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All Medicare fees are par, office, national unless otherwise noted.

Chronic care management

Add practice revenue, get a leg up on MIPS by wrapping in CCM services

Enrolling patients in a chronic care management (CCM) program can cut back on total health spending while adding revenue to your practice, resulting in a win for your bottom line that also positions you to perform well under quality-reporting and value-based programs.

Using CCM on a monthly basis reduces overall expenditures by $74 per patient per month, according to a new white paper from consultancy PYA that assessed costs associated with CCM-enrolled patients between 2014 and 2016. The cost-savings are largely seen on the inpatient side;

*(see **CCM services**, p. 3)*

Practice management

Private equity deals can mean quick cash now and later — for the right kind of practice

While most practice acquisition has been done by hospitals and health systems, private equity (PE) firms are increasingly replacing those acquisitions with investments. If you want to get a private equity deal for your practice, you'll have to demonstrate high future revenue potential and do a lot of due diligence before you even get to the table. But that work could mean a big payday for the physicians and their partners who own the practice.

*(see **Private equity**, p. 6)*

Quality Payment Program

3 last-minute tips to avoid a MIPS penalty for the 2017 reporting year

The reporting deadline for the inaugural merit-based incentive payment system (MIPS) year is coming up fast — it's March 31 for nearly all reporting methods, including claims and electronic health record (EHR) reporting — but that may leave enough time for a final shot.

Practices that have put off reporting MIPS can tap into several last-minute options to avoid a pay cut in 2019, says Jeanne Chamberlin, practice management consultant with MSOC Health in Chapel Hill, N.C. Not reporting MIPS entirely would ding practices for up to a 4% hit to Medicare revenue, but remember that CMS eased the threshold for the 2017 reporting year, setting the bar at just three performance points (*PBN 10/24/16*).

That means you can meet the threshold to avoid a pay cut with some simple measures — even now. Here's some guidance to get your reporting through the door by the March 31 deadline or find out whether you're a late exclusion for the 2017 period:

- **Check out the list of improvement activities for 2017.** "There's a good likelihood that you've been doing one or more of these activities in your practice and can document it for at least 90 days in 2017," says Chamberlin. Navigate to the "2017 Resources" page on the CMS website to access the available improvement activities (*see resources, below*). If you find an activity your practice performed in 2017, go to *www.qpp.cms.gov* and login with an Enterprise Identity Management (EIDM) username and password and attest to that activity. "Doing this before March 31 will avoid any reduction in 2019 Medicare payments," says Chamberlin.

- **Look back to the physician quality reporting system (PQRS) to find an eligible quality measure.** "If a practice reported quality codes on claims for PQRS in 2016, they may have continued to report these on claims for 2017," notes Chamberlin. Even reporting one quality measure for one Medicare patient via claims will get you to the three-point threshold and allow you to avoid the pay reduction for 2017. Go to *www.qpp.cms.gov* and login with your EIDM username and password and check the quality reporting item for each provider to see what claims CMS received during 2017 and how it is scored, advises Chamberlin. Note that if you reported quality data through another approach, such as registry or EHR, CMS will take the highest score it has for the quality category — but any score of three or higher will avoid the pay cut.

- **Take a last look at MIPS eligibility for your tax identification number (TIN) and national provider identifier (NPI)** at *www.qpp.cms.gov*. "CMS took a second run at which TIN/NPI combinations meet the low-volume exclusion based on September

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2016-August 2017 claims data and the lookup feature has been updated," says Chamberlin. "If you do meet the low-volume threshold, you will be paid the standard Medicare payment rate in 2019 regardless of [your] MIPS score." — *Richard Scott (scott@decisionhealth.com)*

Resource:

- 2017 MIPS resources: *www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2017-Resources.html*

Ask Part B News

Some payers accept consult codes — but be sure that's what you did

Question: *For new patients who are not on Medicare, our office uses the office consultation codes* ***99241-99245*** *if referred by a doctor and* ***99201-99205*** *if self-referred. The E/M criteria are met for time, history and exam for all codes. Is our use of the consultation codes correct? Is it commercial carrier dependent?*

Answer: We don't talk much about the outpatient consultation codes 99241-99245 since Medicare stopped paying them in 2010 — though some providers continue, futilely, to bill them (*see benchmark, p. 5*).

Medicare dropped these codes because "they were thought to be widely abused — or maybe it would be better to say, they were misused because of misunderstanding about their purpose," says Stuart Newsome, vice president for business development at Alpha II LLC in Montgomery, Ala., and author of *Medical Decision Making in E/M Coding*.

But CMS includes 99241-99245 (and the inpatient versions, **99251-99255**) in its fee schedule and their rates compare favorably with outpatient E/M codes: Level 3 outpatient E/M for a new patient pays $109.80 (national non-facility par) and $74.16 for an established patient, while the level 3 outpatient consultation code is valued at $124.20. And many private payers still accept these codes.

Why does CMS set fees for services they don't offer? Because many non-Medicare payers use CMS' resource-based relative value scale (RBRVS) to price their services, so Medicare makes those values available in the fee schedule relative value file — but for these codes, the status indicator is "I," meaning "not valid for Medicare purposes" (*PBN 2/11/10*).

There was a fall-off among private payers who accepted consult codes right after CMS dropped them (*PBN blog 5/25/10*). But many payers will still accept them. Providers should check with their plans before billing 99241-99245 to any of them, though, as policy can fluctuate from year to year. UnitedHealthcare, for instance, announced last summer its commercial products would stop accepting consultation codes in October — then backed off at the last minute.

The basic purpose of consultation codes hasn't changed: A consultation is when a provider sends a patient to another physician requesting his or her opinion (*PBN 6/1/08*).

Newsome elaborates: "If you're merely giving expertise — seeing the patient to render opinion — it's a consultation. But if you're servicing the patient for a definitive diagnosis or taking over the care, it's not. If you see the cardiologist and he treats you for the diagnosis, that's not [consultation]. A consult by nature is 'I'll look and talk to your original physician, and you'll go back to the original physician for treatment.'"

Here's how Newsome says you should approach the encounter: "Say I'm a cardiologist, and someone comes with heart murmur," he says. If that patient was referred by his doctor for consultation, "I may take history, review medical records, run additional labs, do chest X-rays, examine him and do all the medical decision-making," says Newsome. "But I don't prescribe anything or do any surgery. I write a report that goes back to the original provider."

Newsome likens the role of the consulting physician to a radiologist. "They may interpret and diagnose" without treating the patient, he says. — *Roy Edroso (redroso@decisionhealth.com)*

CCM services

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after reporting CCM services, the paper found, physician practices brought in an average of $18 in revenue per monthly episode despite the overall reduction in global costs.

"The thing that's loud and clear is that you're reducing inpatient admissions," says Richard Morris, director of value-based strategy with revenue cycle management company Healthcare Administrative Partners in Media, Pa.

More providers are getting involved with CCM, and CMS has eased some of the administrative rules to help spur greater adoption (*PBN 12/4/17*, *11/14/16*). Anecdotally, Morris saw a "big pickup in the amount of CCM billing" in 2017, and the cost results suggest that those practices are reaping substantial benefits from their investment.

"I'm sure this is exactly what [CMS] wanted to see," says Aaron Elias, senior health care consultant with PYA in Boston. "This is really the first study that shows these tangible [financial] results," he says.

Bending the cost curve remains a core part of value-based payment models and the merit-based incentive payment system (MIPS), which factors overall patient spending into a clinician's performance score. For example, the cost category of MIPS measures total patient costs over the course of a year and also assesses the dollar amounts attached to acute patient stays (*PBN 1/22/18*).

Taking advantage of CCM services, which monitor patient's episodic care between visits, can help you succeed, says Elias. "You're spending a little more up front on patient care, but overall you're seeing a total cost reduction," he says. So your cost score will reflect the lower patient spending, which positions you to score highly on the cost category and, coupled with high quality, gives you an inside track on a pay bonus.

Reporting CCM services can help you easily fulfill the improvement activities portion of MIPS, as well, suggests Elias. You'll find 17 distinct care coordination activities, including "regular training in care coordination" and establishing "care coordination agreements" between the patient, your practice and any specialists involved in the course of care.

Build a system to succeed

Many practices have found success by outsourcing their CCM programs, and CMS has actively supported the creation of third-party vendors to help practices fulfill their care management needs (*PBN 3/19/18*). But going outside for help isn't a prerequisite. "We've seen really good in-house care management programs," says Elias.

Focus on the following factors if you want to build a successful CCM program:

- **Identify which patients would make the best fit and prioritize them.** You may want to start with your highest risk patients, suggests Elias, who has witnessed some practices become "hugely successful by stratifying their patients." That is, you can tap into your electronic health record (EHR) or clearinghouse to discover which patients could most use CCM services. List your patients by diagnosis group or number or degree of comorbidities and start from there. Remember that the CCM program requires a patient to have at least two chronic conditions expected to last at least the next year, according to CMS billing requirements.

  For instance, segment your patients by disease group — start with your patients with multiple conditions, such as Alzheimer's disease and heart failure or arthritis and hypertension. The key is to begin by "managing your most complex patients first," advises Elias.

- **Develop the right staffing mix.** You may want to look beyond licensure when working out your staffing needs. More so, you need the "right personalities that can thrive in that communication role," says Elias. You can have a range of professionals fulfill the care management role, from a nurse to a social worker and medical assistant. However, the nature of the role is such that you should make a careful consideration of which staff member has the skills to connect with patients over the phone and establish a connection to help bridge gaps in care. Elias says that a nurse is typically the "highest level" he sees in the position.

- **Consider bringing in additional staff, especially for small practices.** The evidence shows that CCM can provide a revenue boost, but you still need to figure out the best fit for your practice. Coming up with a system and meeting staffing needs is one of the biggest impediments facing smaller groups, says Morris. Several respondents to a recent *Part B News* survey on CCM services cited "getting my physicians involved" and "implementing a system to build our CCM services" as leading challenges. Also, a billing manager from a primary care practice in New Jersey reported that billing patients for the CCM copay leads to fears that patients "would drop the CCM [program]" entirely, according to the survey.

  For the average independent practice, "the administrative staff is already over capacity," says Elias. "To them, hiring a care coordinator just to do this is not worth it."

  However, diving in may be worth the trouble, advises Morris. He says that CCM offers "far and away the most potential revenue" of Medicare's

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Benchmark of the week

Some providers continue to bill Medicare for non-covered consultation codes

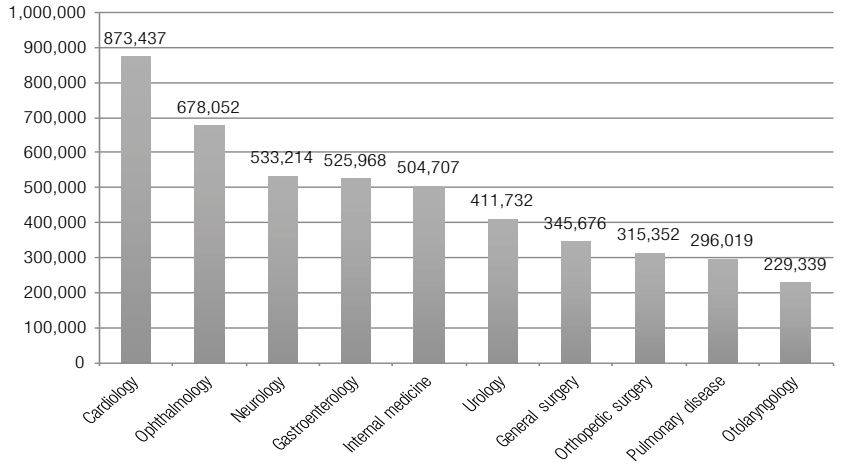
Despite Medicare's decision to no longer cover a suite of five outpatient consultation codes (**99241-99245**) nearly a decade ago, providers continue to pursue a mission impossible and seek payment for thousands of visits per year.

In 2016, practices submitted more than 32,000 outpatient consultation claims to Medicare, including about 13,000 claims for **99244** (Office consultation for a new or established patient) and nearly 10,000 claims for the lower level **99243**. While the total number of claims pale in comparison to the consultation-code heyday of 2009, when Medicare last covered the services, the submissions mark a futile exercise — Medicare denied just about all of the 32,079 claims for 99241-99245 that they received in 2016.

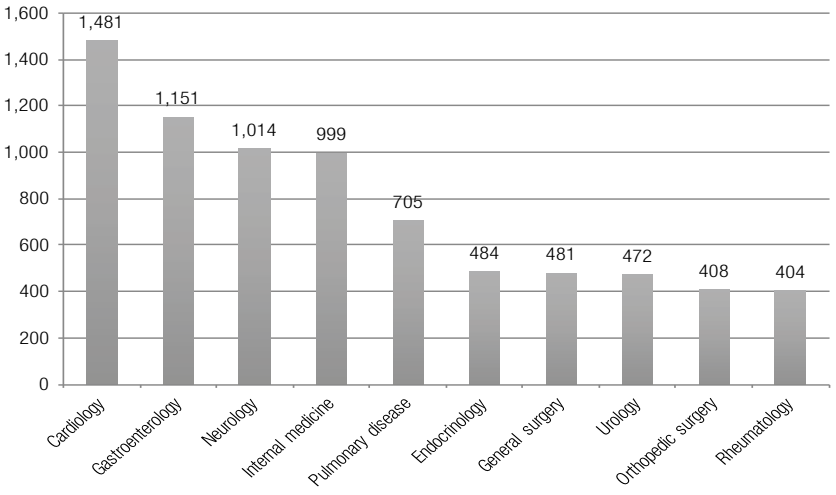
Some specialists led the way with dead-on-arrival 99244 claims in 2014, with cardiologists, gastroenterologists and neurologists each submitting more than 1,000 apiece. Internal medicine providers and pulmonary disease specialists also submitted a fair share. The recent numbers are perhaps an illustration that old habits are hard to break; in 2009, cardiologists submitted the most 99244 claims, with more than 873,000, and neurologists and gastroenterologists placed high on the list as well.

Interestingly, while the denial rates for 99244 and **99245** in 2016 rounded up to 100%, a handful of claims — four, to be exact — cleared Medicare's systems, and providers gained about $525 in payment for those services. That appears to be an anomaly; no other consultation codes successfully passed through Medicare's payment system in 2016 or in the previous two years. — *Richard Scott (rscott@decisionhealth.com)*

Total claims for consultation code 99244 by specialty, 2009



Total claims for consultation code 99244 by specialty, 2016



Source: Part B News *analysis of Medicare claims data*

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fee-for-service-based care management services. A practice that sees 550 Medicare beneficiaries can expect to bring in up to roughly $86,000 in revenue annually when performing CCM services, according to the PYA analysis. Tapping into CCM is a prime way to "bend the cost curve in a way that works within the fee-for-service system," says Morris.

Don't forget that CMS opened the door to prolonged service time with the introduction of complex CCM codes (**99487**, **99489**) in 2017. — *Richard Scott (rscott@decisionhealth.com)*

Resources:

- PYA, Providing and Billing Medicare for Chronic Care Management Services: *www.pyapc.com/updated-white-paper-addresses-changes-providing-billing-medicare-chronic-care-management-services*
- CCM fact sheet: *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*

Private equity

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Bain Capital reports that in 2016, health care private equity investments rose to $36.4 billion, even as other types of PE investments fell.

That doesn't mean the money will never dry up — 43% of respondents to KPMG and Leavitt Partners' 2018 Health Care and Life Sciences Annual Investment Summary survey of finance professionals think specialty physician practice management investment will show just "modest growth" this year.

Even at modest growth, PE firms have a lot more money to throw around than most medical entities, such as hospitals. Also, they don't have the same restraints, says Glenn P. Prives, attorney with McElroy, Deutsch, Mulvaney & Carpenter LLP in Morristown, N.J. While many hospitals are nonprofits that are generally guided by a specific medical "mission" that focuses their efforts on specific communities, PE firms are the opposite of nonprofits and have no such limitations.

Also, hospitals can't pay more than fair market value (FMV) to acquire practices from which they might reasonably expect referrals, says Joseph Tomaino, CEO of Grassi Healthcare Advisors LLC in New York City. The Justice Department could view higher payments as an inducement under the Stark law. PE firms don't have the same constraints.

How it works

The proposition with PE firms isn't usually to buy the practice outright, though the deal may be referred to as an acquisition, but for the PE firm to invest in it and get significant control in return.

Most states have "corporate practice of medicine laws" against anyone other than licensed medical professionals running a medical entity. In such states, "investors can only buy the management company

that the practice contracts with to handle it," explains Tomaino. "The professional corporation must remain owned by the professional providers. The professional PC [private company] contracts with and pays a management fee to the management company."

The professional PC — which consists of the physician-owners — and management company are usually structured so that the former is "captive" to the latter, says Tomaino. That is, the physician partners can't easily extricate themselves from the arrangement. "Typically, a shareholder restriction agreement says if the professionals leave, they have to transfer shares to licensed physicians of the [management company's] choosing," says Roger A. Cohen, a partner in the Life Sciences Practice of Goodwin Procter in New York City.

The PE firm usually lays out a sum for at least a majority interest in the management company and takes control of it, while the physician owners stay on as the professional side of the business. In return for the lump sum, the owners generally get less annual compensation than previously during the contract term — which is generally between three and seven years.

So if the average partner income is $500,000, "they will ask the physicians to take a salary of $350,000 for, say, five to seven years," says P. Shaun McDuffee, senior vice president and senior partner in North Star Resource Group in Minneapolis. "They will then offer to 'buy out' the practice and pay each partner the difference — $150,000 per year for X years. So in, say, a five-year deal, they would pay each partner $750,000." An added attraction: This payout is "typically capital gains versus ordinary income for taxes."

The usual object of the deal is for the PE firm to sell its investment for more money — a share of which may be contractually promised to the owners.

Possible effects of management change

In addition to the money, PE investments usually come with management resources — and sometimes with a strong desire to use them. While some PE firms are nearly passive investors, many will send in management teams to shape up their investment. "There will be inefficiencies that the PE firms can squeeze out through economies of scale — front desk, billing, EMR, etc.," says Rishi Garg, M.D., a neurologist and cofounder of Clineeds in Chicago.

While that can be helpful, it also can be heavy-handed. Remember, the investors may be more profit-driven than you are. "Sometimes there will be a bump in the number of patients," says Garg. "When we talk to doctors [about it], they will say, 'sure, we get an incentive, but we [also] have more patients.'" Because the PE firm is trying to make money, "they need to cut fat in admin and support staff — including RNs, CRNAs, LPNs, PAs, etc.," says McDuffee. "That translates into more work for the physicians."

What investors want

- **Larger businesses with significant assets.** While "there is definitely a market for individual providers with less than $5 million" if they have earning potential, investors generally don't want to play around with small businesses unless they've been rolled up into larger entities, says Garg.
- **Revenue generation.** "Private equity firms are looking for high-revenue, consumer-based practices," says Garg. "What's hot in that world is dermatology, orthopedic, ophthalmology, etc."

But there may be a place for some primary care practices in the portfolios of firms "with a better understanding where health care is going from a reimbursement perspective — that it's heading toward a value-based model that emphasizes the importance of primary care," says Matt Fisher, partner and chair of the health law group at Mirick O'Connell in Worcester, Mass.

Conversely, investors will be less interested in sectors that are troubled. "If Medicare chooses to reduce the reimbursement rates for certain sub-sectors — which happened with toxicology labs or competitive bidding for DME, for example — you'll find that interest in these sub-sectors declines," says Lance Beder, principal in the transaction advisory services practice of Grant Thornton in Stamford, Conn.

- **Scalability.** "It's not the 62-year-old doctor who wants to retire soon that's suited to the PE deal," says Tomaino. "It's more the guy who's developed 12 physical therapy practices in an urban area who wants to spread it out and replicate it by partnering with a PE firm — someone who's got something scalable."

"Funds prefer not to be the first consolidator and are looking for a platform that is scalable with a potential acquisition pipeline in mind," says Beder. "These investments traditionally attract higher multiples."

For example, Beder says, "I assisted on a 35-location DSO [dental services organization] deal that closed. They were more institutionalized and had a centralized corporate function that standardized accrual financial reporting, technology, billing and collections. ... This DSO offered a scalable platform to add additional locations that had already been identified and required financing to execute. This multi-location practice is an example of the type of provider that investors are looking for as a platform investment."

- **Staying power.** "In my experience, investors are not particularly interested in practices where owners are at the end of their careers," says Cohen. "They want practices where the physician is invested in building out the practice and growing it."

How the deal is done

Before you even meet with investors, you'll need rounds of meetings with knowledgeable partners. "The trifecta support team that any seller should have lined up in their corner is the investment banker, M&A [mergers & acquisitions] legal advisor and financial and tax transactions advisors," says Beder.

You'll have to come up with a listing of not only assets and debts, but also compliance issues, licensure and enrollment issues — anything a potential owner might need to know. Some deals may require government consent or approval; in some states, if the provider is under a risk-sharing arrangement, the state "could try to impose insurance-like regulation on the provider," says Fisher.

The firm then will come up with a valuation that will be the basis for compensation — the median is three to eight multiples of EBITDA (earnings before interest, taxation, depreciation and amortization), says Fisher.

"Typically, a PE firm will give a big payout upfront at close of acquisition — much larger than what a hospital can usually do," says Prives. "It's a quick cash hit. But at the same time, as a physician, you are selling some of your earning capability — you'll get employment compensation, but your share of the practice earnings will be smaller."

What you want

- **A partner with health care experience.** "Health care's a different area from anything else, and it makes a difference if you're dealing with firms that know the regulatory constraints, the payers, the market, etc.," says Prives.
- **A more mature arrangement.** Fisher notes that there's a drawback when you're among the first acquisitions in a PE firm's strategy. "Typically, if you're among the first practices they buy, it's a five-to-seven-year deal," he says, during which time they'll be adding practices to their portfolio while you're laboring away waiting for your payday. But if you are among the "last puzzle pieces" they acquire, then "things can be happening much faster."
- **Trust.** When considering PE partnerships "you want to work a trusted advisor who'll introduce you to the good players and get a warm introduction," says Tomaino. "You don't want to partner with people who don't share your vision." Prives suggests practices do a "reverse due diligence" to scope out the potential partner's track record before going forward.

"Make sure your eyes are fully open in terms of the partner," says Fisher. "Make sure you did your diligence. And understand it's an ongoing partnership — it's for years." — *Roy Edroso (redroso@decisionhealth.com)*

Resources:

- KPMG survey: *www.kpmg-institutes.com/content/dam/kpmg/healthcarelifesciencesinstitute/pdf/2018/hcls-investment-outlook-2018.pdf*
- Bain report: *www.bain.com/publications/articles/global-healthcare-pe-and-corporate-ma-report-2017.aspx*

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