EISNERAMPER

Practice Strategies

A Newsletter for Healthcare Professionals

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A Competitive Advantage

Should Your Practice Offer Extended Hours?

Until recently, few physicians offered after-hours care beyond an automated telephone instruction to call 911 or visit an emergency room. But offering 24-hour access is a policy goal today so practices should consider at least some form of extended hours.

Why Stay Open Longer?

There are several good reasons to offer extended hours:

To compete for patients and drive revenue. We live in an era of "right here, right now." When people can book a flight, order from Amazon or step into an Uber car within seconds, they begin to expect a similar experience everywhere.

A medical office with shorter waits and more convenient hours is attractive to busy people. This is why urgent care centers and pharmacy clinics are offering consultations and some treatment during night and weekend hours. While these are popular among patients, a practice that takes the cue can win some of those patients back and bring new ones on board.

To reduce ER visits. Without access to a doctor's office, people who are ailing often head for the nearest emergency room; many older people don't hesitate to call for an ambulance. But a UK study showed a 26 percent reduction in ER visits among patients whose primary-care providers offered extended hours. For children the data are even more dramatic: The *Journal of Pediatrics* reported that pediatricians with evening hours reduced their young patients' ER visits by half.

To reduce hospitalization and improve health. Patients who consult with their

regular physician or group tend to require less time in hospitals. The *Journal of General Internal Medicine* reported that care "outside usual business hours ... is associated with improved patient outcomes."

To deliver personalized care and create patient satisfaction. When you keep your patients in house, your staff not only knows them (and vice versa) but also has immediate access to records. The *Annals of Family Medicine* views evening and weekend appointment options as key to a patient-centered society.

Costs, Risks and Downsides

Moving to longer hours comes with some costs, too. Expenses for staff, utilities, supplies and possibly office rent will rise, although careful planning to see enough patients should generate more than enough revenue to offset these costs.

A less tangible risk is staff morale. If you extend hours without additional hiring, some staff may gladly pick up the slack. But some may resent it, even with a bigger paycheck.

Also consider physician burnout. Doctors can be driven people and jump at the opportunity to work longer hours and see more patients. But whether they admit it or not, the new schedule will affect their work-life balance. (See page 4 for more on physician burnout.)

Before You Leap

A few sensible measures can help you decide whether or not to offer extended hours and implement the change in a smooth and sustainable way.

First, weigh different scenarios. How many more hours would actually help the practice before the returns diminish? Which positions must stay filled during extended times and which aren't needed? Billing, labs and nutrition counselors, for example, might remain on their present schedules or come in one evening a week.

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Not for Everyone – Yet

What You Need to Know About AAPMs

Advanced Alternative Payment Models, or AAPMs, are a key vehicle by which U.S. healthcare will shift to a value-based system. These models aren't just incentives – they're designed to fundamentally reduce the total cost of healthcare and establish a new value proposition for the profession.

AAPMs are one of two tracks that MACRA defined for its Quality Payment Program; the other is MIPS. While AAPMs aren't yet suitable for most practices, they will be soon. In 2017, CMS expects AAPMs to involve about 100,000 physicians and practices, compared to 600,000 in MIPS. The agency expects this proportion to shift steadily in subsequent years.

Benefits for Qualified Practices

An AAPM offers three main benefits to physicians or practices that qualify:

1. Potential exemption from MIPS reporting requirements.
2. An annual Medicare Part B incentive, payable from 2019 through 2024, equal to 5 percent of the previous year's Part B payments. This applies to every entity participating in the AAPM, even those that fall short of performance goals.
3. A higher annual Part B fee schedule increase of .75 percent, beginning in 2026.

Requirements To Qualify

In 2017, an AAPM must use one of eight designated CMS-administered Medicare payment programs. Certain commercial "Other Payer" programs will enter play in performance year 2019. In addition, an AAPM must:

- *Employ certified EHR technology.* This revolves around the concept of meaningful use — a set of criteria by which electronic health records must improve health quality, facilitate coordination, reduce disparities and guard privacy and security concerns. Since meaningful use may be defined somewhat differently by each payment program, understanding a program's definition is critical in choosing a model.
- *Report quality measures comparable to those of MIPS.* AAPMs will encounter little difficulty with this, since CMS has already required robust quality measures. "Comparable to those of MIPS" means evidence-based and driven by similar priorities — clinical outcomes, patient safety and various condition-specific measures.
- *Shoulder more than nominal financial risk or qualify as a Medical Home.* Normally, an AAPM has to incur risk. This is defined by MACRA as exposure to potential financial loss directly linked to performance (mere investment in ACO participation doesn't count). So an AAPM that misses targets will see its payments reduced or eliminated, or even find itself on the hook for payment to CMS. Like meaningful use, the dollar amount of risk is specific to the model: a percentage of price, total cost of care or the sum of Medicare A and B payments.

But the rule is flexible in defining how risk must be assigned. One ACO, for example, could shoulder all the risk and leave its members with none while another could do the opposite and place all the risk on its members. Still another could assign risk in a proportion somewhere between those extremes.

Approved AAPMs for 2017

There are currently eight CMS-operated AAPMs:

1. Comprehensive ESRD Care (CEC) - Two-Sided Risk
2. Comprehensive Primary Care Plus (CPC+)
3. Next Generation ACO Model
4. Shared Savings Program - Track 2
5. Shared Savings Program - Track 3
6. Oncology Care Model (OCM) - Two-Sided Risk
7. Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1 - CEHRT)
8. Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

Exemption for Medical Homes

There's an exception to the risk rule for AAPMs that acquire a medical home certification, which exempts them from the requirement. To achieve such certification, an organization must demonstrate a model for comprehensive care delivery that is coordinated by a PCP across various health entities and is patient-centered, accessible and committed to quality and safety.

A practice that has gotten its feet wet in a related alternative model — like Meaningful Use (MU), Physician Quality Reporting System (PQRS) or Value-Based Modifier (VBM) — will find an advantage over those that haven't. These will be merged into MIPS in 2019.

Use 2017 to plan

Unless your practice is ready to move to an AAPM — only around 17 percent are – make this your year for gathering data, analyzing options, thinking and planning.

Understanding your payment mix, IT readiness and approach to risk will help you make any necessary adjustments and put you on a firm foundation for good choices next year and beyond.

Participating in AAPMs is a complex decision. Contact us to discuss your options in more detail.

Early Attention Pays Off

Prevention Is the Key to Reducing Denied Claims

However healthcare reform plays out, pressures on medical practices – complex codes, MACRA rules, declining payment rates – highlight the importance of capturing more revenue from insurance claims.

Procedures focused on prevention are an overriding healthcare best practice. Prevention is less expensive than treatment and this is true in the billing office as well: You can expect initial rework on a single claim to cost $25.

So what would it take to shift your claims management to a prevention model? Here are the main steps involved:

Track, then analyze. A well-defined tracking process centered on payer, reason and amount — and with clear responsibilities, recording and double checks — is essential to everything else. Analysis is less common, but a little work can reveal the patterns that will show you where to concentrate.

Stress accuracy up front. Because most claims are denied based on minor inaccuracies, establish a culture of precision throughout the office. Set concrete goals to reduce specific errors and reward success. A restaurant gift card for diligent billing associates is a small cost if they can lift your reimbursement rate.

Be proactive and timely. Claims will still be denied, of course, but prevention remains key. For example, you can prevent latency, or time spent waiting on a denial before correcting and resubmitting a claim. Understand each payer's protocols (they vary considerably, both for submission and payment) and contact each one before being notified. This is common practice in business, where accounts receivable departments use a polite and friendly tone with customers to create friends in the offices that cut checks.

Automate. With the accelerating complexities of healthcare, do you really want employees memorizing codes, remembering problem claims or spending valuable time tracking claims with Excel? Instead, use an automated system to do these things. Compare software costs (including training) to the cost of denied claims and then get the best tool you can afford.

By preventing denials in the first place, you can avoid hours of rework. And by extending a preventive culture beyond initial denials, you can avoid rework further. The end result can be significantly more revenue.

Contact our firm for help in strengthening your process for preventing denials and recovering those that get through.

Offering Extended Hours

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And how many patients do you expect to use the new extended hours? Conducting a survey can help you find out. This kind of planning may feel a bit abstract but it's crucial to have a good idea of costs and benefits.

Next, align the troops. Get everyone on board, including doctors and staff. To do this, be transparent and willing to accommodate inconvenience one way or another – for example, with flex time or a modest shift differential and a liberal policy on shift trades. And consider generational differences: Younger staff may prefer starting later and ending later. Younger physicians, meanwhile, may volunteer quickly in order to see more patients and build their own base.

Commit to more than a month or two and make this clear from the outset. A popular move that's quickly withdrawn won't help your reputation. Then make the change known widely — to have an impact, it has to be advertised.

Leadership Can Make It Work

Extended hours can mean different things to different practices. If practice leadership is aligned, creative and flexible, offering extended hours can please patients and staff while increasing practice revenue.

There are good reasons to extend practice hours but it's not a simple decision. Our firm can help you navigate it.

Help Physicians Get off the Burnout Track

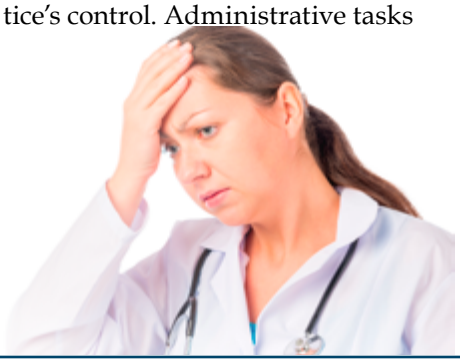
In a recent survey, the Mayo Clinic found that more than half of U.S. physicians are experiencing symptoms of burnout. This was up significantly from a study three years earlier, although burnout among the general population stayed flat.

In both studies, the rate of depression among doctors was 39 percent. But the rate of suicidal thoughts for doctors jumped from 4 percent to 7 percent — meaning one in 14 physicians has considered suicide.

The pressures doctors face continue to increase amid accelerating change in healthcare and the relentless demand to demonstrate business value. So there's reason to believe these upward trends will continue in the future.

A medical practice alone can't solve the problem of physician burnout, but a practice can help mitigate it. For example, consider a 2017 Medscape survey in which 51 percent of doctors — both male and female — reported burnout. The two main causes they identified were excessive paperwork and long hours.

Neither of these is beyond a practice's control. Administrative tasks like paperwork are a poor use of a physician's time — an investment in staff or technology can ease the burden considerably. And adding one doctor to a practice will immediately free up at least 40 hours for the rest of the physicians.



But won't revenue suffer? It could — but every practice has to weigh this against the cost of human suffering. The classic symptoms of burnout are loss of enthusiasm for work, feelings of cynicism and a low sense of personal accomplishment. The end result can be far worse.

Our firm can help you quantify the financial impact of implementing work-life balance measures at your practice.