Centers for Medicare and Medicaid Services
Physician, Nurses and Allied Health
Open Door Forum
Moderator: Jill Darling
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2:00 p.m. ET

Operator: Good afternoon. My name is (Amy) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Physician, Nurses and Allied Health Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, please press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

I would now like to turn the call over to Ms. Jill Darling. You may begin.

Jill Darling: Thank you, (Amy). Good morning and good afternoon everyone. Thank you for joining us today for the Physician's Open Door Forum. I'm Jill Darling in the CMS Office of Communications.

Before we get into the agenda, one brief announcement from me. This Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

So first stop, we have Felicia Lane who will go over Open Payments, review and dispute. Felicia?

Felicia Lane: Great. Thank you, Jill. My name is Felicia Lane from the Division of Data and Informatics in CPI, the Center for Program Integrity. We're in the Data Sharing and Partnership Group.

I wanted to share with you as a reminder and if you were on the March call, Open Payments is a national program that promotes transparency by publishing data on the financial relationships between the health care industries and health care providers.

The data includes payments and other transfers of value made to physicians and teaching hospitals along with the ownership or investment interest held by the physicians or their immediate family members in the reporting organizations.

Information reported by industry to CMS about a physician could include items such as speaking engagement, consulting fees, travel expenses, meals, entertainment, gifts, research grants, just to name a few.

Based on our January data refresh, CMS published 11.91 million payment records, transfer of value or incidence of ownership or investment interest that occurred in 2015. This financial transaction totals nearly $7.33 billion.

The data collected by the Open Payments program are self-reported by applicable manufacturers and our group purchasing organizations (GPOs) and CMS publish the financial data for each program year by June 30th on our public CMS Open Payments website at openpaymentsdata.cms.gov/

The public website is designed to increase access to and knowledge about these relationships and provide the public with information to enable them to make informed decisions. The public can search, download and evaluate the reported data.

Applicable manufacturers and GPOs should have submitted data to CMS for payments, transfers of value, and ownership /investment interest that were incurred in calendar year 2016, as well as corrections for 2013, 2014 and 2015.

We are currently in the review and dispute period which started on April 1st through May 15th. The resolution are directly between the physicians or teaching hospitals and the reporting entity.

CMS does not mediate disputes between the reporting entities, physicians and teaching hospitals. The dispute resolution takes place outside of the Open Payments system. In order for the dispute or correction to be reflected in our June 30th publication date, the dispute must be initiated by May 15th. There is an additional 15 days after the review and dispute period from May 16th through May 30th for reporting entities to change, correct or validate the data. As mentioned earlier, the data is published on our CMS public website for this year, it's going to be Friday, June 30th.

Physicians and teaching hospital can still register in the Open Payments systems and there are several steps that you can take. For those new to the Open Payments system, you can register – the registration requires two steps.

First, register into our CMS Enterprise Identity Management System, EIDM and then register into the Open Payments system via the EIDM. In doing this process, we ask you to have handy you're National Provider Identifier Number, your Drug Enforcement Agency Number and your State License Number.

The registration process takes about 30 minutes to complete and must be finished in a single session. Users can't save entries or complete your profiles at a later time.

Now for those who are already register with the Open Payments system, you can log on to confirm in EIDM that your account has not been deactivated. For physicians' accounts, if you have not logged in within 60 days, you are locked out but you can gain access by answering the challenging questions you previous setup within the system.

If it has been over 180 days since a physicians or teaching hospital has logged in to the EIDM, your account has been deactivated for security purposes and

we ask that you call out help desk at 1-855-326-8366. Hours are Monday through Fridays from 8:30 to 7:30 Eastern Time or you can visit our website at openpayments@cms.hhs.gov.

On our website, we do have links to our Review and Dispute Process Quick Reference Guide, Review and Dispute Timing and Data Publication Quick Reference Guide and our Physician and Teaching Hospitals: 2016 Program Year Registration Tutorial.

Now is the time to start gathering any documentation which you can use to track the payments and transfers of value you received from industry in 2016 so you can be prepared to review, affirm or dispute any data now that we are in the Review and Dispute period.

For more information about Open Payments in general and about our Review and Dispute process, please visit our website at www.cms.gov/OpenPayments. I think that's all I have to cover today. Thank you for allowing me the opportunity to share this information.

Jill Darling: Thank you. Up next, we have Michael Dorris who has some updates to products from the CERT A/B MAC Outreach and Education Task Force.

Michael Dorris: Thank you, Jill. My name is Michael Dorris. I'm with National Government Services and I'm proud to lead the CERT A/B MAC Outreach and Education Task Force.

The task force is an effort to educate and assist on ways to address claim errors to our physicians. A Medicare A/B Contractor CERT Task Force was established in 2010 and I'm proud to say that all the MACs throughout the country as well as close to nearly 50 members from each of the MACs participate on a monthly task force call.

Our goal is on the CERT A/B MAC Outreach Task Force to ensure consistent communications and education to reduce Medicare Part A and Part B error rates so we coordinate together, we share ideas and so the task force education is intended to complement the CMS and MAC individual error reduction

activities to enhance those and to maybe put our little spin to it onto where we can help reduce errors on claims.

On the agenda, you'll see if there is a link – that like takes you to a presentation. You may need to copy that link and put that into your browser without the bullet point. It will take you directly to the presentation as well as to link you to other important resources that I will mention on this presentation.

Next, we looked at as a task force how we can work together and coordinate our messaging throughout the country – we have a lot of different products that we have out on the CMS website and I provided you on the presentation a direct link. They'll take you there.

One of – the ways that we thought would help our Medicare providers to give a short blast on important topics and so there is a fast facts on this CMS Provider Compliance Page and then there is also previous fast facts that we've used throughout the year as they are stored out there as well. These are 800 characters or less and it gives important direct information that you might need and also the resources to back up the fast facts that we are trying to promote.

We also looked at another way of how we can work together in building more detailed products, working with CMS and the Medicare Learning Network on some co-branded products and these are more like scenarios, articles, fast facts that kind of thing as well as a fact sheets we work together, we spent a lot of time on is Caring for Medicare patients as a Partnership. It's more of an article. It's geared towards our treating physicians and non-physician practitioners and it's important for sharing your documentation, your orders with the other physicians and health care providers that may need the doctor documentation or certification.

A highlight that we pointed out in this document is the Health Insurance Portability and Accountability Act, HIPAA, privacy rule, permits disclosure, protected health information benefit sharing or authorization to carry out

treatment, payment or health care operations. Providers request for documentation cannot be charged for. It is not a HIPAA violation.

All the MACs have received some feedback from our providers or physicians that they are not allowed to share that particularly to a home health agency or to a DME supplier because they think that they could violate the HIPAA rules and this document clearly states that it does not.

It also demonstrates a sign of strength that all our medical directors at each A/B MACs throughout the country have endorsed this article and in support of Caring for Medicare Patients as a Partnership.

Another documentation that you'll see out there, the CMS A/B MAC Task Force webpage is complying with medical record documentation requirements and that expands off of the document that I just mentioned earlier in the importance of sharing documentation with anyone who needs it – for your treatment plan of care for your patient.

Those are just a couple ones I want to highlight and we're also moving into a new direction of some other ideas. You know, maybe fast facts work for you, maybe fact sheets work for you or maybe you'll need a computer-based training module or potentially video so we have a CBT out there – that might be of interest to you on a topic specifically on in-patient rehab facilities. That would be a really good one to view and share with your billing staff and specifically addresses improving documentation positively impacts CERT (errors).

So those are just things that we're looking at. I want to bring highlight to those documents, to those different various educational products that we are working together with CMS and the Medicare Learning Network and all MACs to enhance your efforts to submit error-free claims.

Thank you, Jill. That's all I have for today.

Jill Darling: Thank you, Michael. And last we have Renee O'Neill who will go over the medical record request for the HHS Risk Adjustment Data Validation Program.

Renee O'Neill: Thank you, Jill, and thank you everyone for giving me the opportunity to discuss this with you. So I represent the Center of Consumer Information and Insurance Oversight Division also known as CCIIO, which is in charge of implementing many provisions of the Affordable Care Act.

I particularly represent the Division of Risk Adjustment HHS-RADV Team. I am here today to provide you with information regarding the HHS Operated Risk Adjustment Data Validation Program, also known as HHS-RADV and the requirements related to medical record request.

So first, I'll provide you with an overview of the Affordable Care Act Risk Adjustments Program, which is a budget-neutral program that transfers funds from plans with low-risk enrollees to plans with high-risk enrollees in the state market risk pool.

The participants in this program are health insurance companies, which we refer to as issuers who is in an Affordable Care Act compliant non-grandfathered individual and small group market plan inside or outside the marketplace. This is done through – this is all established through criteria in methods developed by the secretary of HHS in consultation with states and issuers.

So having said that, now I'm going to just give you a high overview of what HHS-RADV is all about. So HHS is required to annually validate the accuracy of risk adjusted data submitted by health insurance companies with risk adjustment covered plans through the validation of medical records. This process is known as HHS-RADV and is through Section 1343 of the Patient Protection and Affordable Care Act, which establishes a Permanent Risk Adjustment Program of which HHS-RADV is a component of and the HHS Operated Risk Adjustment Methodology is a component of.

So to that end, HHS needs providers to help in that they need to be aware of the activities related to the ACA risk adjustment and we feel they play an important role in this process; thus, providing the ICD-10 diagnosis codes and providing the highest level of specificity are critical to an enrollee and issuers risk scores. Medical record review is necessary to evaluate the success of the ACA risk adjustment.

Under HHS-RADV, an issuer or health insurance company or its delegated entity that they might contract to do this for them on their behalf will be required to review medical records as part of – as part of a random sample audit. The audit pertains to services provided during a calendar year, with the current year being for the benefit year of 2016 which is what we're working on – on this year.

So the 2016 HHS-RADV Medical Record Review process will begin May of 2017 and will be completed in January of 2018. So compliance with this request is applicable to all providers whether or not the provider has the contractual agreement with the issuer or health insurance company.

All the medical records will be requested directly through the issuer or Health Insurance Company or their designated company and the providers are required to send the medical record requested directly to the requesting issuer or insurance company or delegated entity. This does not come directly to CMS or HHS or any of our contractors.

So again, I want to thank you for the opportunity to provide this information to you all. We just are trying to use any venue that we have in order to communicate this to physicians and providers, so that they are aware of this requirement. Thank you, Jill.

Jill Darling: Thank you, Renee and Michael and Felicia. Amy, please open the lines for our Q&A please.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your

questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may again press star one to join the queue.

Your first question today comes from the line of Carl Langhoff of Marshfield Clinic. Your line is open.

Carl Langhoff: Good afternoon. Can you hear me? Sorry.

(Crosstalk)

Jill Darling: Yes, go ahead.

Carl Langhoff: OK, sorry, I wasn't sure. My question is in regards to the National Diabetes Prevention Program. Given that CMS is recommending that we follow a CDC requirements for the program, how do you anticipate the service to be billed if a lifestyle counselor is providing the service? It's our understanding that they're not a billing provider, so would it – would it require a supervising dietitian or an MD?

Felicia Lane: Hi, this is Felicia Lane from the Provider Billing Group. That will be coming out, those details, as part of the physician fee schedule rule. So you will be able to read, answers all those questions and many more about the Diabetes Prevention Program. You're correct that it will be following CDC guidelines for credentialing of the programs themselves but all of the details about how they – coaches will bill and how the services will be reimbursed will be included in the rule.

Carl Langhoff: OK and do you anticipate when that would be coming out?

Marge Watchorn: This is Marge Watchorn with the division of practitioner services. Generally speaking the proposed physician fee schedule rule comes out on or about July 1st of each calendar year.

Carl Langhoff: All right, I appreciate it, thank you.

Operator: Your next question comes from the line of (Paul Kesselman), a practitioner. Your line is open.

(Paul Kesselman): Yes, hi, good afternoon. My line got very staticky at the time the first speaker was giving the phone numbers regarding open payments. It's been a while since I check, so I'd like to get that phone number to reactivate my number.

Felicia Lane: Sure, it's 1-855-326-8366.

(Paul Kesselman): OK and for purposes of clarification what information do I – will I need besides my NPI number?

Felicia Lane: Your DEA number and your state license number.

(Paul Kesselman): OK, all right, thank you very much.

Felicia Lane: You're welcome.

Operator: Your next question comes from the line of (Kim Shada) of Texas Oncology. Your line is open.

(Kim Shada): Hi, on the ACA audits did you say that it was a random audit. We're being told by our payers that we have to submit every date of service for every patient that we saw which is terribly cumbersome.

Renee O'Neill: No, ma'am it is – say, random audit is specific to a certain number of enrollees that the sample will be provided to them for in certain HCCs that they would have to be reviewed.

(Kim Shada): OK.

Operator: Your next question comes from the line of (Peggy Evans) of (EAD). Your line is open.

(Peggy Evans): Oh I think my question has been answered. I too have heard from members about every patient that they've seen for the last – this last year or last year, 2016, that they're asked to send those records. And for small specialties of

one or two doctors, that's very onerous. They don't have enough staff to do that type of work, so it's certainly not random from – from what I hear from our members. Thank you.

Renee O'Neill: You're welcome and just to clarify again, it is only for high-risk pool and certain HCC and the number of enrollees being pooled per issuer is limited.

(Peggy Evans): It doesn't seem to be that though. I have to – and I don't – I don't have the paperwork in front of me. I am just repeating what I'd been told by our members that this has gotten to be, you know, and it seems should – they do the same patients over and over again, even though the patient haven't been seen.

Renee O'Neill: Right and again, also to clarify that, we haven't provided them the sample yet. So if you're being required to provide something to them, I am not sure that's coming from some other source but we have not provided the sample yet for 2016 benefit year.

(Crosstalk)

(Peggy Evans): OK, so this isn't – this is new but as I understand Medicare requires – of what we've been told by the Medicare Advantage program that Medicare requires that they look at a certain amount – they audit a certain amount of charts to make sure that the physicians are following suit of what they're supposed to be doing. So, that they – the Advantage programs can answer back to Medicare saying, that yes, we've identified these records and they're fine. So, this is a different program that we're talking about.

Renee O'Neill: That's right, so the program that I'm talking about is related to the Affordable Care Act and so this is, you know, non-Medicare, Medicaid members, the CERT.

(Crosstalk)

(Peggy Evans): OK. Are you familiar with what I'm talking about?

(Crosstalk)

Renee O'Neill: No, I'm not.

(Peggy Evans): OK, all right, because this is getting to be very onerous that – that they're just asking for huge amounts of charts, I mean 100 of charts for small offices, it's crazy. So I appreciate your help, thank you.

Renee O'Neill: Thank you.

Operator: And your next question comes from the line of (Laura Helt) of the Medical College. Your line is open.

(Laura Helt): Yes, thank you. Mine is on the same thing about the records request. So for clarification you're saying this would be commercial payers based on ACA and it would requesting from a list and will they be using a standard request to form that references this program?

Renee O'Neill: Yes, this if for commercial and each individual insurance company will have their own method of requesting it because they are also contracting companies to do this on their behalf which are called Initial Validation Audit companies, IVA companies that will be doing the validation. So – because this is something that is their population, HHS or CMS doesn't regulate on how they go about requesting it, so there's no specific method but they will be requesting HHS for the market – ACA market pool.

(Laura Helt): Great, thank you.

Operator: Your next question comes from the line of (Frederick Diplo) of Yale University. Your line is open.

(Frederick Diplo): Yes, hi, I just wanted to point out on the agenda, the hyperlink to the Physician and Teaching Hospital 2016 Program doesn't seem to be working. And I may have missed part of that presentation but can you just review the highlights of that again please?

Felicia Lane: Sure, you can actually go to our website, www.cms.gov/openpayment and you should be able to pull the guide up that way.

(Frederick Diplo): Thank you.

Felicia Lane: You're welcome.

Operator: Your next question comes from the line of Emily Graham of Hart Health Strategy. Your line is open.

Emily Graham: Thank you so much. Similar to a lot of the concerns that folks are describing related to the Medicare Advantage risk adjustment record request. Specialty providers are going to be very concerned about their record request that they get associated with the HHS-RADV program and this is – apart from the first Friday call, this is also another venue where they're hearing about for the first time and there still doesn't to be any information available on CMS or the (Inaudible) website.

Can you tell us when you're going to be able to post information on CMS' website, so that it can be disseminated more broadly?

Renee O'Neill: Sure. So, we're right now working with leadership on clearing that information. So as soon as possible, we will have something up, hopefully, you know, again the sample doesn't go out to issuers until May – the end of May. So, we hope to have it all work out by then.

Emily Graham: And do you anticipate that some of the educational materials will note that providers can charge for these medical record requests?

Renee O'Neill: Yes.

Emily Graham: OK, great, thank you so much.

Renee O'Neill: Thank you.

Operator: And again, if you would like to ask a question, please press star then the number one on your telephone keypad.

And your next question comes from the line of (Kathleen Taipo) of the University of Rochester. Your line is open.

(Kathleen Taipo): Yes, I was wondering for those record requests for the Affordable Care Act one, is it mandatory that somebody response and sends in 100 records, whatever they asked or is that mandatory or is it optional?

Renee O'Neill: This is the requirement from HHS and it – I'm not sure about the number of records. It will depend on the level of HCCs that the particular issuer might have.

(Kathleen Taipo): Well what happens if you don't do it?

Renee O'Neill: Well, nothing really happens if you don't do it but the issuer and, you know – does not get credit for those HCCs in their risk pool.

(Kathleen Taipo): OK, thank you, that's what I thought.

Operator: And there are no further questions at this time. I turn the call back over to Ms. Darling.

Eugene Freund: This is Gene Freund. I just want to make a quick comment concerning the HHS-RADV. I really do want to stress that, you know, the risk adjustment is how they compensate some issuers for getting a worse distribution of their enrolled lives than others. And that you really are helping the system work if you do participate, that's separate and we would like to hear about issues if they're coming up regarding onerous request but we really would encourage you to participate as much as you can in those efforts because it really is important to do.

Jill Darling: Well, thank you, everyone. Thank you to all of our speakers and participants. Our next Physicians Open Door Forum is scheduled for June 14th but note that the date is always subject to change as well as the agenda items. So thank you everyone, have a great day.

Operator: Thank you for participating in today's Physician Nurses and Allied Health Open Door Forum. This call will be available for replay beginning today at

5:00 p.m. Eastern through April 28th at midnight. The conference ID number for the replay is 57730665. The number to dial for the replay is 855-859-2056.

This concludes today's conference call. You may now disconnect.

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