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IN THIS ISSUE

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

2020 predictions

Single payer will stall, E/M changes will stay on track, ransomware will proliferate

Part B News editors surveyed readers and interviewed experts to come up with 11 predictions of what will affect physician practices in 2020.

Prediction: Except for small changes around the edges, federal health care reform will stall in 2020. It's been three years since President Trump promised a "beautiful" alternative to Obamacare, but all the proposals Congressional Republicans put forward went down in flames and Trump has been pretty quiet on the subject of late (*PBN 10/2/17*). Don't expect him to get louder about it in 2020.

*(see **2020 predictions,** p. 2)*

2019 predictions

PBN's 2019 predictions: Hit on M&A and MIPS, missed on E/M codes, Obamacare

Part B News staff holds ourselves accountable for our predictions every year by sharing with our readers how we fared with last year's predictions. Here are 2019's results.

Prediction: Chronic care management (CCM) services will surpass 5 million claims.

Probably true. Though there are no official 2019 figures on chronic care management code **99490,** we learned last year that the base CCM code 99490 was billed 4.3 million times in 2018,

*(see **2019 predictions,** p. 7)*

Activate, update remote E/M services in 2020

The new year will usher in six new CPT codes for online digital E/M services, more remote physiologic monitoring codes and three new HCPCS codes for online digital E/M services. Take advantage of the high-tech revenue opportunity in 2020 by attending the Jan. 28 webinar **Remote Control: Bring New Remote E/M Services Online in Your Practice.** Learn more: *www.codingbooks.com/ympda012820*.

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2020 predictions

(continued from p. 1)

With Democrats running the House and Republicans shifting focus to other issues, "health care policy in 2020 will be driven by court decisions and Democratic presidential politics," says Beth Halpern, a partner at Hogan Lovells in Washington, D.C.

Probably the biggest court challenge would be *Texas v. U.S.,* which currently threatens the entire Affordable Care Act structure (*see separate prediction, p. 4*). But Trump opponents have been pursuing legal options as well, and they've been getting results. In November, for example, a U.S. District Judge in Oregon issued a restraining order against a presidential proclamation issued in October that prevented immigrants without health insurance from entering the country, and another District Judge in New York vacated the "conscience" exemption Trump issued in May that let providers refuse to perform services such as "gender dysphoria-related surgery" to which they had a moral objection (*PBN 5/30/19*).

Halpern also mentions the administration's direct-to-consumer advertising rule, pricing transparency rule, 340B drug reimbursement policy and site neutral payments for hospital clinic visits among other proposals that "either lost in court or are facing suits now."

Expect that resistance to continue, and for the administration to continue to give them something to resist: "I expect that the administration will continue to be aggressive about promulgating regulations intended to address the cost of care, regardless of whether they can withstand court challenges," Halpern says.

But in the legislative and political arenas, Halpern expects that Republicans will be less likely to act and will instead "react to Democratic proposals on expanding access to coverage, either Medicare for All or refinements to the ACA."

Prediction: The 2021 E/M office visit documentation revisions will proceed as planned, but CMS will face adamant pushback on the payment side — and the proposed E/M rates will get chopped.

Experts don't envision CMS making big changes to the planned revisions to the documentation guidelines for E/M office visit codes (**99202-99215**) ahead of the Jan. 1, 2021, start date.

"As finalized E/M changes stem from a fundamental shift in code criteria as crafted by the AMA, my sense is CMS will continue to endorse this in future rulemaking," says Cathy Archuleta, manager with SunStone Consulting in Harrisburg, Pa. "Really, it makes sense that the complexity of medical decision making would play an integral role in driving the level of service."

But what could cause a stir throughout the rulemaking period in 2020 is the substantial amount of money on pace to change hands the following year. With established office visits seeing an approximate 25% pay increase, that would impact other specialty groups who don't report a bulk of E/M services.

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"That should be very interesting in the landscape of budget neutrality," Archuleta says. "How valuation of E/M services impacts reimbursement of other services compensable under the [fee schedule] will be compelling indeed. I think we can anticipate some highly charged discussion in this regard." We'll go out on a limb to say opposition to payment cuts among other groups will be vociferous enough to force CMS to mend its projected E/M payments.

Prediction: The increase in malware, ransomware and phishing attacks against health care facilities will continue substantially in 2020.

Medical practice personnel need to watch when and where they click their mouses in 2020. Phishing emails masquerading as vendors are one of the biggest scams targeting health care (*PBN 6/27/19*).

The industry — most notably independent clinics and hospitals — is becoming more proactive to fend off breaches, cyber threats and hackers, according to medical IT experts. Cyber criminals skilled in malware and ransomware will continue to go after social security numbers and other personal information entered into electronic health records (EHR).

"We are going to see more breaches; we will continue to see an increase," says Pam Hepp, a shareholder and co-chair of the data privacy and security group at the law firm Buchanan, Ingersoll & Rooney in Pittsburgh, Pa. "I don't agree providers are not being proactive. I think they are being proactive, but if you look at the causes of breaches, ransomware and malware are significant issues."

You may want to conduct a fresh round of training, given the most likely entry points for malignant campaigns. "Insider threats are still the leading cause of breaches," Hepp explains. "It is not individuals intentionally behaving badly, but no matter how good training is, you're always going to have employee errors being the biggest contributor. That runs the gamut of individuals misdirecting emails or security protocols being accidently lifted or opening phishing emails."

Another troublesome trend emerging in health care are ransomware attacks on medical devices, which could create serious vulnerabilities in health care security. While these attacks have been rare or unreported, you can expect an increase in these highly targeted attacks through the new decade.

"It is possible, but we have not seen, to my knowledge, actual attacks for that purpose," Hepp says of hackers targeting individual medical devices like pacemakers or insulin pumps. "It is very possible; we have to watch for this."

Hepp says the FDA has issued guidance to health care device manufacturers, including security measures when developing new-age devices.

Prediction: Medicare for All will not be the Democratic rallying cry. Democratic Presidential contender and Vermont Senator Bernie Sanders has remained a strong advocate for Medicare for All, which as described by his Congressional bill would virtually eliminate private insurance and create the sort of socialized health care found in most European countries (*PBN 9/25/17*). And for a time, "M4A" seemed to be the hot trend among top-tier Democratic prospects, as Massachusetts Senator Elizabeth Warren and California Senator Kamala Harris announced separate M4A plans.

But Harris has left the race and Warren has already backtracked somewhat on Medicare for All — moving to a "Reducing Health Care Costs In America And Transitioning To Medicare For All" plan that begins with a "public option" — leaving Sanders as the only first-tier nominee committed to a complete replacement of the current system. And, though none were willing to put their name to it, a recent Politico story claimed several "Sanders supporters, advisers and aides" admitted "maybe there won't really be 'Medicare for All,' thanks to Mitch McConnell and a Republican Senate, but they at least see less expensive prescription drugs and health care for more people than currently have it."

In Congress, meanwhile, there's an alternative vision being floated by Senator Debbie Stabenow of Michigan: The Medicare at 50 bill, which is "flying under the radar," according to Danielle Kunkle Roberts, a Medicare insurance expert and founding partner at Boomer Benefits in Forth Worth, Texas.

"It would allow people to buy into Medicare as early as age 50 and be able to use any subsidy or tax credit they may qualify for under the ACA legislation to help them pay for it," Roberts says. "It would keep standard, original Medicare intact but would also grow the Medicare Advantage program, which saves Medicare a lot of money and is very popular with beneficiaries as well." Also, insurance carriers "are far more likely to support such a program, which involves them, while they are likely to be in the biggest lobby against

Bernie-style Medicare for All which would send them into neverland," Roberts says.

As the election draws closer, we can expect the Democratic establishment — whose idea of health care reform during the previous administration was based on a conservative Heritage Foundation proposal once known as "Romneycare" — to push whatever candidate is nominated toward a party plank that is much less radical than Medicare for All.

"I expect that the eventual Democratic nominee will campaign on expanded coverage at lower prices, but either [they] won't call it 'Medicare for All' or will try to change the meaning of that term to describe a more gradual change in health coverage," Halpern says.

On the practical side, getting M4A or a similar plan passed would be a huge challenge even in the event the Democrats sweep the 2020 elections. Affordability questions will continue to keep the legislation in neutral on Capitol Hill, predicts Mike Strazzella, attorney with Buchanan, Ingersoll & Rooney in Washington, D.C. "It will be an uphill battle to get it passed," he says. "I think there are significant economic challenges to fund it."

Of course, this prediction becomes inoperative if the nominee is Sen. Sanders, who is still one of the top candidates in polls. But if the establishment gets its way, as it usually does, Democrats will proceed on a platform of reform rather than revolution.

Prediction: Obamacare's biggest judicial challenge will fail in the Supreme Court. Notwithstanding executive and Congressional inaction, there is one huge monkey wrench that may upend the current health care order: The legal decision in a suit promulgated by Republicans that suggests Obamacare is unconstitutional — not just the individual mandate, which was mooted by the 2017 Tax Cuts and Jobs Act that made the mandate unenforceable, but the whole thing, including guaranteed issue and mandatory coverage of essential health benefits and pre-existing conditions.

Texas v. U.S., a suit brought by several Republican state attorneys general and two Republican governors as a challenge to the law, was advanced late in 2018 by Judge Reed O'Connor of the Northern District of Texas. Plaintiffs maintain their rights were infringed by the mandate, notwithstanding that the 2017 law prevented the government from collecting a penalty from them for failing to acquire health care coverage.

"The original ruling stated that, since the 2017 Tax Cuts and Jobs Act eliminated the individual mandate, in turn the entire ACA must be thrown out since in their haste to pass the ACA, the Democrats did not include a severability clause," explains G. Seth Denson, co-founder and president of GDP Advisors in McKinney, Texas. Judge O'Connor said the elimination of the mandate "sawed off the last leg it stood on."

The case was recently before the Fifth Circuit — "thought to be the most conservative court in the land," Denson says — which also held the mandate unconstitutional in a decision rendered Dec. 18, but did not rule on its "severability" and remanded it to the lower court.

The Supreme Court seems a likely final destination. This would be the third time the ACA has ended up before the Supreme Court. In the second, *King v. Burwell* in 2015, the law's premium subsidies were challenged but upheld (*PBN 6/29/15*). In the first case, *National Federation of Independent Business v. Sebelius* in 2012, the mandate was declared a tax by Supreme Court Chief Justice John Roberts and upheld on that ground — which left it vulnerable to the current challenge as soon as Trump and Congress zeroed it out, on the grounds that a tax with no revenue is no tax at all (*PBN 12/11/17*).

But Denson says that vulnerability isn't all it seems.

"Under the 2017 Tax Cuts and Jobs Act, the individual mandate was not actually repealed — rather the tax was lowered to zero dollars," Denson explains. Republicans couldn't actually repeal the mandate itself, he adds, because they did not have the 60 votes necessary in the Senate. "Without a filibuster-proof supermajority, the language of the law could not be altered," he says. "However, per a process established in the Congressional Budget Act of 1974, only a majority is required to change laws as they relate to taxation, as Congress, per the 16th Amendment, is the authority that can levy taxes."

By that logic, the mandate "tax," Denson says, "is still very much in place even though there is no penalty and the cost for the tax is $0.00." And he expects the Roberts Court, which first called it a tax, to accept that logic and find the remainder of the law, at least, constitutional.

Prediction: Medicare Advantage will continue to grow — and so will enforcement threats based on faulty risk adjustment coding. Is there any sign that the steady growth of Medicare Advantage over recent years — going from 5.3 million enrollees and 13% of the Medicare population in 2004, to 22 million and 34% in 2019, according to the Kaiser Family Foundation — will slow in 2020? On the contrary, we expect the rate of growth to accelerate.

(continued on p. 6)

Benchmark of the week

Practices express desire to use new CCM codes, while virtual visits remain untapped

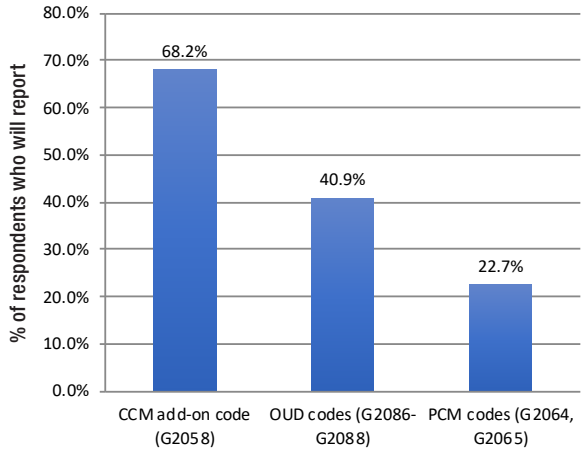
Many providers anticipate seizing the new chronic care management (CCM) add-on code that's debuting Jan. 1, 2020, but far fewer plan to dive into the virtual realm of tech-backed E/M services in the new year.

That's according to a year-end poll of medical practice professionals that *Part B News* conducted in December. As you can see in the charts below, more than two-thirds of respondents (68%) said they planned to start using the CCM add-on code **G2058** in 2020. The code accounts for an additional 20 minutes of CCM service per month and is reportable with base code **99490** (*PBN 11/18/19*).

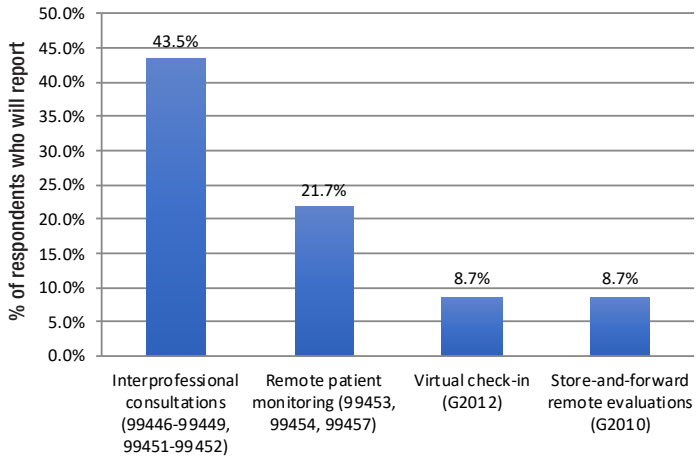
A sizable amount of practices said they would utilize the new services aimed at addressing opioid use disorder (OUD) in the office. About two in five, or 41%, of practices said they would report the series of codes **G2086-G2088,** which are counseling-intensive, in the new year (*PBN 12/16/19*). "As with everything new we've see in this arena, utilization is low, or at least initially," says Cathy Archuleta, manager with SunStone Consulting in Harrisburg, Pa. "This is a response to an epidemic, however, not just another preventive service. Hopefully with heightened awareness and provider education, we'll see a level of engagement that is impactful."

About 23% of respondents reported they would use the new principal care management (PCM) codes **G2064-G2065** (*PBN blog, 11/22/19*). The outlook for virtual visits, however, is bleaker, with only about 9% of respondents saying they'll use virtual check-in code **G2012** or the remote evaluation code **G2010** in 2020. — *Richard Scott (rscott@decisionhealth.com)*

Which new services will you report in 2020?



Which existing services will you report in 2020?



(continued from p. 4)

For one thing, the Trump Administration loves Medicare Advantage and has gone out of its way to promote its use. It announced in September that "Medicare Advantage premiums in 2020 are expected to decline 23% from 2018 while plan choices, benefits and enrollment continue to increase." And in an October executive order, Trump demanded regulation that would "encourage innovative MA benefit structures and plan designs" *(PBN 10/10/19)*.

Such innovation is already taking place, thanks in part to new rules encouraging MA plans to cover items affecting "social determinants of health" — that is, items such as air purifiers and transportation that alleviate negative health factors (*PBN 8/1/19*).

"Some plans are starting to offer coverage for home modifications, such as wheelchair ramps and bathroom grab bars, and others are even including services like pest control," says Anastasia Iliou, senior content manager for MedicarePlanFinder.com, an insurance agency and beneficiary service in Nashville, Tenn. "As more plans enter the market and more plans lower their costs, carriers know they have to be competitive by adding benefits like these."

Prediction: Non-physician practitioner (NPP) utilization will rise in 2020. OK, this is as close to a safe bet as you can get in health care. NPP use has been rising for years (*PBN 7/3/19*). The reason is obvious: They're cheaper than physicians and, as CMS and state boards increase the range of services they can provide and reduce the amount of administrative hassle they must face, they're bound to find more work in the practice world (*PBN 11/18/19*).

Michael Powe, vice president of reimbursement and professional advocacy at the American Association of Physician Assistants notes the Department of Labor predicts the PA profession will grow 31% between 2018 to 2028. That's "much faster than the average for other occupations," Powe says. "The looming shortage of physicians combined with growing health care needs of patients will create increased demand for medical and surgical services delivered by PAs."

"At the state level, we continue to see barriers between patients and their nurse practitioners being removed and laws enacted that authorize nurse practitioners to practice at the top of their education and clinical training," says David Hebert, J.D., CEO of the American Association of Nurse Practitioners (AANP). "In the last few years, eight states and two U.S. territories have retired the unnecessary requirement for a physician relationship as a condition of NP licensure and practice. We anticipate this trend to continue."

Hebert also mentions the role NPs are taking in the fight against opioid abuse thanks to the Comprehensive Addiction and Recovery Act of 2016, which authorized them to prescribe medication-assisted treatment, an authority made permanent by the Support for Patients and Communities Act, which "has led to a substantial increase in access to this medically necessary treatment for opioid use disorder, particularly in rural and underserved populations," Hebert says.

Prediction: Tech solutions will be used to ease the pain of prior authorization. The Medical Group Management Association (MGMA) consistently finds providers complaining about the hassle and care obstacle of prior authorization (*see 2019 predictions, p. 1*). With both government and private payers more rather than less likely to push for prior authorization, providers are casting about for their own solutions. Rob Tennant, director of health information technology policy for MGMA, sees one coming down the pike: Communications tools that will connect payers and providers to speed procedure authorizations the way Surescripts and other vendors currently connect them to pharmacy benefit managers to speed drug approvals.

"People are asking: How can we apply this technology to the medical services side?" Tennant says. "We could streamline approvals through automation, so instead of waiting days or weeks for an answer, you get it quickly, perhaps while the patient is sitting in front of them."

With such "real-time benefit tools," Tennant imagines encounters where providers can tell a patient, "This isn't covered, it'll cost X amount, but the alternative, which we think is similar, is covered, doesn't require prior authorization, and has a lower out-of-pocket cost."

Tennant has been talking to payers about this and finds "some are already doing it — so it's not Jules Verne. We assert that in 2020 there will be a movement toward increased automation of prior authorization."

Prediction: Telehealth initiatives and participation will continue to soar in 2020. Projections forecast booming telemedicine numbers and expanding programs — like hospitals at home and chronic care management — for 2020.

In 2016, an estimated 61% of U.S. health care institutions and 40 to 50% of U.S. hospitals used telemedicine.

Now, individual physicians are jumping on the telehealth bandwagon.

"I just saw some data shared by the American Association of Medical Colleges (AAMC), and out of 6,000 physicians, 33% have adopted some form of telehealth," says Joe Kvedar, M.D., president-elect of the American Telehealth Association in Arlington, Va. "The data point before that was from 2016 from the AMA, who said 16% [adopted some sort of telehealth]. So it's doubled in three years."

Kvedar says that the hottest trend in telehealth involves virtual video exchanges, particularly between mental health patients and providers. — *Roy Edroso and Jim Dresbach with additional reporting by Richard Scott (pbnfeedback@decisionhealth.com*

Editor's note: *For additional predictions on drug pricing and diagnosis coding for vaping, visit* www.partbnews.com.

2019 predictions

(continued from p. 1)

while the newer complex chronic care codes combined that year for a total of 444,521 claims — 236,054 for **99487** and 208,467 for **99488** (*PBN 10/10/19*).

It's very likely 99490 had the 16% increase in 2019 necessary to break 5 million. For one thing, the increase between the 2017 total of 3.5 million and the 2018 total of 4.3 million was about 23%.

And we know CMS pushed in 2019 to make the service more attractive. Back in 2018, a survey found that a lot of providers said they weren't bothering with CCM because they found it too difficult and/or low-paying (*PBN 7/5/18*). CMS gave providers new reasons to get into the process, including a fourth CCM code, **99491** (*PBN 12/13/18*). And tech solutions have been emerging to help overcome the problem of data interoperability between CCM patients' care partners — for example, health information exchange (HIE) networks (*PBN 12/13/18*). When the final tally emerges we're confident CCM will have been billed over 5 million times.

Prediction: Medicare's new remote internet, phone and device service and consultation codes won't take off at first but will find adopters and grow steadily.

Unclear. As with CCM, no final Medicare claim numbers are available. Survey results put out by the Spyglass Consulting Group of Menlo Park, Calif., in November 2019 found that "88% of hospitals and health systems surveyed have invested or plan to invest in remote patient monitoring (RPM) solutions" for chronic care patients. That suggests clinics associated with health systems have the means, at least, to take advantage.

As to whether independent practices are actually using the codes, the *Part B News* year-end survey finds 43% of respondents planned to use remote evaluation code G2010, while and 22% said they planned to use interprofessional consultation codes **99446-99449** and **99451-99452** in 2020 (*see benchmark, p. 5*). But that doesn't mean they're using them now. We'll just have to wait and see.

Prediction: Disruptions in the Affordable Care Act (ACA) probably won't mean fewer insured patients in 2019 — but their insurance may cover less, especially if a Supreme Court case requires Congress to start over.

Probably false. The 2019 numbers aren't available, but the trend is ominous: A Kaiser Family Foundation survey found that the number and percentage of uninsured Americans went up in 2018 — from 25.6 million to 27.5 million, and from 7.9% to 8.5%, for the first time since 2009. The second half of the prediction might be true, though — with the Trump Administration allowing ACA exchange shoppers to renew cheaper, low-benefit short-term limited-duration (STLD) plans, chances are good that younger and healthier insurance shoppers will go for them (*PBN 8/7/18*).

Prediction: Spurred by new benefits, practices will see more Medicare Advantage patients in 2019.

True. According to the Kaiser Family Foundation, MA had a big jump in 2019, from 20.4 million to 22 million enrollees. It's even more impressive when you look at it from a 15-year perspective: going from 5.3 million enrollees and 13% of the Medicare population in 2004 to 22 million and 34% of enrollees in 2019.

Prediction: Prior-authorization pain will persist in 2019.

True. In 2018, 82% of medical practices responding to a Medical Group Management Association (MGMA) survey reported very or extremely high rates of regulatory hassle vis-a-vis prior authorizations. In a later MGMA STAT poll survey, with results announced in September 2019, MGMA found that 90% of health care leaders "report that payer prior authorization requirements have increased in 2019." And in the MGMA Annual Regulatory Burden Report in October, 83% of practices found prior authorization "very or extremely burdensome" (*PBN 10/31/19*).

Prediction: 2019 will be another banner year for health care mergers and acquisitions.

True. Baltimore's Sage Growth Partners November 2019 survey revealed M&A activity remained strong in 2019, with deal volume exceeding 250 deals in the first three quarters. Kaufman Hall, a Chicago, Ill., consulting firm, surveys quarterly health care acquisitions and reported hospital and health system transactions in 2019 remained steady in the third quarter, with 25 announced transactions. In short, 2019 M&As ran ahead of 2018, which had 68 announced transactions through Q3.

Although the number of transactions announced in 2019's third quarter exceeded the number announced in the second quarter, the total revenue for the quarter was lower, at $8.1 billion, compared with a near record high of $11.3 billion in the second quarter.

Significant transactions involved a Beaumont Health and Summa Health merger, a joint venture between HCSC Ventures, the venture capital arm of Health Care Service Corp. (HCSC), and Sanitas, a multinational advanced primary care provider, which opened 10 advanced primary care medical centers in the Dallas and Houston markets.

Prediction: Your Merit-based Incentive Payment System (MIPS) success rates will fall in 2019.

True. According to Ellie Evans of Symphony Performance Health Analytics in Alpharetta, Ga., the MIPS success rate in 2019 saw a drop, with the median final score coming in at 78.72. That accounts for a decrease of 11.5% from the median score of 88.97 for 2018. But whatever the health of your median MIPS score is, practices are confident they will score well in 2020.

According to the 2020 *Part B News* Predictions Survey, practices are confident they will score high in the four MIPS categories of quality, promoting interoperability, improvement activities and cost. About 63% were very confident of a strong quality score while 73% were very confident of a positive promoting interoperability score. Very confident scores were also high for cost (63%) and improvement activities (68%).

Prediction: The E/M documentation revisions will have little meaningful impact.

True. "The E/M documentation changes for 2019 were not all that significant," says Ellie Evans of Symphony Performance Health Analytics in Alpharetta, Ga. But the changes are scheduled to have a "much bigger impact" when they go into effect Jan. 1, 2021.

"As we saw, a lot was changed in the PFS 2020 final rule," Evans says. "CMS pulled back on the single payment for E/M codes and revised the CPT codes aligning with the changes adopted by AMA. The CPT code changes also revise the times and medical decision-making process for all the codes and eliminate history and physical documentation as elements for code selection."

Prediction: CMS will announce a three code E/M series.

False. Medicare announced plans to revamp the E/M coding structure in 2018 and was met with a quick and fierce response from the medical community. Heading into 2019, *Part B News* editors speculated that CMS would pivot to three codes each for new and established office visits. But that didn't quite happen. CMS did trim the list of new patient codes to four by accepting the planned deletion of **99201**. However, the agency also adopted the AMA's plan to maintain five levels of established office codes and, doubling down on E/M services, sent rates soaring. The changes are now scheduled to hit the books in 2021. — *Roy Edroso and Jim Dresbach (pbnfeedback@decisionhealth.com)*