July/August 2015

Your Healthy Practice

Get ready for the two-tiered payment system

In a little more than three years, medical practices will have to make a major decision, spurred by recent legislation repealing the sustainable growth rate formula.

Practices will have to decide whether to participate in either a new fee-for-service payment model that offers a carrot and a stick

The April legislation scrapped the sustainable growth rate formula in favor of a two-tiered, value-based payment system designed to push physicians toward alternative payment models.

or a higher-paying alternative payment model (APM) like an accountable care organization, bundled payment arrangement or patient-centered medical home.

The legislation signed into law in April that scrapped the sustainable growth rate formula in favor of a two-tiered, value-based payment system is designed to push physicians toward APMs.

The law, known as H.R. 2: Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114-10), supports the goal of the Department of Health & Human Services set by Secretary Sylvia Mathews Burwell last January. Her goal is to have 50 percent of Medicare spending (not including managed care) in value-based payment models by 2018.

Adjusting to the new paradigm

The implications for physicians and their practices are enormous. Value-based payments are the future. Physicians who choose to participate in the new payment model, the Merit-Based Incentive Payment System (MIPS), will be paid less in the future than those in APMs.

Practices, particularly those that have been slow to embrace transformational initiatives, will need to adjust their business models to align with the new paradigm.

Specifically, it will be important for practices to identify cost efficiencies to reduce the risk of downward payment adjustments. Some experts predict an acceleration of the trend toward consolidation into large groups and hospital systems.

Certainly, H.R. 2 adds pressure on physicians to adopt an electronic health record (EHR) system. Physician usage of EHRs stood at only 62.8 percent in January 2015, according to a survey by research firm SK&A.

Not surprisingly, hospital- and health system-owned practices on

See Two-tiered system on page 2

Inside

July/August 2015

→ Are you making the most of your patient portal?

→ Receptionist embezzles from practice, commits credit card fraud

Inside

A financial and management bulletin to physicians and medical practices from:

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Two-tiered system *continued from front*

average reported the highest usage at nearly 71 percent and at 70 percent, respectively. Larger practices show higher usage (79.5 percent for offices with 11 to 25 physicians) than solo practices (54.5 percent usage).

"The new payment system heightens the burden on providers to track, report and improve quality performance," said Lisa Bielamowicz, M.D., chief medical officer for The Advisory Board Company. The company is a leading provider of performance improvement software and solutions to the healthcare and higher education industries.

Physicians are under added pressure to adopt an electronic health record system.

In an April 15 *Daily Briefing*, Bielamowicz noted that "providers need to ensure they are on track to building dynamic capabilities for monitoring and analyzing quality performance."

The legislation sets aside $20 million each year from 2016 through 2020 to help small practices of 15 or fewer professionals with the transition. Priority will be given to practices in rural, shortage and medically underserved areas, as well as to low-scoring practices.

What's at risk?

The Merit-Based Incentive Payment System goes into effect in 2019 when fee-for-service payments will be frozen. It consolidates and replaces current performance programs for eligible professionals.

MIPS will score physicians in four performance categories – quality, resource use, clinical practice improvement activities and meaningful use of certified EHRs.

The score will determine eligibility for a bonus or a penalty ranging from +/- 4 percent in 2019 and rising each year through 2022, when it maxes out at +/- 9 percent. An additional 10 percent bonus can be earned for reaching a threshold for excellent performance each year.

In 2026, the two-tiered payment system begins.

Participants in APMs are exempt from MIPS and will be eligible for a 5 percent annual bonus from 2019 to 2024 provided a certain percentage of their Medicare payments come through the APM. In 2019 the amount is 25 percent.

The threshold rises to 50 percent in 2021 and 75 percent in 2023. However, in each of the latter years, the total can include all payers with a minimum of 25 percent from Medicare.

The healthcare industry may well see greater growth and competition among payment models, but not without risk.

Under the legislation, "APMs must include more than nominal risk," said Danielle Lloyd, MPH.

Lloyd is vice president of policy and advocacy and deputy director of the Washington, D.C., office of Premier, Inc., a healthcare performance improvement alliance. She notes that the question remains how much will need to be at risk for an accountable care organization (ACO) to be qualified.

In April, Centers for Medicare & Medicaid Services reported that only three of the 404 ACOs in the Medicare Shared Savings Program participate in the two-sided risk track.

Bielamowicz believes the 5 percent bonus may spur greater participation in an ACO model with downside risk.

Tiered payments

In 2026, the extra bonuses given to excellent MIPS performers and the 5 percent bonuses to APMs expire, and the two-tiered payment system begins.

Rate hikes will favor participants in APMs, whose increases will be three times that of nonparticipants, specifically 0.75 percent vs. 0.25 percent.

The full fallout from H.R. 2 may not be known for several years.

"We don't know all of the implications yet," said Lloyd. "A lot will be left unclear until we get the rule making." – *Irene E. Lombardo* ■

Are you making the most of your patient portal?

Many physicians have been struggling to meet the Stage 2 Meaningful Use patient engagement threshold, requiring that more than 5 percent of patients view, download or transmit their health information electronically.

A study published last September in *Health Affairs* found that only 24 percent of physicians routinely provided patients with that ability. It's no wonder, then, that many stakeholders applauded the changes proposed by the Centers for Medicare & Medicaid Services (CMS) last April to relax the requirements.

Acknowledging "significant challenges," CMS proposed replacing the 5 percent requirement with only one patient who uses the technology. The agency also proposed replacing the 5 percent threshold of patients sending a secure message using certified electronic health record technology with a "yes" or "no" acknowledgement that they can. The final rule is expected to be released in August.

Patient engagement isn't going away

While CMS may relax the rules, practices should continue to encourage patient use to make the most of their portals. Patient engagement isn't going away because physicians will still need to provide access to information electronically to meet not only Stage 2 but also Stage 3.

There are efficiency benefits to a practice when a substantial number of patients actively use a portal. For example, the number of distracting phone calls and phone tag can be reduced. In addition, staff time can be freed up from tasks like locating and copying lab or imaging reports for patients, as well as mailing the reports.

A patient portal can facilitate coordination of care. Patients can directly share their health information electronically with other physicians, such as specialists. Patient portals also can increase patient satisfaction, in turn benefiting a practice's reputation.

If you build it, will they come?

Offering a patient portal doesn't mean patients will sign up or use it. For the most part, simply having a wall poster up or giving patients a handout about the portal as they leave the office doesn't work.

Practices that have been relatively successful in engaging their patients have some of the following tactics:

- **Give patients an activation code.** At Cleveland Clinic, patients are given an activation code for the portal at their first appointment. The code does not expire, and patients are told that the portal is the preferred mode of communication except in emergencies.
- **Link use to the time of an action.** Experience has shown that linking a benefit of portal use to an action at an appropriate time enables a patient to see the value of establishing an account. For example, when a patient is given a prescription for lab work, explain that results will be available online within a few days after the test is done – no need to wait until the next appointment.

  If a patient calls with a question, the emailed response should include a link to additional information available on the portal. (Emails from office personnel should have the physician's name on it, rather than the practice name, since patients are more likely to open an email from an individual they know.)
- **Identify patients who can benefit most.** Many experts note that people with chronic conditions or those who are undergoing regular or complex treatments are more likely to benefit from and use a patient portal. Identifying these patients and promoting the portal to them is especially important.
- **Make the portal relevant to patients' needs.** Go beyond offering online appointments, refills and lab results by including interactive decision tools and personalized messages. HealthIT.gov says a patient portal can be used to assist in self-management tasks through tools for interactive monitoring and coaching.
- **Involve the staff in portal promotion.** Informing patients about the portal can begin at the front desk, be noted by the doctor during face time and be suggested at checkout. Employees at one practice wore buttons reading "Ask me about our patient portal!"
- **Engage patients through regular use.** Patients can become more accustomed to communicating with the practice electronically if they receive email confirmations of upcoming appointments, referral authorizations and reminders for regular testing.

In whatever way you increase awareness, however, patients will not use a portal if their email to the office doesn't get a timely response. Also, a portal should be easy to navigate. Confusing features create patient frustration and lead to low usage rates.

According to a survey by Software Advice, Inc., a software advisory company, unresponsive staff (34 percent) and confusing portal interfaces (33 percent) topped the list of what patients find most irksome about patient portals. – *Irene E. Lombardo* ■

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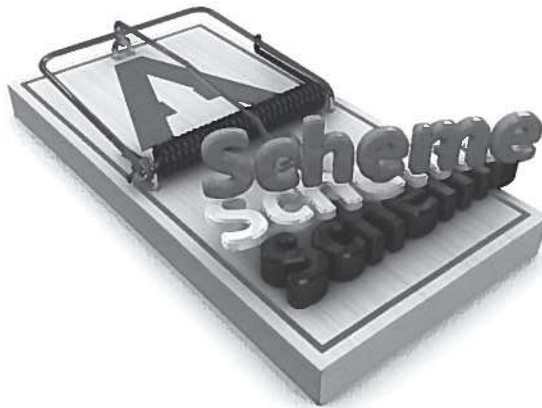
Receptionist embezzles from practice, commits credit card fraud

It's a hard lesson to accept, but medical practices – just like other businesses – can't unconditionally trust their staff members when it comes to money.

A recent New Jersey case illustrates how important it is to stay alert to the effectiveness of your practice's security procedures.

Gwendolyn Muller, a 53-year-old medical office receptionist, took advantage of her position with a medical practice in Kearny, N.J., to embezzle more than $446,000. She cashed and concealed checks received from insurance companies for the practice's services to patients. The practice had employed her from 2007 through 2011.



In addition to embezzlement, Muller used fraudulent credit cards taken out under the name of a practice principal to acquire over $200,000 in goods and services. She also evaded taxes on the illegal income from these activities by filing false returns. She pleaded guilty to the charges.

The U.S. District Court of New Jersey sentenced Muller in late March to 34 months in prison, as well as three years of supervised release. Muller also must pay $556,000 as restitution.

If you're concerned about your medical office's fraud prevention procedure, you may want to consult with your CPA about an evaluation and suggestions for tightening security. ■

The technical information in this newsletter is necessarily brief. No final conclusion on these topics should be drawn without further review and consultation.

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