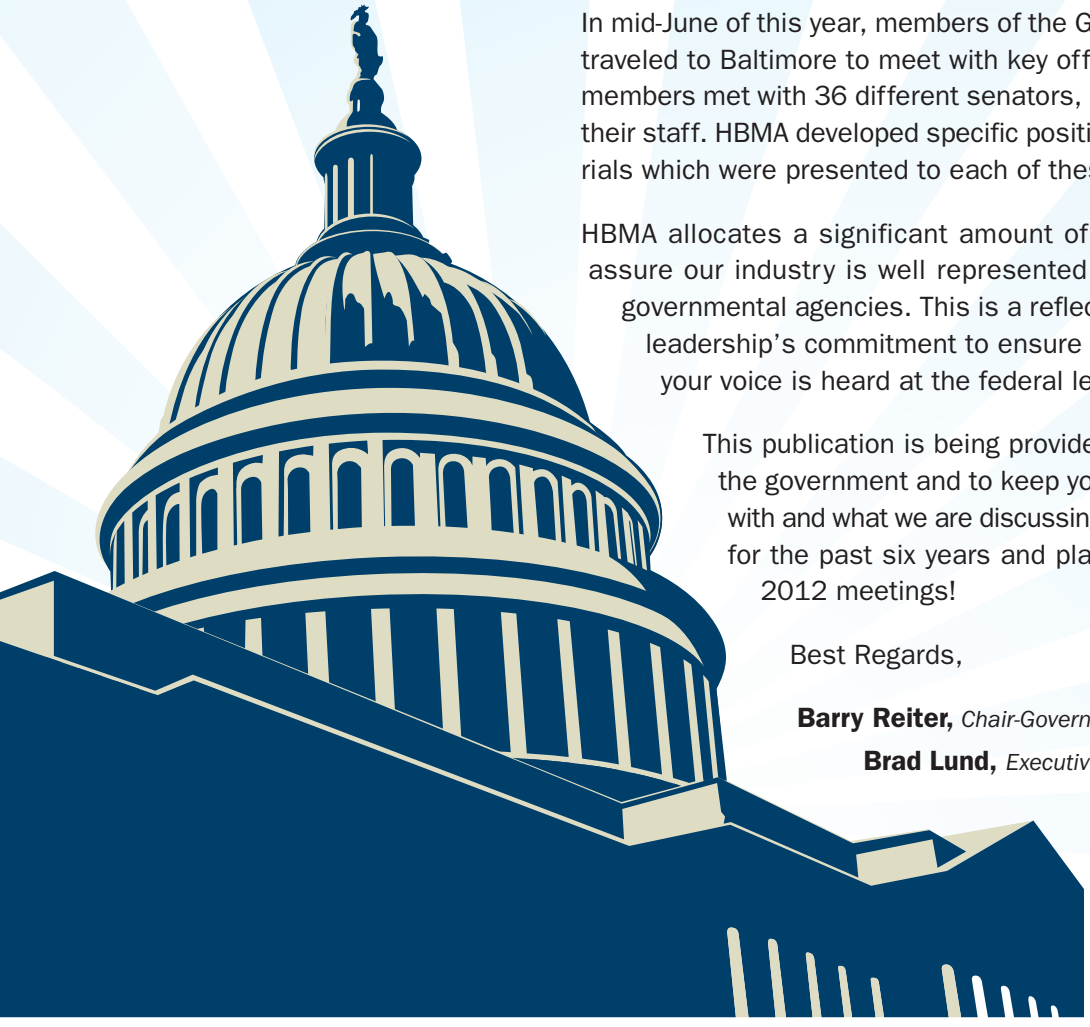
HBMA Healthcare BILLING & MANAGEMENT Association

GOVERNMENT RELATIONS update

A Publication of the HBMA Government Relations Committee | Summer 2011

Dear Members of HBMA,

HBMA is dedicated to high quality and effective representation of our members and our industry with both the legislative and regulatory bodies of the Federal Government. HBMA's advocacy in Baltimore and Washington, DC, has existed from its inception in 1993. **The Government Relations Committee is charged with the management of our educational and advocacy efforts with government.**



In mid-June of this year, members of the Government Relations Committee traveled to Baltimore to meet with key officials of CMS. The following day, members met with 36 different senators, representatives and members of their staff. HBMA developed specific position statements and related materials which were presented to each of these elected officials.

HBMA allocates a significant amount of its annual operating budget to assure our industry is well represented with Congress, CMS and other governmental agencies. This is a reflection of our core mission and our leadership's commitment to ensure your interests are protected and your voice is heard at the federal level.

This publication is being provided to report HBMA's efforts with the government and to keep you abreast of who we are working with and what we are discussing. HBMA has held these meetings for the past six years and planning has already begun for the 2012 meetings!

Best Regards,

Barry Reiter, *Chair-Government Relations Committee*

Brad Lund, *Executive Director*

inside:

CMS Visit : June 13, 2011

Attended by: Brad Lund, Bill Finerfrock, Sherri Dumford, CHBME, Joe Schendel, CHBME, Don Rodden, CHBME, Barry Reiter, CHBME, Bob Burleigh, CHBME, Lonnie Johnson, CHBME, Randy Roat, CHBME, Kathy Canny, CHBME, Dave Nicholson, CHBME, Scott Everson, CHBME, Jud Neal, CHBME, Jackie Willett, CHBME, Lou Silverman and by phone Holly Louie, CHBME. Special thanks to William Rogers, MD, FACEP, Director of Physicians Regulatory Issues Team, for participating with HBMA for the day.

PROVIDER COMMUNICATIONS GROUP

Valerie Haugen, Director, Division of Provider Information Planning & Development

Valerie Haugen provided an overview of an exciting initiative currently under development that will provide an opportunity for billers and provider staff to obtain education on the Medicare program. Upon successful completion of the educational track, attendees are eligible to receive a certificate. HBMA has participated in quarterly meetings with CMS staff to provide feedback regarding the curriculum development. This program will include a Medicare Basics module, Part B module, and Part A module. Currently, an evaluation is being developed for the program. Look for additional information from CMS regarding this program in the near future.

In that this program is new, it will likely evolve over time with feedback from users. HBMA will continue to serve on the workgroup to provide feedback from the billing community. Education outreach efforts are also being developed to reach and provide resources for Compliance Officers. The Provider Communications Group has invited HBMA members to recommend subject matter for MLN articles. If you have a particular topic that you feel would be appropriate for an MLN article, please contact Sherri Dumford at **sherri@hbma.org** to submit your request.

SATISFACTION SURVEY

Colette Shatto, Deputy Director, Division of Provider Communications Technology

Bob Burleigh, CHBME, provided the results of HBMA's Medicare Contractor Provider Satisfaction Survey. Every year, HBMA conducts a parallel survey to the CMS Medicare contractor Provider Satisfaction Survey. It did not come as any surprise that the highest scores achieved by Medicare contractors were in the category of claims adjudication and the lowest scores received by contractors were in the category of provider enrollment and MAC communications. While there are clearly inconsistencies across contractors relating to provider enrollment, communication, and ease of access, the CMS survey results are shared with the CMS Medicare Contractor Management Group in order to make continued improvements in quality and performance by the contractors. To all HBMA members who participate in the HBMA survey, thank you. CMS values our feedback and uses the information from the CMS survey to make continued improvements in all areas.

5010/ICD-10

Denise Buenning, Director, Administrative Simplification Group

Christine Stahlecker, Director, Division of Transactions, Applications & Standards

Holly Louie, CHBME, led the 5010/ICD-10 discussion and expressed to the CMS staff that HBMA is working hard to provide our membership with the most current information available related to 5010 and ICD-10 transitions. Members have been reporting inconsistent answers to some questions surrounding testing. CMS clarified whether billing companies will have to test for every provider OR by submitter identification number. Their answer was that testing is by submitter ID. CMS also wanted to dispel any rumor that there will be a delay in 5010. The message is clear in that there will be NO DELAY in 5010 imple-

mentation. There is also no indication that a delay in ICD-10 would be likely. Fines imposed on health plans for not meeting the standards by the effective dates will be severe.

Government Relations Committee with CMS representatives.

ACOs

Terri Postma, MD, Medical Officer, Performance Based Payment Policy Staff

Dr. Postma recently joined the CMS staff as one of several Medical Officers for the Center for Medicare Management (CMM). A neurologist by training, Dr. Postma's most recent work included a role in the Senate Finance Committee on Healthcare Reform (PPACA). During our meeting, Dr. Postma provided HBMA with an educational overview of Accountable Care Organizations (ACOs) a "new" shared savings program legislated under PPACA (Health Care Reform). The comment period for responding to the proposed rule for the Medicare Shared Savings Program ended on June 1, 2011. To clarify confusion and speculation surrounding the ACO healthcare model:

ACOs:

- Are collaborations of primary care professionals and other health service providers, such as other physicians and hospitals;
- Must have the capacity to improve health outcomes and the quality of care while slowing the growth in overall costs for a population of at least 5,000 patients, cared for by a well-defined group of primary care professionals;
- Must be capable of measuring improvement in quality, data gathering and reporting; payments will increase when such improvements take place;
- Providers are eligible to share in savings demonstrated by the ACO

Potential challenges to ACOs are as follows:

- **Cost.** ACOs will likely face start-up and first-year costs six to 14 times higher than HHS has estimated, according to a study released by the American Hospital Association.
- **EHR**. 50 percent of participating providers must successfully meet EHR meaningful use requirements, which may be difficult.
- **Specialty physicians.** This program is geared toward primary care, and there does not currently appear to be a well-defined role for specialty physicians.
- **Lackluster industry support.** To date, a number of key health care organizations have expressed serious reservations about their participation in the program without significant structural changes, including: Mayo Clinic, Cleveland Clinic, Geisinger Health Systems and Intermountain Health.
- **Onerous reporting.** ACOs will be expected to report on over 60 "quality reporting metrics" – several times higher than both hospitals and physicians are reporting today.
- **The unknown.** Providers will not know who their patients are until they are through the first full year of the new healthcare delivery model. In addition, those anonymous ACO patients may seek health care anywhere they want. If they run up a health care bill at another provider's office or facility, their ACO is still responsible for the cost. This puts the ACO at risk.

Dr. Postma's Educational Overview

1. The intent of the legislation is to provide quality improvement and cost reduction through coordinated patient care.
2. CMS seeks to use the ACO model as a means of replacing the current "silos" existing in today's healthcare system. It is also a means of enhancing communication, reducing duplicate and unnecessary services which would result in enhancing patient care.

3. ACOs are an attempt to take successes experienced by integrated systems such as Geisinger, University of Michigan, and InterMountain Health Care and apply them throughout the broader health care community.
4. ACOs are seen as PQRS on steroids.
5. ACOs are not HMOs. While the goals with respect to managing care are similar, the tactics are very different. ACOs are not envisioned to pay for medical services. Although certain models have the latitude to incorporate capitated payments, the initial proposal is to simply track quality and costs across the ACO group and, should goals be met, CMS will issue the ACO a shared savings check at the end of the period.
6. This is a very ambitious project and results may not be realized for 15 years.
7. Based on results from a Physician Group Practice (PGP) Demonstration Project, quality improvements and cost savings are achievable.
8. ACOs are voluntary and there is no statutory requirement for physicians or medical providers to form or participate in ACOs
9. Beginning January, 2012, CMS is authorized to contract with ACOs that meet program requirements.
10. ACOs are based on fee for service reimbursement.

Randy Roat, CHBME, represented HBMA in the Q&A that followed Dr. Postma's presentation:

- HBMA expressed skepticism that the start-up costs of an ACO would be recovered through shared savings. Dr. Postma acknowledged that cost has been reported as a concern with this legislation. However, she cited that 60% of the PGP participants received shared savings, which, in some cases, exceeded their cost of program development.
- We discussed the premise that the FFS payment model would be unaltered in most cases. HBMA and others share concerns that ACOs may lead to full capitation, and are therefore closely following regulatory updates and implementations.
- Industry comments, including HBMA's comments, were accepted through June 6, 2011. CMS is evaluating the comments and hopes to have final guidance prior to the end of the year.

HBMA Assessment:

HBMA believes that the proposed ACO regulations, as written, contain significant flaws that have dampened industry enthusiasm toward the initiative. All of the entities that participated in an earlier CMS sponsored Demonstration Project that sought to test key components of the ACO model, have informed CMS that they will not form an ACO unless significant changes are made in the final rule. Virtually all medical trade associations (representing physicians, hospitals, insurance companies, and billing companies) have commented on serious deficiencies in the proposed rule.

It does not appear that many organizations (if any) will volunteer to become an ACO unless significant changes are made in the final rule. If CMS does make the program more appealing in the final rule, it will still be difficult for organizations to restructure and become operational by January 1, 2012. If CMS does not revise the program in the final rule, then to quote Gail Wilenski (former HCFA Administrator), "CMS may have created a party that no one will attend."

Further information about the program can be found at: www.cms.gov/sharedsavingsprogram.

RAC AUDITS

Connie Leonard, Director, Division of Recovery Audit Operations – Medicare

Monica Harris, Director, Division of Recovery Audit Operations – Medicaid

The Recovery Audit Contractor (RAC) program was established as part of the agency's comprehensive efforts to identify improper Medicare payments and to fight fraud, waste and abuse and to ensure the longevity of the Medicare Trust Fund. Barry Reiter, CHBME, Government Relations Chair, facilitated the discussion with Ms. Leonard and Ms. Harris regarding the RAC program. He will orchestrate HBMA's effort as we communicate quarterly with CMS. Barry will provide feedback from our members to ensure that we have the desired communication and information available to our membership.

Connie Leonard provided a snapshot of the first quarter's staggering results of the RAC program. $365 million in returned funds to the Medicare program and over $22 million in underpayments were reported by the RACs. The focus of the program in the coming months will likely continue to be medical necessity, reduction of the CERT error rate, short hospital admissions, and documentation deficiencies.

Monica Harris reported that the Medicaid RAC audits are run by the state RAC programs and as such, follow state standards. Because of this, there will likely be variability across the state programs. HBMA will stay close to this topic and provide members with information as it becomes available. Click on the link below to obtain further information on provider compliance education that assists providers in avoiding common billing errors and other inappropriate activities when billing Medicare fee for service.

www.cms.gov/MLNProducts/45_ProviderCompliance.asp

PROGRAM INTEGRITY

Mary Agnes Laureno, Deputy Center Director, Center for Program Integrity

John Spiegel, Director, Program Integrity Group

Zabeen Chong, Director, Medicare Program Integrity Enforcement Group

Jackie Willett, CHBME, moderated the discussion surrounding provider enrollment and shared some of the ongoing challenges facing our member organizations with CMS. She also reported on some of the areas where our members are seeing improvements.

Provider enrollment has long been a significant challenge to billing companies and their clients. During the last year, HBMA has participated with CMS during quarterly meetings focused on the improvement of the PECOS internet based system for provider enrollment. Significant resources have gone into improving PECOS and ensuring that the MACs can stay fairly current with enrollment applications. CMS understands the challenges we face in provider enrollment. They are working toward an enterprise system that will achieve a single point of access for the many systems utilized by providers to improve the provider experience, reduce costs and improve data quality. There are seven key initiatives that are included in the first phase of development. Look for additional information regarding this initiative in an upcoming issue of *Billing*. Note that updates to the PECOS system occur quarterly. If you have not attempted to use PECOS in the recent months due to previous frustrations, try again because substantial improvements have been made and turnaround times are reported to be much faster.

MACs

Karen Jackson, Director, Medicare Contractor Management Group

During our meeting, Don Rodden, CHBME, provided Ms. Jackson with questions surrounding the day to day challenges faced by HBMA members. Ms. Jackson indicated that CMS welcomes comments from HBMA as it relates to the performance of your local MAC. If you are experiencing significant issues (or if you have good experiences to report), please let the national office know.

Ms. Jackson discussed concerns within the agency on the practice of Medicare data and PHI moving offshore for processing. At this point it appears that CMS leadership is unclear as to how to interpret and enforce existing data security guidelines (see www.cms.gov/informationsecurity/downloads/ars.pdf).

These rules, although developed primarily with MACs and other CMS contractors in mind, may also apply to providers and their agents (i.e., billing companies). CMS has asked their legal department for an opinion. In the meantime, they are anxious to gain a better understanding of the extent of offshore processing within the industry. In particular, they've asked HBMA to help them understand how our industry utilizes offshore labor – what kinds of tasks are typically performed offshore, how the work is performed, what technology is used, how secure the data is, whether the offshore personnel are employed by US-based or foreign companies, etc. It would appear that CMS motives are driven by a desire to ensure data security and privacy, and that they have no intention of implementing any immediate or drastic policy changes that would "break" the healthcare delivery system. HBMA intends to work closely with CMS on this important issue and will keep the membership informed as we learn more. ■

HBMA Goes to Washington

Although no one was mistaken for the Jimmy Stewart character in "Mr. Smith Goes to Washington," a group of HBMA representatives spent a day on Capitol Hill on June 14, 2011, visiting with their elected representatives and/or staff for those members of Congress.

These Hill visits have become an annual event for the HBMA Executive Committee and the Government Relations Committee and are held in conjunction with HBMA's annual meetings with senior management officials at the Centers for Medicare and Medicaid Services (CMS).

This year, HBMA leaders visited nearly 40 Congressional offices and engaged in spirited discussions about the need to repeal the Sustainable Growth Rate (SGR) formula that is projected to result in a 30% reduction in physician fee schedule payments on January 1, 2012. Additionally, they urged their elected officials to support the repeal of the looming 3% IRS withhold that was originally schedule to go into effect on January 1, 2012 but which the IRS has now delayed until January 1, 2013.

In general, the HBMA leaders were warmly received by the elected officials or staff they met. Support for repeal of the SGR was near universal; although no one was able to predict whether Congress would approve an outright repeal or simply adopt another one-year "fix."

The lack of progress on fixing the SGR problem continues to hinge on how to pay for the fix.

The Congressional Budget Office estimates that a permanent repeal of the SGR formula would result in an additional $350 billion in Medicare expenditures over the next 10 years. This money has not been budgeted.

While Congress has the authority to add the cost of an SGR fix to the current Medicare debt, doing so would mean that the Medicare Trust Fund would be exhausted before the end of this decade. Consequently, it will be necessary for Congress to either cut Medicare spending elsewhere (hospital payments, SNF payments, other physician/provider payments) to pay for the SGR fix or raise the Medicare portion of the Social Security tax.

Sadly, far fewer Congressional offices appeared aware of the 3% IRS withhold issue and needed to be educated about this policy and the justification for repeal.

Originally enacted in 2005 as part of a tax compliance initiative, the IRS is authorized to direct all federal agencies who contract with non-governmental entities for the delivery of goods or services, to withhold 3% of the value of those contractors payments. This withheld money will be transferred to the IRS to satisfy any future tax liability the contractor may have to satisfy. These withholds will apply to Medicare payments to physicians and other providers.

Due to the controversial nature of this policy, Congress has intervened on several occasions between 2006 and now to prevent the policy from being enforced. The most recent Congressional intervention occurred in 2009 when Congress delayed the effective date from January 1, 2010 to January 1, 2011. Recently, the Internal Revenue Service announced that they were going to take an additional year to develop the appropriate internal mechanism to make these financial transfers. Consequently, the IRS has stated that they will not begin enforcing the 3% withhold policy until January 1, 2013.

Given the large number of newly elected federal officials, it is not surprising that many Congressional offices were not aware of this issue until the HBMA representatives brought it to their attention. In addition to being grateful for making them aware of this problem, the offices universally agreed to look into the matter further and will let us know how they feel about retaining or repealing this policy.

These Hill visits, in addition to creating a forum for a dialogue between elected officials and medical billing companies on issues of interest to the HBMA community, allow HBMA (and its members) to be viewed as experts in the medical billing and practice management arena. From these meetings, several HBMA leaders have been asked to serve on Advisory Committees set up by representatives and senators who advise them on emerging health policy issues.

An example of the value of HBMA's outreach efforts to elected federal officials was seen quite clearly during these recent visits to Capitol Hill.

Sherri Dumford, HBMA Director of External Affairs, set up an appointment with her Congressman to discuss both the SGR and IRS issues. Initially, Sherri was told that her Congressman was unavailable due to a scheduling conflict and that instead, she would be meeting with the Congressman's principle health policy advisor.

When Sherri arrived at her meeting at the appointed time, she was told that the Congressman, seeing her name and affiliation on the schedule, did want to meet with her personally. Sherri and her Congressman then spent the next 35 minutes discussing issues ranging from Medicare payments, to healthcare reform to the 3% withhold.

Although Sherri's experience was not typical, it was also not unique. More importantly it demonstrates the value that HBMA members can bring to future healthcare reform and Medicare reform debates.

HBMA members are strongly encouraged to reach out and make contact with your representatives and senators over the next six months. HBMA members are truly experts in medical billing and practice management. You have a unique insight and perspective on the business operations of a medical practice. Just as you offer your knowledge and expertise to your clients, you should make a similar offer of assistance to your representatives and senators.

As Congress debates and considers changes to the Medicare program, encourage your elected officials to solicit your assessment of the impact these changes might have on the ongoing financial viability of the medical practices you serve.

Who knows, just as we have doctors, nurses, physician assistants and other health professionals serving in Congress, someday, maybe we'll see an HBMA member there as well! ■

OFFICES VISITED BY HBMA REPRESENTATIVES:

Pennsylvania	Casey, Gerlach, Toomey
Illinois	Durbin, Kirk, Roskam
Georgia	Isakson, Chambliss, Price, Woodall
Arizona	Kyl, McCain
Virginia	Warner, Webb, Cantor
California	Feinstein, Boxer, Campbell, Sanchez
Kansas	Roberts, Moran, Yoder
Maryland	Mikulski, Cardin, Harris, Ruppersberger
New York	Schumer, Gillibrand, Lowey
Florida	Rubio, Nelson, Buchanan
Ohio	Brown, Portman, Jordan
Montana	Baucus, Tester, Rehberg
Texas	Hutchinson, Cornyn, Barton

Healthcare Billing and Management Association
1540 S. Coast Highway, Suite 203
Laguna Beach, California 92651
Phone: 877/640-4262 • Fax: 949/376-3456

www.hbma.org