CMS has a grand plan to sync up its payment systems by using bundled outpatient codes that many doctors are calling "mini-DRGs," after the familiar inpatient diagnosis-related groups. But even if these new bundles are more efficient for CMS, what effect will they have on physician practices?

The CMS' proposed outpatient payment rule, released recently, states that the government will begin using "comprehensive APCs" starting January 1, 2015. CMS is now proposing 28 Comprehensive APCs for 2015. Comprehensive APCs are also called "mini-DRGs." They represent a specific outpatient service, like a hip replacement or pacemaker procedure, and incorporate all other related ancillary services into a lump-sum payment.

Similar to the hospital payment system, the comprehensive APC will be a single payment rather than separate, individual APC payments.

The policy includes a proposed "complexity adjustment," which already is stirring up controversy. The adjustment is applied when a primary procedure assigned to a comprehensive APC is reported with other specified procedures also assigned to comprehensive APCs or with a specified packaged add-on code. If you report one of these combinations, CMS will increase the payable APC to the next higher APC in the clinical group, similar to DRGs on the inpatient side. (See the story on p. 3 for more on how the policy works.)

"We are also proposing the restructuring and consolidation of some of the current device dependent APCs with similar costs based on the 2013 claims data," CMS wrote in the policy. "After the APC consolidation and restructuring we are proposing a total of 28 comprehensive-APCs for 2015 versus the 29 comprehensive-APCs that were described in the CY 2014 final rule."

**Could reinvent the reimbursement system, practices**

The effect will be significant for physicians, says Christopher Parrella, JD, an attorney with the Health Law Offices of Anthony C. Vitale in Miami.

“It’s going to change the whole dynamic of the
reimbursement industry,” he says. “They’re almost equating the new model to the inpatient DRG model. At this point the provider community is incentivized by the volume of services rendered, so CMS is moving toward a model that emphasizes quality of care.”

Outpatient mini-DRGs will reinvent the way physicians run their practices, Parrella says, pushing them further toward CMS’ long-stated goal of emphasizing quality over volume of care. No matter how devoted a physician is to the best interests of his or her patients, the current system of reimbursement practically requires a focus on volume just to keep the practice financially viable, Parrella notes.

Patients should benefit from the quality emphasis over volume, but the overall impact also could be good for physicians, Parrella says. If the mini-DRG is structured so that it provides fair reimbursement for the entire diagnosis rather than each service rendered, physicians may be able to practice medicine more and worry about reimbursement less, he says. However, setting fair reimbursement levels will not be easy or without controversy, if every other CMS payment model in the past is any indication. Whatever benefits may come for physicians, they are unlikely to come without a rocky transition.

“I don’t think any of the payers, nor the contractors, are anywhere near understanding what this concept would entail,” Parrella says. “There are so many things that will need to be changed on a systematic level throughout the contractor world in order for this to be implemented.”

Even with that delay, Parrella advises physicians to watch CMS’ movement toward quality and away from volume. Knowing that mini-DRGs and other quality-related changes are coming 10 years from now could influence decisions you make now about practice expansions, mergers, joining an accountable care organization (ACO) and other long-range business strategy.

Comprehensive APCs have been needed for years and mark a real step toward emphasizing quality, says Douglas J. Jorgensen, DO, CPC, an osteopathic physician in central Maine practicing pain management and osteopathic manipulation. He also serves on the physician advisory board for the American Association of Physician Coding (AAPC) in Salt Lake City.

“I think this is where the whole system is supposed to be headed,” Jorgensen says. “It’s going to drive the need for the primary care medical home or a more comprehensive group of practices working together...
to contain costs. We need to be asking if there is a more cost-effective way of doing things, and if there is evidence to prove that things do or don’t work.”

“We need to look for allies, people with whom we want to work, people whom we trust and with whom we can align ourselves from a medical philosophy perspective.”

—Douglas J. Jorgensen, DO, CPC

Start allying now with other providers

Financial considerations and political motivations from specialty organizations also will influence how comprehensive APCs alter the current reimbursement system, he says. Jorgensen advises physicians to start planning for the move to mini-DRGs now.

“We need to look for allies, people with whom we want to work, people whom we trust and with whom we can align ourselves from a medical philosophy perspective,” Jorgensen says. “Independent physicians need to start looking now for people with whom they want to collaborate. If you have a hernia patient to be treated in an outpatient setting, for instance, you need to be working with an interventional suite that might be able to save the patient money because moving to mini-DRGs will punish you financially if you are not cost-efficient.”

Likewise, physicians should line up specialty surgeons, physical therapy groups, and other providers who have a good outcomes and low costs relative to the average expense, Jorgensen says. Managing a patient’s condition should be more cost-effective than each provider operating separately and billing separately, Jorgensen says.

“That interdependent relationship, that type of collaboration, is what’s going to be necessary to make you successful,” he says. “Those allies can then share that piece of pie when revenue comes in. There is still a question of how everyone will get paid under a comprehensive APC. Does one provider get paid and they distribute it to individual providers?”

If the physician community can remove some impediments, like local contractor determinations that are supposed to be national but aren’t yet, collaborate with like-minded allies, and set a fair rate for the mini-DRGs, Jorgensen believes the move to comprehensive APCs could improve quality of care and revenue for physicians.

“But there are a lot of questions to be answered before this plan is implemented,” Jorgensen says. “We’re hoping it will be good for the reimbursement system and for physicians, but there are so many ways it could be derailed.”

Mini-DRGs pay for diagnosis, not each treatment

With comprehensive APCs or mini-DRGs to be introduced in 2015, physicians will soon be using much larger bundles with no separate payment for additional items or services.

CMS originally pitched comprehensive APCs in its 2014 rule, but decided to delay the rollout until it received feedback from providers. Now, the agency is ready to move forward with 28 “device-dependent” comprehensive APCs. These classifications cover procedures that include costly devices, such as implantable cardioverter-defibrillators, stents, and orthopedic implants.

Proposed payment rates vary for each bundle. More complex ICD procedures will fetch the largest reimbursement, at more than $32,000. Pacemaker procedures will pay anywhere from $7,000 to $17,000, depending on the level of resources required. Reimbursement for intensive orthopedic surgeries, excluding those on the hands and feet, will pay about $11,000. The two newest comprehensive APCs are intraocular telescope implantation ($21,000) and single-session cranial stereotactic radiosurgery (about $10,000), CMS said. As with most rules, there are some exceptions to the comprehensive APC policy. Medicare will still make separate payments for select outpatient claims. These include ambulance services, pass-through drugs and devices, preventive services like cancer screening tests and diabetes tests, and self-administered drugs, among others.

But the push for bundled outpatient services is not likely to relent soon. CMS officials have said as much, writing in the rule: “We may extend comprehensive payments to other procedures in future years as part of a broader packaging initiative.”
Physician group reduces bad debt by 85%

Founded in 1977, Holston Medical Group (HMG) is one of the largest physician-led, multi-specialty groups in the southeastern United States, and, like most groups, it constantly struggled with a load of bad debt from patients who could not or would not pay their share of treatment costs. Deciding to address the problem directly, HMG embarked on a program that eventually reduced the physician group’s bad debt by 85%.

Located in Tennessee near the borders of Kentucky and Virginia, HMG has approximately 150 primary care physicians, specialists, and midlevel providers, with 24-hour medical and surgical coverage. The physician group’s patient and community-focused mission, vision, and values have been put to the test in recent years as individual responsibility for out-of-pocket medical expenses have continued to increase, says Chief Medical Officer Sam Breeding, MD.

“We are seeing more patients now with high deductible insurance plans. Our area is very industrial and we have had a high penetration of insurance plans that have deductibles even in the $5,000 range or higher,” Breeding says. “When patients come in and have to pay out-of-pocket for their deductibles, they often have to pull out a credit card to pay these expenses up front, but then they are looking at an 18% or 20% interest rate.”

Even with a health savings account (HSA), patients may not have had enough time to put much money in or the account may have been depleted already, Breeding says. In some cases, the patient refuses treatment because of the out-of-pocket cost. In other cases, the patient asks to be billed later but is never able to pay.

Chief Financial Officer Randy Sharrow agreed that patient expenses were hurting the practice, noting that the financial aspects of running a physician group cannot be separated from HMG’s mission to provide the best patient care with the best possible outcomes. The group has grown dramatically over its 35 years, with much of the growth coming in the last 10 or 15 years as it became one of the larger multi-specialty groups in the region. That growth required many instances of process change, so Sharrow and Breeding were willing to make a significant shift in order to reduce bad debt.

“HMG had offered a patient payment plan but we managed it all in-house and carried all of receivables,” Sharrow says. “We needed an alternative.”

“The discount that you pay for this service was more than offset by hard and soft dollar costs in the way of staff reduction and less dependency on short-term borrowing under lines of credit.”

— Randy Sharrow

When Mike Carter joined HMG as the group’s revenue cycle manager, he set out to find a financial solution that would provide a more flexible and affordable payment option for patients while curbing the encroaching threat of rising bad debt. He selected CarePayment, a healthcare financing company that offers HMG’s patients access to a 25-month, interest-free payment option for paying their out-of-pocket expenses. All patients are eligible, regardless of insurance coverage, credit history, or employment. There is no application process.

“A zero-interest rate is a terrific alternative to pulling out that credit card that already has a balance on it and carries a very high interest rate,” Breeding says. “This is all dealt with at the front desk, so we doctors don’t have to deal with the patient saying they don’t have the finances for appropriate care. It allows the doctor and the patient to concentrate on the care plan instead of talking about the money.”

HMG introduces patients to its financing option by placing brochures and posters at all of its 12

Questions? Comments? Ideas?

Contact Editor Greg Freeman at gafreeman@bellsouth.net or 770-998-8455.
clinics. It has also included a banner and a landing page about the program on its website. The practice wants patients to inquire about the financing option as early as possible, and staff are trained to answer initial questions. Once referred to the financing company, it answers all financing questions.

In addition, patients have the opportunity to accept the financing option when they receive their first bill from HMG for their share of the balance. If they choose to accept the program, the financing company takes on responsibility for sending out all subsequent statements. These statements are co-branded with both the HMG and CarePayment logos.

Carter notes that the patient financing option has cut down the call volume at HMG tremendously, allowing staff to be more efficient. HMG cut its patient assistance group in half because so many of the calls they previously handled are now being made to the financing company. That yields a significant benefit to the bottom line in addition to the improved cash flow from patients paying their bills over time instead of not at all.

“The discount that you pay for this service was more than offset by hard and soft dollar costs in the way of staff reduction and less dependency on short-term borrowing under lines of credit,” Sharrow says.

“When you start weighing all the advantages, with the time value of money, if you can get your money up front it is very valuable.”

— Randy Sharrow

HMG managed to reduce its bad debt reserves by 85% in relation to its receivables balance in its patient payment plans. Breeding says physicians must keep in mind the importance of cash flow for any practice, and the hidden costs of some payment options, such as the transaction fee the practice pays for credit cards.

“When you start weighing all the advantages, with the time value of money, if you can get your money up front it is very valuable,” Breeding says. “Also, the practice doesn’t have to spend time running people down to get payment.”

**Medicare fraud can lure in unwitting physicians**

A recent settlement in a whistleblower case alleging Medicare fraud highlights the risk of physicians being pulled into an illegal scheme if they are not vigilant when signing agreements with other healthcare entities.

Meridian Surgical Partners, a healthcare company specializing in the management of ambulatory surgical centers (ASC), has agreed to pay a total of $5.12 million to settle a False Claims Act (FCA) lawsuit brought by a whistleblower. The FCA whistleblower provisions permit private citizens known as “relators” to bring *qui tam* lawsuits on behalf of the United States and receive a portion of proceeds of any settlement or judgment.

Thomas Reed Simmons sued Meridian in the U.S. District Court for the Middle District of Tennessee under the whistleblower provisions of the FCA for allegedly engaging in an illegal kickback scheme that defrauded taxpayers out of millions of dollars in Medicare payments, explains Simmons’ attorney Michael D. Palmer, JD, senior litigation counsel at the firm of Sanford Heisler.

“This settlement reaffirms that relators who choose to pursue their claims after the government has declined to intervene can achieve successful results,” Palmer says. “While we were fully prepared to take this case through trial, we are pleased with the recovery obtained on behalf of Mr. Simmons and the government.”

Simmons worked as a business office manager for an ASC, which was managed and principally owned by Meridian. In his complaint, Simmons alleged that Meridian offered and paid remuneration to physicians of the ASC in order to secure patient referrals...
for services paid for by Medicare, in violation of the federal anti-kickback statute and the FCA. Simmons accused Meridian of both paying more than fair market value for a majority ownership of the ASC and rewarding physicians for referring patients by offering them minority ownership stakes.

The alleged kickbacks were provided to the owners of the ASC, who were physicians.

Simmons initiated the case on behalf of the United States government in May 2011 while he was still employed by Meridian. After the government declined to intervene, Simmons and his counsel Jonathan Kroner, JD, of the Jonathan Kroner Law Office, decided to litigate the case on the government’s behalf. Simmons and Kroner brought Sanford Heisler into the case to act as lead litigation counsel. The case was scheduled to go to trial starting on September 23, 2014.

Ross Brooks, JD, cochair of Sanford Heisler’s whistleblower practice, says the victory should be a warning to physicians, even though the physicians in this case were not charged. There are strong incentives for many organizations in healthcare, including turnaround firms like Meridian, to engage in healthcare fraud, he says.

“There is enormous pressure on these companies to outdo their competitors and secure these dollars for themselves,” Brooks says. “Doctors can get caught in the middle of this. There certainly are doctors who will knowingly engage in healthcare fraud and violate the anti-kickback statute, but there are some doctors who are relatively innocent. They may think they are engaging in innocuous behavior but be caught up in a scheme perpetrated by another company.”

Brooks notes that the anti-kickback statute criminalizes both ends of the kickback—the person offering the kickback and the person receiving it are both liable. The doctor can be held liable even if the kickback was structured in such a way that it did not blatantly appear to be illegal.

“Physicians need to really proactively think about the kinds of transactions they are engaging in,” Brooks says. “Even if their knowledge of understanding the criminal act doesn’t rise to the standard necessary for their culpability, they can get caught up in an illegal transaction that they certainly are not going to want to be involved in. Nothing good comes of that.”

The FCA includes recklessness as one indicator that the person is responsible for the illegal activity, so Brooks warns that you can be held liable for turning a blind eye to the evidence. Under some situations, the plaintiff could argue that you should have known even if you did not, that your failure to notice the illegal activity was reckless.

“There certainly are doctors who will knowingly engage in healthcare fraud and violate the anti-kickback statute, but there are some doctors who are relatively innocent. They may think they are engaging in innocuous behavior but be caught up in a scheme perpetrated by another company.”

— Ross Brooks, JD

Also, Brooks notes that it does not matter whether the kickback resulted in overpayment, harm to patients, or any other negative result. The simple fact that a kickback was provided is illegal, even if it had no detrimental effects financially or to patients.

“This was not the typical kickback case regarding referrals,” Brooks says. “Kickback cases usually involve the Stark Act, which says physicians can’t refer patients to themselves or to providers in which they have an interest. Generally the Stark Act doesn’t apply to ASCs, so sometimes doctors may think they don’t have to be so conservative when it comes to referrals. But this is a case that shows ASCs can be involved with kickbacks, and the physicians can be caught up in it.”

The physicians in the Meridian case may have gotten off easy, Brooks says.

“They were willing to accept these sweetheart deals in exchange for referrals, either with the knowledge that the intent of the deal was to secure these referrals or by turning a blind eye to the fact that these were violations of the anti-kickback statute,” Brooks says. “We could have included the physicians as defendants but chose not to. This arrangement with Meridian will disappear for them and, hopefully, they will have learned about the proper way to structure these agreements.”
Sharp pulls out of ACO, unwinds its LLC

The Medicare Pioneer program for accountable care organizations (ACO) continues to lose members and the program’s future is now being questioned.

Sharp HealthCare, a five-hospital system in San Diego, which covers 28,000 Medicare beneficiaries, dropped out of the Pioneer ACO program recently. The decision was made public in its third-quarter financial statement, in which it stated that Sharp notified CMS and the Center for Medicare and Medicaid Innovation. That leaves 22 Pioneer ACOs of the original 32.

Sharp’s ACO is moving its patients to other care-management programs and unwinding its limited liability company.

The Pioneer ACO Model was developed and administered by the CMS Innovation Center. The healthcare industry has been keenly interested in its experience, seeing it as a harbinger for what other ACOs may face. The 32 organizations across the country were chosen to participate because they were considered among the most advanced, able to coordinate care, and manage financial risk.

The financial risk in the Pioneer program was too much for Sharp, according to the company’s disclosure. The Pioneer contracts were structured so that participants could be forced to return Medicare money if they did not meet quality benchmarks and reduce costs.

“Because the Pioneer financial model is based on national financial trend factors that are not adjusted for specific conditions that an ACO is facing in a particular region (e.g., San Diego), the model was financially detrimental to Sharp ACO despite favorable underlying utilization and quality performance,” Sharp’s disclosure states.

Sharp’s ACO broke even in 2012 and 2013, its first two years. The ACO did succeed in reducing readmission rates and utilization while at the same time improving its performance on quality metrics.

Increased Medicaid pay could end Dec. 31

One feature of the Affordable Care Act welcomed by physician practices was the temporary increase in Medicaid reimbursement for primary-care services to match Medicare rates. That boost in pay may soon come to an end.

The Primary Care Reimbursement Increase (PCRI) provision expires December 31, but there are efforts underway to extend it. Reverting to the previous reimbursement levels could be detrimental to patients if some physicians shy away from Medicaid patients for financial reasons, some healthcare leaders say.

A study by the Ohio State Medical Association (OSMA), for instance, found that the temporary increase in payments to doctors delivering primary care services has prompted nearly 40% of Ohio’s physicians to accept more Medicaid patients.

The PCRI has allowed primary care physicians in Ohio to receive full Medicare payment rates for seeing Medicaid patients, up from the 59% rate that Ohio’s Medicaid program usually pays. The OSMA’s Primary Care Reimbursement Survey results offer a compelling public health argument for lifting the temporary tag and making the rate increase permanent for primary care and specialty care physicians alike, says OSMA president Mary J. Wall, MD, JD.

“This current rate increase is only temporary and yet has proved invaluable for introducing more patients to high-quality healthcare, so just imagine how impactful extending this rate increase could be for improving the long-term overall care of Ohioans and bettering the health of our communities,” Wall says. “If we go back to reimbursing primary
care physicians at 59 cents on the Medicare dollar, doctors may lose money each time they see patients and thus be forced again to turn away patients who have Medicaid.”

The survey was conducted in June and July 2014 and drew responses from nearly 600 physicians. Not only does the survey reveal that access to high-quality healthcare would be more readily available to patients if the rate increase were made permanent but physicians also indicate they would be willing to hire additional staff to accommodate the influx of new patients.

About 25% of Ohioans—just over 2.7 million people—have access to health coverage through the state’s Medicaid program, and nearly a million of those covered by Medicaid are children.

Ninety percent of the physicians who responded to the OSMA said they were already seeing Medicaid patients before the pay increase, but 40% said they had started seeing more. About the same 40% said they would discontinue seeing Medicaid patients if the parity provision is not extended.

“This current rate increase is only temporary and yet has proved invaluable for introducing more patients to high-quality healthcare ...”

—Mary J. Wall, MD, JD

Six states have acted to extend the parity provision for one year: Alabama, Colorado, Iowa, Maryland, Mississippi, and New Mexico. Legislation has been introduced in Congress that would extend the pay increase: A Senate bill introduced by Sens. Sherrod Brown (D-Ohio) and Patty Murray (D-WA) would extend the pay raise for two years; a House of Representatives bill sponsored by Rep. John Lewis (D-Ga.) would extend it for five years. 

Number of uninsured projected to decrease

The number of uninsured is expected to decline by nearly half from 45 million in 2012 to 23 million by 2023 as a result of the coverage expansions associated with the Affordable Care Act (ACA), according to a report from CMS Office of the Actuary.

Health spending growth for 2013 is projected to remain slow at 3.6%, which would mark the fifth consecutive year of spending growth under 4.0%. National health expenditures (NHE) are projected to grow at an average rate of 5.7% for 2013 through 2023, about 1.1% faster than the expected average annual growth rate for the Gross Domestic Product (GDP).

Average annual growth of 6% per year is projected for 2015 through 2023, largely as a result of the continued implementation of the ACA coverage expansions, faster projected economic growth, and the aging of the population, the actuary office reports. While projected growth over the projection period is faster compared to recent experience, it is still slower than the growth observed over the last two decades. From 1990 to 2008, the average rate was 7.2% and health spending grew 2% faster than the GDP.

The NHE projections report, issued annually, contains estimates of spending for healthcare in the United States over the next decade by type of service and source of funding.

The report also indicates that the 2014 spending growth is expected to accelerate. For 2014, the health spending growth rate is expected to be 5.6%, as 9 million Americans are projected to gain health insurance coverage, predominantly through Medicaid or the health insurance marketplaces. Out-of-pocket spending is projected to decline by 0.2%.

By 2023, health expenditures financed by federal, state, and local governments are projected to account for 48% of national health spending. In 2012, such expenditures constituted 44% of national health spending.