to pay your balance today?" train your staff to ask, "How would you like to pay your balance today?" By changing just one word in that question, the entire conversation related to the patient's balance changes. If you have staff who find it difficult asking patients for payment, use role plays and scripts to help them build their confidence. If they still aren't consistent with collecting patient copays and balances at the time of service then you may need to consider a change in duties or potentially a change in staff.

Be sure that your staff is familiar with common insurance terms and is able to explain them to patients in layman's terms. Many patients don't understand the difference between a deductible and an out-of-pocket maximum. While it may be tempting to simply refer a patient to their insurance company if they don't understand their benefits, sometimes spending a little time educating the patient on what their responsibility is will go a long way in getting a balance paid. It can also solidify a positive relationship with your patient.

Providing your staff with the authority to be flexible in setting up payment plans for patients who are unable to pay their balance in full can also go a long way in reducing bad debt and making your patients feel like you care. Having a clearly defined payment plan policy that provides guidelines for staff to follow will ensure that policies are consistent from patient to patient and that you comply with all state and federal guidelines regarding debt collection. It is also a good idea to have a written payment agreement for the patient to sign as a way to clarify what they have agreed to and provide some backup to your staff in the event that the agreement is not followed.

Conclusion

Independent practices face challenges today that were unheard of a decade ago. Fortunately, the adaptability of smaller practices can be their greatest asset in navigating changing regulatory environments, increasing patient collections, and thwarting tactics from payers to avoid paying for services.

In order to maximize revenue in 2019, independent practices will need to:

- Embrace new technologies
- Maximize collections at the time of service to reduce bad debt
- Fully engage in the changing payment models under the Quality Payment Program

About the **Author**

Aimee Heckman is a Healthcare Business Consultant with more than 30 years of experience in Medical Practice Management, Revenue Cycle Management, PM/EHR implementation, and business development. As a Certified Professional Biller (CBP) and Certified Physician Practice Manager (CPPM), Aimee has demonstrated success in assisting physicians with maintaining their independence and surviving the ever-changing healthcare business environment.

As a related resource, Aimee also offers a free on-demand webinar on Getting Paid in 2019.

Go to kareo.com/resources for that and many other free resources to support the success of independent medical practices and their billing partners.

About kareo

Kareo is the only cloud-based complete medical technology platform purpose-built to meet the unique needs of independent practices in more than 45 specialties.

Today Kareo helps over 50,000 providers in all 50 states run more efficient and profitable practices, processing more than 60 million patient records through the Kareo platform. The Kareo platform is the first to help independent practices find more patients, manage their care with a fully certified and easy-to-use EHR, and get paid quickly all in one complete and integrated package.
More information can be found at www.kareo.com

Contact us for a free assessment on your patient collections, insurance reimbursement and CMS incentive program reporting needs.
Or call us at 888-775-2736.

CONTACT US