Dear Members of HBMA,

Former President John F. Kennedy, in his inaugural speech, uttered the famous line, “Ask not what your country can do for you, but rather, ask what you can do for your country.” These inspirational words ring as true in 2012 as they did when he first uttered them more than 50 years ago.

It is hard to imagine, but when President Kennedy stood before the nation to be sworn in as the 35th president of the United States, the Medicare program didn’t exist. In fact, it would be another four years before the 89th Congress approved the creation of both the Medicare and Medicaid programs.

Now, as the nation stands on the cusp of celebrating the 50th birthday of the Medicare program, we find ourselves in the midst of a major debate over how our nation should reform the delivery and financing of healthcare. HBMA has been, and will continue to be, part of the national dialogue on healthcare reform.

On June 13 and 14, 2012, a group of HBMA leaders traveled to Baltimore, Maryland and Washington, DC, not to ask what the country could do for HBMA and its members, but rather to see what HBMA could do for our country. How can the collective knowledge and wisdom of our members help policy makers in the Medicare program and in Congress adopt and enforce rational policies affecting the delivery of healthcare to millions of Americans?

The trip the HBMA leaders took to CMS headquarters in Baltimore, Maryland was not new – there have been six prior trips. However, this was certainly the most productive meeting we’ve ever had.

I am pleased to tell you that, through the persistence and perseverance of those who went before us, CMS officials now have a very accurate and clear understanding of the role that medical billing companies play in the operational world of healthcare delivery. More importantly, CMS’s leadership values the insight and knowledge that we can share with them about what it takes to operate a successful medical practice. Finally, they know that we work on the front lines of the Medicare program, helping providers to comply with Medicare’s rules and regulations so they can focus on delivering quality healthcare to their patients.

We are providing you with this report so that you can see what we are doing in the government relations arena and how we are attempting to help shape the future of healthcare financing. Your continued support of our efforts is appreciated and we hope you will let us know when governmental issues are adversely affecting your business or the ability of your clients to deliver quality, cost-effective healthcare.

Sincerely,

Jackie Willett, CHBME
Chair, Government Relations Committee

Don Rodden, CPA, CHBME
President, HBMA
CERTIFIED MEDICAL BILLER
Valerie Haugen, Director, CMS Division of Provider Information, Planning and Development

In 2009, after consultation with HBMA, the Centers for Medicare and Medicaid Services (CMS) embarked on the development of a Certified Medical Biller initiative. This program would be operated by CMS and would provide online educational tools and resources as well as an online examination that would lead to the awarding of the “Certified Medical Biller” certificate.

On March 28, 2012, CMS announced the roll-out of this new initiative and we met with Valerie Haugen, Director of the Division of Provider Information, Planning and Development Division within CMS, to discuss the new program and HBMA’s ongoing involvement with this initiative.

CMS was very interested in securing HBMA’s formal endorsement and use of this examination as part of an ongoing effort to elevate the education and training of individuals primarily responsible for building and submitting a medical claim.

Jackie Willett, CHBME, HBMA Government Relations Committee Chair, led the discussion about the Medicare Certified Biller program. Some of the questions she raised included:

I. How will the Medicare Certified Biller Program work?
II. How many hours will someone invest in completing the Medicare Billing Certification Program?
III. Who determines what the correct answer is to the questions?
IV. Who determines what is a passing score, the individual organizations that have “approved” the program, or CMS?

HBMA is currently putting the final touches on being able to use CMS Web Based Training credits for Category III of the CHBME certification.

The Certified Biller initiative would require the individual to take 21 hours of coursework before certification is granted. In addition to the coursework, individuals would have to take an exam and achieve a score of at least 75% accurate responses in order to receive certification.

HBMA will continue to communicate with CMS and participate in the MLN Workgroup to further develop and monitor this program.

While most of the questions on the exam were developed internally, CMS expressed a desire to get feedback from HBMA on the exam questions, their relevance to determining an individual’s understanding of medical billing, and a process for ongoing feedback.

HBMA will continue to work with CMS on this important initiative. Individuals wishing to learn more about the
Medicare Certified Biller program are encouraged to visit their website.

Since the Medicare Certified Biller initiative was launched in March, more than 1,700 people have started the Part B program. Of those, approximately 10% have completed the coursework.

Once on the training website, click on the “Medicare Billing Certificate Program for Part B Providers” link and follow the instructions.

MEDICARE PROVIDER SATISFACTION SURVEY
Shana Olshan, Director, CMS Provider Communications Group

For the past several years, CMS has conducted annual Medicare Contractor Provider Satisfaction Surveys (MCPSSs), and HBMA has conducted corresponding annual surveys of its members and presented its findings to CMS.

For 2012, CMS decided to suspend the survey, reexamine the survey tool, and resume the survey in 2013. As part of this review process, CMS reached out to HBMA for feedback and assistance.

In February and again in May, CMS convened an HBMA member focus group to solicit feedback on the survey process, the types of questions being asked, and overall opinions on the value and validity of the process. At our June CMS day, we met with Shana Olshan, Director of the CMS Division of Provider Communications, to talk more about the survey process and HBMA’s ongoing involvement with CMS on providing feedback on the Medicare contractor evaluation process.

Olshan said that the survey is an important tool that CMS uses as part of their process for evaluating the Medicare Administrative Contractors (MACs) and that HBMA’s involvement in the evaluation process has been invaluable. She indicated that “customer” feedback is critically important as CMS seeks to further consolidate the MACs into larger regions with fewer contractors.

Much of the discussion with Ms. Olshan centered around the evaluation process and how medical billing companies can be included in the formal survey process. Currently, only physician offices are surveyed and, while the instructions to the provider recommend that the survey be completed by the individual(s) with the most direct contact with the Medicare contractors, it is not clear how often these surveys make their way to the medical billing company. CMS is looking into the practicality and feasibility of developing a statistically valid method for soliciting information from medical billing companies.

MEDICARE AND MEDICAID AUDITING
Connie Leonard, Director, Medicare Recovery Audit Contractor Program
Tanette Downs, Director, Medicare Division of Plan Oversight and Accountability
Steve Calfo, Director, Medicaid Division of Audits and Accountability

Due to the success of the Medicare Part A and B Recovery Audit Contracting (RAC) program, Congress authorized expansion of the initiative to Medicare Part C, Part D, and the Medicaid Program.

According to Connie Leonard, approximately 900,000 Medicare claims (mostly Part A) were denied following RAC reviews. Of those denials, approximately 50,000 were appealed.
Auditing of providers has expanded dramatically in the past few years as more post-payment reviews (and soon, pre-payment reviews) are being undertaken by both Medicare and Medicaid. HBMA leaders sat down with key CMS staff to discuss the agency’s general approach to provider audits, efforts to coordinate provider audits, and long-term steps to ensure proper payments while minimizing provider problems.

Barry Reiter, CHBME, asked about efforts to coordinate the auditing process. He pointed out that some providers finished with a “clean bill of health” from a RAC auditor only to find themselves the subject of a Medicaid audit just a few weeks later. He asked if the agency couldn’t direct the various programs to coordinate with one another to avoid the problem of seemingly redundant audits. CMS agreed to look into this situation and see if anything could be done.

Tanette Downs informed the group that CMS is still developing the RAC program that will be used for Medicare Part C and Part D, but that this program should be ready for rollout sometime in the later part of 2012.

CMS staff did indicate that they expect Medicare pre-payment auditing for certain providers to begin this summer.

HBMA will continue to explore ways to better coordinate the auditing process with the CMS staff responsible for overseeing these initiatives.

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ICD-10 AND 5010 IMPLEMENTATION

Lorraine Doo, Senior Policy Advisor, CMS Office of E-Health Standards and Services

Cathy Carter, Director, CMS Business Applications Management Group

Meeting with the senior staff of the CMS Office of E-Health Standards and Services is nothing new for HBMA leaders. Holly Louie, CHBME and Chair of the HBMA ICD-10/5010 Committee, has become a familiar face amongst the leadership of this important office.

Given the recent decision by Secretary of HHS Kathleen Sebelius to seek a delay in the effective date of the ICD-10 initiative, this meeting was particularly timely.

The office was particularly interested in discussing the billing industry’s current status in terms of 5010 readiness and discussing “lessons learned” from 5010 that could be applied to the transition from ICD-9 to ICD-10.

Louie led the 5010/ICD-10 discussion and pointed out that the failure of CMS to work with industry stakeholders to develop a definition of “5010 ready” led to a myriad of problems, not least of which was a false sense of security that the industry was further along in meeting the 5010 standards than many believed as late as December, 2011.

Furthermore, the HBMA group informed Ms. Doo that the lack of end-to-end testing of claim submissions proved to be a serious flaw in the testing process. Many providers, billing companies, and clearinghouses were able to successfully submit basic 5010 transactions to their payers, but encountered rejected claims when they went into a 5010 “live” mode.

These comments were later shared with the National Committee on Vital and Health Statistics, before whom Louie was invited to testify shortly after the HBMA-CMS Summit.
Jud Neal, CHBME, President-elect of HBMA, asked our federal hosts what their expectations were when the June 30 deadline for 5010 compliance rolled around. The CMS officials seemed reasonably optimistic that the 5010 problems would be sporadic at that time.

With regard to the proposed delay in the ICD-10 effective date, Lorraine Doo stated that they had received over 350 public comments and that the comments were all over the map. Some commenters supported the proposed one-year delay. Others were passionately in favor of keeping the original October 1, 2013 date, and others wanted an even longer delay of two years.

Finally, we discussed concerns about state Medicaid agencies being unprepared to go live on 5010, and subsequently, ICD-10. There was specific discussion about problems being seen in California and the state’s announcement that they simply will not be ready.

We were informed that CMS staff had made their recommendations to the CMS Administrator and were awaiting word on the Administrator’s decision. The CMS staff were hopeful that a new policy could be announced “soon.” However, like the term “ready,” no definition of “soon” was provided.

Committee member Dave Nicholson, CHBME pointed out the problems that this is creating – particularly with cross-over claims to commercial payers and Medicaid.

To the specific question – Where is CMS on announcing and enforcing a new POS or DOS policy? CMS had no answer. They initially thought that this would be a fairly simple policy change, but as they have gotten into it more deeply, they have concluded that it is a lot more controversial than they had anticipated.

Bob Burleigh and Holly Louie walked Amy Bassano through the white paper they had prepared along with other HBMA members on this issue. The paper outlined the problems this was creating and offered various
options for resolving them. While no solution is necessarily perfect, the HBMA representatives were strong in their statement that CMS must announce a final policy soon.

In addition to the need to have a single national POS policy, Holly Louie pointed out the problems CMS created when they attempted to only adopt a new POS policy, effectively leaving it up to individual contractors to announce a MAC-specific DOS policy.

Dave Nicholson also made Ms. Bassano aware of issues involving Independent Diagnostic Treatment Facilities (IDTF). Although IDTF is a recognized provider type for Medicare, the term has no relevance outside of Medicare. Consequently, there is not a specific “site of service” code for an IDTF, and different contractors recommend the use of different site of service codes to identify services provided in an IDTF. Nicholson asked that CMS publish a policy specifying exactly what code should be used to avoid this type of contractor-by-contractor approach.

Bassano agreed that this should be resolved and agreed to work with HBMA to get some consistency in this area.

In conclusion, HBMA recommended that CMS permanently rescind the previously announced POS instructions. Further, HBMA recommended that the physical address of the technical component be used to report the associated professional component even when the “read” may have occurred in a different location.

Bassano did state that, by and large, CMS did not care if an image was read by the physician at his/her home, car, in a park, etc. and that in these instances, the provider should use his/her office address or work location as the place of service.

MEDICARE ADMINISTRATIVE CONTRACTORS (MACs)

Karen Jackson, Director,
Medicare Contractor Management Group

Shana Olshan, Director,
CMS Provider Communications Group

Problems with Medicare contractors often head the list of issues that HBMA wants to discuss with CMS staff during the annual summit. 2012 was no different.

Of particular interest this year was the consolidation of the 15 A/B Medicare Administrative Contractors (MACs) into ten A/B MACs that CMS began in 2012. To date, only two of the consolidated MACs have been awarded: Region F – Noridian Administrative Services (NAS) and Region H – Novitas. Together, Region F and H account for 17 states in the west and south central regions of the country. CMS anticipates awarding additional MAC consolidation contracts in 2012, but Jackson offered no definitive timetable for completion of the consolidation process.

HBMA President Don Rodden led the discussion with Karen Jackson and, as in past years, the meeting was both cordial and productive.

Although not originally scheduled to be part of this meeting, Shana Olshan asked to sit in on the meeting to elicit additional feedback on the Medicare contractors.

Dave Nicholson lead a discussion on the provider enrollment revalidation process. He noted that some newly enrolled physicians were being subjected to “revalidation” by Medicare contractors within months of enrolling in the Medicare program. This issue was also raised during a meeting with CMS provider enrollment staff. Jackson
agreed that this should not be happening since it is a waste of resources; they will look into the problem.

Given the recurring problems with Medicare contractors, the HBMA officials also discussed the best process for raising and resolving contractor problems. Jackson agreed to provide HBMA with the names of the CMS regional contacts for contractor oversight and recommended that if billing companies were having problems with contractors that they were unable to resolve at the contractor level, billing companies should contact the CMS R.O. person responsible for that MAC. HBMA will share that list with the membership when it is received from CMS.

Finally, Jackson announced that CMS would be issuing a clarification “soon” on Medicare’s policy on the use of off-shore entities by providers and billing companies. In 2011, some CMS contractors had announced that due to data security concerns, they would no longer allow non-U.S. based entities to “submit” or access their electronic claims submission system. They cited a CMS policy on the use of “off-shore” data processing subcontractors as their justification.

It appeared at the time that these contractors were improperly applying a policy that CMS had developed for their MACs, FIs, and other contractors. Subsequent conversations with CMS officials seem to have confirmed this.

HBMA has been working with Ms. Jackson’s staff and the lawyers at CMS for over a year to resolve this issue.

PROVIDER ENROLLMENT
Zabeen Chong, Director,
Provider Enrollment Operations Group

No area of the Medicare program has created more problems for HBMA members and their physician clients over the years than provider enrollment. However, after years of hearing, “Sorry, there’s nothing we can do,” in response to numerous inquiries, it appears that change is finally happening.

HBMA officials previously met with Zabeen Chong when she became the new Director of Provider Enrollment. Unlike her predecessors, Ms. Chong did not come from the provider enrollment world. Rather, she came into the position from a technology background. Her lack of work in Provider Enrollment raised some eyebrows, but it soon became clear that her lack of experience was an asset, not a liability.

Right from the start, one got the impression that she actually wanted to solve problems, not lament the fact that the problems existed. Shortly after our meeting, Ms. Chong created the “PECOS Power Users Group” and invited HBMA to be a part of this group of industry experts.

Sherri Dumford, CHBME, HBMA Director of Operations, was tapped to represent the billing community on this group due to her extensive knowledge in the provider enrollment area. For the past year, Zabeen and her colleagues in Provider Enrollment have used Sherri and the other user group members as a sounding board for ideas and as a test group for enrollment innovations.

During our meeting, the HBMA leadership extended it’s profound appreciation to Ms. Chong for her work in Provider Enrollment and the many improvements she has made in such a short period of time.

Since Chong took over as Director of Provider Enrollment, numerous improvements in the PECOS system have been adopted; more will be announced in the near future.
Of particular interest to billing companies will be the policy Medicare will likely announce in the fall dealing with the ability of “surrogates” to complete the on-line application for individual physicians. CMS recently announced a new policy on using an electronic signature for physicians who enroll as members of a group and Chong indicated that CMS is working to extend the electronic signature policy to individual physicians.

In addition to discussing the ongoing improvements, Dave Nicholson and others made Ms. Chong aware of some problems billing companies have been experiencing relative to “revalidation.”

Many HBMA members have reported they are finding physician client names appearing on the CMS website that identify those providers as subject to “revalidation,” yet these physicians have not received any notification from the MACs. When the MAC has been contacted, they show no record of the physician being included in the quarterly revalidation – even though the CMS website does list the physician.

According to Ms. Chong, CMS identifies those physicians who are subject to revalidation and shares those names with the appropriate MAC. The MAC is then supposed to contact the providers and notify them that they have 60 days to update their enrollment information or be subject to having their Medicare billing privileges suspended.

Clients of several HBMA companies have come dangerously close to having their Medicare billing privileges suspended because they never received the revalidation notice and it was only due to the diligence of their billing company that they became aware of the problem.

Ms. Chong agreed to look into this problem as this should be not happening.

CMS AND INNOVATION

Mandy Cohen, MD, CMS Center for Innovation Stakeholder Engagement Group

Where is healthcare headed and more importantly, what changes in healthcare delivery and payment are CMS promoting?

CMS, as a result of the Affordable Care Act, has approximately $10 billion dollars available to support the development of alternative delivery systems and methods of payment. Through the Centers for Innovation, a division within CMS, the federal government is making seed money available to promote “new and innovative” changes in our nation’s healthcare delivery system.

It seemed somehow fitting that our meeting with Dr. Cohen occurred via a “new and innovative” way of conducting meetings when the person cannot be physically in the room: via a web connection.
Although the CMS main office is located just outside of Baltimore, Maryland, many of the senior officials also maintain offices in Washington, DC. Dr. Cohen splits her time between both cities and it so happened that on the day we were in Baltimore, she was in DC. Therefore, CMS arranged for her to “meet” with us via their internal telecommunications network.

Dr. Cohen is an internist who has taken time out from being a “practicing physician” to assist CMS in the development of these new and innovative delivery models.

Dr. Cohen informed us that thus far, CMS has obligated “only” $1 billion of the $10 billion the agency was given as part of the Patient Protection and Affordable Care Act. Dozens of “new and innovative” projects are underway, but it will likely be several years before we see the results of those projects.

Although the projects are long-term in nature, the early findings may translate into nationwide reforms if CMS can demonstrate that the projects improve quality and save money – two of the criteria Congress set when they approved the funding.

In addition to the money the Center for Innovations has to support alternative delivery models, Congress gave CMS new authority to “nationalize” an initiative without seeking congressional approval if the project could save money and improve quality.

Historically, whenever CMS identified a new or innovative change that they believed would improve healthcare and make the system more efficient, they had to go to Congress and seek specific congressional authority to adopt the program nationwide.

Now, thanks to new authority granted as part of the ACA, CMS can authorize the nationwide adoption of a new delivery model or payment policy without having to first secure congressional approval.

Jud Neal, Dave Nicholson, and Brad Lund listen and take notes.

Mission Statement

The mission of the HBMA Government Relations Committee is to monitor ongoing national regulatory activities affecting the medical billing industry; actively comment on or otherwise explain HBMA’s position on such regulatory activity through HBMA’s lobbyist group; offer HBMA expertise and research to regulatory agencies as appropriate; inform HBMA membership of pertinent regulatory activity; and where appropriate, solicit the HBMA membership position on regulatory activities.
HBMA Goes to Washington

EHR AND THE NATIONAL COORDINATOR
Farzad Mostashari, MD, National Coordinator for Health Information Technology
Judy Murphy, Deputy National Coordinator for Programs and Policy
Jacob Reider, MD, Medical Officer and Senior Policy Advisor
Nora Super, Senior Stakeholder Outreach Coordinator

Due to the success of the annual HBMA-CMS Summits, the decision was made to ask the HBMA leaders to spend an additional day away from home and visit other government agencies and congressional leaders with whom HBMA has a natural connection.

In recent years, with the advent of federal incentives for the adoption and use of electronic health records, the role of the National Coordinator for Health Information Technology has taken on greater and greater relevance for the medical billing community. Recognizing this greater relevance of ONC, the decision was made to develop stronger relationships with the senior leadership within ONC. There is no better place to start that process than at the top.

Unlike CMS, which is headquartered in Baltimore, Maryland, the Office of the National Coordinator is located near Capitol Hill. Given that the HBMA leaders were already scheduled to meet with senior congressional aides, it made sense to try and meet with Farzad Mostashari, MD, the National Coordinator, while we were “in his backyard.”

On the morning of June 14th, HBMA leaders met with Dr. Mostashari and his senior staff, including Judy Murphy, RN, Deputy National Coordinator for Programs and Policy; Jacob Reider, MD, Senior Policy Advisor and Medical Officer; and Nora Super, Senior Stakeholder Outreach Coordinator.

The meeting with Dr. Mostashari and his senior policy team covered a wide range of issues, from the long-term viability of alternative payment models and their reliance on electronic health records, to issues involving hospitals requiring the use of certain practice management software in conjunction with making the hospital’s EHR software available at a very low cost.

Dr. Mostashari’s unbridled passion, energy, and enthusiasm for making the healthcare delivery system more efficient and producing quality outcomes is obvious from the moment you meet him. The Obama Administration couldn’t ask for a more effective communicator.

The meeting was an excellent opportunity for HBMA to get to know not only the National Coordinator and his senior staff, but for them to become familiar with HBMA and medical billing companies.

COMBATING MEDICARE FRAUD AND ABUSE
Kim Brandt, Chief Healthcare Investigative Counsel, Senate Finance Committee (Republican Staff)
Matt Kazan, Senior Health Policy Advisor, Senate Finance Committee (Democratic Staff)

Who says bipartisanship is dead in Washington? Eliminating unnecessary, improper, and duplicative payments is a bi-partisan issue and HBMA proved it!

As the Government Relations Committee was preparing
their itinerary for the trip to Washington, a bi-partisan group of senators announced that they wanted to hear from healthcare stakeholders on ways to combat waste, fraud, and abuse in the Medicare and Medicaid programs. Senators Orin Hatch (R-UT), Max Baucus (D-MT), and four colleagues sent a letter to the healthcare industry asking for ideas and suggestions.

In response to this request, the HBMA leaders asked for a face-to-face meeting with the staff working on this initiative and, in the spirit of bi-partisanship, asked if we could meet jointly with the Republican and Democratic staff – and they agreed!

For nearly an hour, HBMA leaders met with Kim Brandt, Chief Healthcare Investigative Counsel (GOP staff) and Matt Kazan, Senior Health Policy Advisor (Democratic Staff) to discuss ideas and concepts on eliminating or reducing fraud and abuse. In addition, we discussed ideas and options for reducing unnecessary and redundant administrative costs.

As part of this discussion, HBMA pointed out the cost of the failure to permanently “fix” the SGR problem and the cost incurred by practices when the SGR “fixes” are enacted retroactively.

The Finance Committee staff has requested that HBMA submit formal recommendations by early July on ways we think Congress and/or CMS can reduce unnecessary Medicare and Medicaid expenditures. HBMA will convene a workgroup to produce ideas for the committee’s consideration.

CONNECTING WITH OLD FRIENDS

Bill Rogers, MD was recruited to come to CMS by former Administrator Tom Scully as part of an effort by Scully to bring providers with “real world” experience into the CMS policy making process. Although Scully is no longer the CMS Administrator, Rogers remains as a powerful force for change within the CMS bureaucracy. In addition to his work as the head of the CMS Physician Regulatory Issues Team (PRIT) and a senior advisor to the Administrator, Dr. Rogers continues to work clinically as an emergency room physician in Washington, DC, area hospitals. If that didn’t keep him busy enough, Dr. Rogers is also a reservist physician in the United States Air Force.

Over the years, HBMA has developed a strong working relationship with Dr. Rogers; he has been a tireless advocate for physicians and billing companies. On numerous occasions, Dr. Rogers has intervened with a Medicare contractor at the behest of HBMA to assist a member company in getting a problem resolved for one or more of their physician clients.

Although we didn’t have any specific issues to address with Dr. Rogers, we felt this was an excellent opportunity to say hello, bring Dr. Rogers up-to-date on what was going on within HBMA, and to say “thank you” for all of his efforts on behalf of physicians and billing companies.

During our “dutch treat” lunch, Dr. Rogers expressed a willingness to address the HBMA membership at the 2012 Fall Conference at the Gaylord National Harbor Hotel. Plans are underway to find time on the agenda for Dr. Rogers to address the HBMA membership.
HBMA LEADERS PREPARE TO TAKE WASHINGTON BY STORM!

(L-R) Don Rodden, CHBME, HBMA President; Bill Finerfrock, HBMA Government Relations; Holly Louie, CHBME, HBMA ICD-10/5010 Committee Chair; Jackie Willett, CHBME, Chair, HBMA Government Relations Committee and Immediate Past-President, HBMA; Barry Reiter, CHBME, Secretary HBMA Board of Directors and Member, HBMA Government Relations Committee; Dave Nicholson, CHBME, Member HBMA Government Relations Committee; Bob Burleigh, CHBME, Member, HBMA Government Relations Committee.