KPMG US KAUDIOKCONF

Moderator: Celeste Scavetta
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9:00 am CT

Man: Good morning everyone. Welcome to the Department of Health facilitated discussion with our payers representing the state of New York. As it relates to opening remarks I am going to turn it over to (Tony Negliari) representing the Department of Health.

(Tony Negliari): Appreciate everybody coming. The payer association meeting we are having today is kind of limited to the personnel in the association. And personnel from (unintelligible) we've been auditing and have audited in the past simply to get as much information and feedback from you people as we possibly could, with the hopes of trying to make the process as smooth as we can on a going forward basis.

It seems like we have some common issues that are coming up in both the payer and provider audits. And, you know, I really think it goes a long way if we can have a good frank discussion about what the issues are, how they've been handled in the past and also, you know, how we can make it better. So, alrighty (sic), you know, we have had a couple of meetings this week. First with the provider association and then with the payer association representatives which we felt that it went very well.

And again, you know, a lot of the issues are common to both sides of the fence on this. You know, obviously discreet physician billings and co-pay deductible issues. You know, (unintelligible).

So, you know, that being said during the course of the discussion (unintelligible) person from the Department of Health kind of described (HICKRA) as a perfect screwed up system. And when you think of audit it is in a lot of ways, you know, there are a lot of (unintelligible) repairs with the (lower). With that being said 99% of (it) is working the way it should be worked. So (unintelligible) today to kind of address that 1% and see how we can make it better. So that being said I will turn it back over to (Anthony).

(Anthony Monico): Thank you (Tony). (As a way) to formal introductions, my name is (Anthony Monico). I am a partner at KPMG. I do have ultimate responsibility as it relates to our current contract with the Department of Health. We have a number of team members here this morning that we'll introduce as well. But what is most important is that we have - over the years, have developed a great working relationship with the Department.

And I am very pleased to see and even in (Tony)'s opening comments as it relates to trying to make the perfect storm better as I would put it. And - which gives reasons for our meeting this morning with the payer community. And then this afternoon we have a similar meeting scheduled for the provider community. I applaud the Department as it relates to trying to identify those issues as it relates to what is coming out of these audits.

And put (a) better process in place so that ultimately it would be less painful for the payers as well as the providers throughout the state of New York. As it relates to certain administrative matters, for those of you who are participating via Webcast. You can dial in, there is a phone number that you can dial in as well from a conference call standpoint. Questions will appear on your media player on the left hand side of your screen because there is going to be a mechanism for questions to be submitted for those who are participating via Webcast.

We are scheduled to provide CPE credits for this session. And so for the folks that are participating live here in the New York City area, not to be concerned. However for the folks who are participating via the Webcast there will be questions presented throughout the duration of this morning's session. And you need to respond to effectively get the credit. Okay?

So those of you who are in here again in the New York City area there is no reason for you to respond to the questions. You will be getting the CPE credits automatically. We will be circulating a form for you to sign. So to the extent you (are required) CPE credits, please make sure you sign that form prior to leaving today.

You can see one of our directors (Megan Watson), she is standing in the back of the room. As it relates to submitting questions, there is a button located in the media player.

Please submit the question using that (vehicle). For the folks that are here live in New York City, we do have a cordless microphone that will be available.

So please raise your hand and any who is facilitating the session this morning will bring that - will address the question. The question will be repeated to the extent to folks who are participating Webcast can not hear it. So one of our facilitators will repeat the questions for the purposes of everyone again who is participating. To the extent you are having problems seeing our slides or hearing.

Again, please - there is a number that is on Slide 1. That you can call and one of our technicians will help you through the technical problem that you're experiencing. Just to make note that there is a 30 second delay for those who are participating via Webcast. So please be patient as it relates to the open dialogue that we will be having this morning.

As it relates to what we're going to try and cover today, either today's session unlike maybe some of the other sessions we've had in the past with the commute pay community. This is meant to be an open dialogue. We do not have a number of slides to walk through as it relates to actual content. We are going to talk through many of the issues that have been identified. That have been coming back from the reviews that have been conducted by KPMG as well as the other firm that is support KPMG in the subcontractor relationship standpoint.

And so we've - have issues that we're identified. We've pulled the group as it relates to the level of importance. And so our plan today is again, to have an open discussion as it relates to that. The discussion will be open. So to the extent again, the folks who are participating via Webcast we do have someone who will be receiving the questions in a timely fashion.

And those questions will be presented to the group so then again, we can have an open dialogue. Just moving through the actual introduction on Slide 3. (Tony Negliari) already provided us with open comments representing the Department of Health. We have two other representatives here from the Department of Health. (George Lengio) and (Jackie Duros), as it relates to our KPMG team who is representing and will be facilitating this session.

You have (Rory Castello) who is a manager and director. (John Kanitennis) a manager, (Pat Bliend) who's name is not listed on the side who is also a manager. And (Chris Paul) who will also be representing KPMG as it relates to this facilitated discussion. Moving to the next slide which is going to talk about session objectives and ground rules. As I already have mentioned the purpose of this meeting is to have an open dialogues and facilitated discussion as it relates to the issues that have been brought forth from the payer community.

Also as it relates to what has been identified from our conduct of these audits. And so what is going to be given back to the community is as much dialogue that we get here today. So the plan on how we're going to move forward is that we have a number of issues that were previously identified that were submitted through the survey process and we will walk through each one of those questions. And the plan - and where the dialogues comes in is really trying to identify with the folks that are representing via here in New York City as well as via Webcast.

What are some recommendations on how to fix the issues that have been identified? Okay, and so we will then - coming out of this meeting summarize all of the recommendations that have been brought forth. And work with the Department and the Department will then try to figure out what other appropriate costs action as it relates to fixing the issues that have been identified.

And with the recommendations that are coming back from this community. I think the important thing to note is that, you know, there are no promises here. I know the Department has been very proactive in trying to fix many of the issues that have been previously identified. I know over the years that I have been involved with this engagement.

There have been a number of items that have been appropriately addressed and actions have been put in place as a way to try to (remedy) the situations. But, you know, the plan is, is to look at the ones that are in front of us today. And working with the Department, try to put appropriate costs of action as it relates to fixing the issues that are in front of us. The conversation needs to be constructive.

The plan is at this point is that the Department will not interact as much as it relates to this dialogues. It's going to be between KPMG and the payer community. So this is not one that's going to be a back and forth between the Department. We're here to facilitate the discussion. So the more discussion we get I think the ultimate results will be better for the communities. So we need to have an open dialogue as it relates to each of the topics that we'll be covering.

We do recommend that you refrain actually using payer names and so on. And providing examples if it gets to that point as it relates to having that dialogue. We can more - from a standpoint of using examples versus again, payer names because obviously we have a number of other folks that are participating. And we want to try to remain this to be at a level of confidentiality or keep the names out of our discussion.

So that's the plan of attack as it relates to us moving forward. Does anyone have any questions before we - before I turn it over to (Rory) and commence with this mornings discussion? So with that I will turn it over to (Rory Castello). He's going to walk us through the feedback received to date. And then we will get into the actual discussion.

(Rory Castello): Good morning everybody. Thanks again so much for taking time out of your busy day and your busy week to come down here and be with us. As (Anthony) said, you know, we've done a few number of outreach sessions like this. The ones before that were obviously - (we're us) up here or (Tony) up here pontificating about what we are doing and telling you what it is.

Here you really have true opportunity to kind of give us your thoughts on what these topics are. So please avail yourself for the opportunity we have here today. And for those of you who are on the Webcast it's actually kind of funny. This is a little like - I don't know, like a college class. There are no - there is nobody sitting in the first two rows.

I bet you if this was a Yankee game those first two rows would be completely full, you know. So I don't know what that's about. I think I go to church on Sunday, it's the same way. Nobody sits in the first two rows either. So let's talk about the feedback we've received. We put together - (Meg Watson) and (John) and (Chris) came up with the

survey that was sent out. You know, so the feedback that we had received so far in order of significant - on the topics that you all wanted to discuss.

Sorry, let me go to - was all - obviously the one that was tried and true to everybody is our private practicing physician's dilemma. The second one was historical membership data. I think we have had that problem I think since the day we started pretty much. And we continue to have that issue. Some people thought Medicare - we had some issues around that that we wanted to talk through.

Co-pays and deductibles, that's a new one. But it has a - there is no less pension around that one than I would say the private practicing physician's one. We have some service level exclusions we need to talk through. And a tried and true one which is referred out patient labs which continues to dog a number of people, I see a couple of people nodding their heads already about Number 6.

So before we go forward those are the six that are - order. They're (first stack) ranked. We are expecting to spend, you know, ten to fifteen minutes on each topic, as much as we can. Does anybody have anything else that they want to add to the list before we go forward? We have a - well there is a good one. We do have a mic.

Man: Risk sharing arrangements.

(Rory Castello): Risk sharing arrangements. You couldn't pick an easier one? Why don't we pick an easier one than that?

Man: Medical home (pass through).

(Rory Castello): Medical home (pass through). (Anthony) is being our scribe. So you have risk sharing arrangements, medical home (pass through), anybody else? Anybody else brave enough? No? Okay, we will make sure we get to those items. So the way we like to do this, this is truly a facilitated session. I could get up here, I could go through the seven or eight slides we have. I could be done in 25 minutes. I could let you know what I think of these issues.

But that's not what we are trying to do. These are the main questions that were given back to us through this survey to discuss through private practicing physicians. So just to kind of make sure that we're level setting around the same - on the same wave lengths. Private practicing physicians in terms of an issue people what to know what's the difference between discreet billing for private practicing physicians and professional services rendered by a facility?

How should records relate to instances of this be identified within the data? And what is considered sufficient supporting documentation for the criteria identified? So why do we start with the first issue. What is the difference between discreet billing for private practicing physicians and professional services rendered by a facility?

Can someone tell me what they think the issue is here?

Man: (Unintelligible).

(Rory Castello): Does everybody else have the same understanding? Anybody else want to add anything else to that? (Kyle) there is one.

Man: (Unintelligible).

(Rory Castello): Right. I think that's the key differentiator, right? So (there has) to be a private practicing physician as opposed to a (salaried) physician at a hospital. And that is the distinction that we make. So the problem that we have when we're pulling the data, we see (that that) identification number from the provider on a technical slide - on a professional claim and it's hard for us to make the distinction between what is a private practicing physician who was using discreet billing mechanism and a salaried physician.

So we understand what the issue is. Are we all in agreement on that? So what do we need to do? Seriously, what do we need to do? What's causing our problem? Or what would you like to do?

Man: (Problem is solved).

(Rory Castello): It's solved, excellent.

Man: (Unintelligible)

(Rory Castello): You got that right. So we're not using the modifier. So is that our action item? Is that our action item to get the - describe to - or educate the provider community about this modifier? We've got an awful lot of other mechanisms in place. I mean we've got this - a group of letters that we're gathering. And using them on the reviews that we're conducting. Does everybody think it's as simple as that?

(Harold), (Matt) - (Harold Issm) has got a question.

(Harold Issm): I don't think it's a (unintelligible) because the variation in the arrangement is a little more complicated than just they're either salaried or they're not.

((Crosstalk))

(Harold Issm): And physicians can sometimes be (unintelligible). And there are so many arrangements between physicians and (unintelligible). So, you know, and then, you know, working at the ground rules for the modifier and requiring it, that it really be required as a matter of regulation and then saying to the payers you can rely on that would be a good provision. But, you know, there may be other more fundamental solutions as well.

(Rory Castello): Okay, so...

(Harold Issm): (Unintelligible).

(Rory Castello): Okay. So (Harold)'s thought there is the modifiers - not going to work. There is too much complexity.

(Harold Issm): I didn't say it couldn't work, it wouldn't work completely. I think it would largely work if you could specify very clearly when it must be used.

(Rory Castello): Okay. Let's think about that. You've got the mic, you're still on. You're still - ah. Let's think about that. If you said - we have to specify how it's going to be used, what kind of instructions do we have to give? Because again, folks, remember we're trying to drive towards (at least) action items that get us to solutions.

But if we can get to a solution so much the better. So what do we need to - how do we need to instruct?

Man: (Unintelligible).

(Rory Castello): By the way, for the people getting the mic you have to talk up pretty loud so people on the Webcast...

Man: Okay, this is simple. I mean, take a look at, I don't know, the IRS. They give very specific instructions with a lot of examples (unintelligible) case studies (unintelligibles) every form (unintelligible). With all due respect to the (unintelligible) rule, this could have been fixed about two years ago. (Unintelligible). What needs to happen is take all of the examples that you come up with (unintelligible) all these issues and create a whole bunch of scenarios and address them in a very clear manner. (Unintelligible) very clear bias on where they're (unintelligible), on what terms. So (unintelligible) very clear guidance and very specific instructions.

Woman: (Rory)?

(Rory Castello): Yes?

Woman: Just for the purpose of the Webcast, individuals cannot hear (unintelligible).

(Rory Castello): Okay, fair enough. If I may paraphrase a little bit, I will try anyway. The idea being that, you know, (Ugala) came up with the idea - or the idea has been out there actually. That, you know, this modifier on a claim form has to be toggled by the providers which would indicate how (this one) then came back and indicated that well - that is relatively simple. But yes it would work as long as we provide to (Ugala)'s point as many scenarios and examples as we possibly can to provide the appropriate guidance.

To the provider community to make this work. Does everybody agree with that? So our action item I think - well it is kind of two I think. The action item would be first of all, we've got to set - what (Chris) wrote up there on the board is we've got to set the ground rules. We have to come up will of the examples and provide all of the instructions. And then we have to turn around and we have to educate the provider community. Does anybody have an issue with that?

Does that sound like a logical action item for this issue? I will tell you what if that works, things would be a lot easier. I can guarantee you that the reviews will go a heck of a lot faster. (Unintelligible) solution but obviously, you know, there are reviews that are ongoing right now and - places we're starting a few more (out). I think one of the other sort of goals of this session is to sort of work through - okay the modifier, that would be great if we can get that up and working.

Is there anything else that you guys a community or - on your individual engagements, you know, think would be another solution? So, you know, I think the modifier would be a potential good solution. Is there anything else out there that we could use now? And I think that's why we have everybody together here so that if, you know, we can just kind of brain storm it, right? I think that's kind of the goal.

So certainly the modifiers - I think that kind of - we came to the end of walking that one through. Is there anything else out there that you guys, you know, maintain in your claims system that you guys think are - you know, can get us to where we all need to be to get that level of comfort? I know that, you know, there are some letters out there that sort of thing. So, I mean any comments about a different approach maybe?

The (unintelligible) of the approach we just talked about would be well - certainly take care of questions two and three on the slide. To get that, if there really is - so the question is how should records related to (instance) of this (be) identified within the data that would actually be relatively simple? Direct - you direct to the set modifiers (show) us the field and we're (unintelligible).

Assuming that works and that was considered sufficient (for the) documentation for the criteria identified, we'd have to work through that. But this answer is probably a good answer. I just don't know how long it would take us to put in play. So to (John)'s point, is there anything more short term that would work before we move on?

Man: I recommended that I think you issued some (prior) advice (unintelligible).

(Rory Castello): Correct.

Man: (Do we talk) (unintelligible) assuming that (unintelligible). Professional corporation (of employment) (unintelligible).

(Rory Castello): Well that's going to hard for me to (counteract). But the idea was that, you know, we rely on 1099 forms and several other items that don't always get us all the way to the answer in the end is the (way to summarize that). And that is true. I think everything that has come up so far has been relatively (unintelligible). There hasn't been a full answer or full solution. So I would agree with that. Another question.

(Ugala): (Unintelligible) challenges. (Unintelligible) indication that (unintelligible). Are you putting the (letter of proof on the data) then (unintelligible). On the (insurance) provider (unintelligible). Should be (in some respect) that (unintelligible). The second thing is the letters that are being used (that aren't resisting to hospitals) they don't really want to sign anything.

Again, that has to be something (unintelligible). You have to do that to (the physician). (Unintelligible).

(Rory Castello): So there were two primary points there. (Ugala) opened up by summarizing that, you know, which every way you go. If you use the (HICKRA 1500) approach, you know, somehow that becomes acceptable. And we're not saying that it is. You know, you have to understand payer policies and procedures in order to understand whether the (HICKRA 1550) is acceptable. If you go the modifier approach which then puts the burden of proof actually out on to the provider community you have to understand

policies and procedures and the law out on the provider side to figure out whether this is acceptable or not.

Fair point, I mean so I think, you know, I think maybe one of the action items there is depending on which way we go I think you're going to have - you (will) have to dig in a little bit, you know, which side of the fence we're on. And understand better their policies and (ill) role procedures from an industry perspective. So I think the action item is understanding of industry policies - standard industry policies. Depending on the decisions (unintelligible).

(Tony Negliari): (They) received a letter from a hospital and (Frank) touched base about - on this a little bit. Okay, which kind of expanded on the letters we previously got from facilities, okay? I am going to ask (George) to - (George) has a copy of the letter with him.

But the key point in this letter is not only are they telling us that the physicians are private practicing and (discreetly billed). But they are also going in to the - both the legal structure and the accounting structure of the facility to allow us to gain comfort that these are indeed separate from the Article 28, and therefore not so chargeable.

So that being said (Matt) if you can just hand the microphone over to (George) he can go into the letter a little bit.

(George Lengio): Basically what they discussed in the letter was the fact that the (revenue) was (unintelligible) included (unintelligible) through the financials instead. When they got the confirmation from the legal Department that this was (unintelligible) further support from the accounting Department and then obviously (finding) from the billing Department (that let them bill discreet) (unintelligible). The concerns prior to that (unintelligible).

Woman: (Unintelligible) online that (unintelligible).

Man: (Unintelligible).

Woman: We had gathered many letters throughout on the surveys. Would it possible to compile a listing of these?

(George Lengio): A listing to do what? (Unintelligible) reviews?

Woman: I believe that...

Man: (Unintelligible). So in other words, did we pick up (unintelligible)? So if we started the first three audits - okay. So the question was, you know, for the letters that are associated with discreet billing for private practicing physicians. As KPMG is going along and conducting the reviews, are you compiling them and making a list? And the answer is yes. I don't think we're posting that list anywhere, right?

At the moment, but as we compile more and more letters that the Department approves we absolutely bring them to the next set of reviews. So the answer is yes.

Man: (Pat) on that (too though) we - for the reviews where we have - where we see the (station) letter that the Department has approved. The way to get those, you know, claims removed from the surcharge (able) population we need to be able to differentiate between the institutional and profession - institutional and professional claims.

So just - when we do receive data we need to have an identifier that can distinguish between those two types of claims. And we are carving out the professional component for those (at the station) letters that have been received related to discreet physician billing.

Woman: Another question from online. This is another potential solution. It said, could they possibly have the salary physicians bill the surcharge on the claim form? So essentially have the physicians take care of the surcharge on their end.

Man: Isn't that close to what we started with - right? Is that different than what I heard (Harold) and (Ugala) say? I don't think it is. I mean because the idea being that you're going to - we're going to work off of the claim form. There is going to be some sort of modifier

(toppled), there is something along those lines to - it's going to basically come from the provider's side.

And I think that's what I just think I heard. So I think that is one of the things that we're going to work on from a long term solution perspective.

Woman: (Unintelligible).

Man: That I don't have an answer for.

Man: I think what will be coming in to play is, you know, if the hospital is currently billing the insurance company, you know, the surcharge needs to be accounted for at some point in the process. And so just making the identification of whether it's the hospitals or the Article 28 facilities responsibility to work that out with the payer. Or in this case, would it be the private practicing physician because they're sort of taking responsibility for that revenue.

The revenue is going up to them. So would it be on them to sort of facilitate - work it out with the payer to say, well who is remitting that? I think that that's sort of the - your point, right? In terms of whoever the revenue is going to would sort of be responsible for working out with the payer community to say, at what point is surcharge going to be remitted?

Woman: Well (probably)...

Man: (Unintelligible).

Woman: There are problems with billing. The surcharge on the claim form and that claim systems don't regularly accept that if they billed it they don't really readily accept it. And it's not easy to change the systems to accept it.

Man: And I think that's one of our bigger challenges. Any recommendation we come up today is going to have implications on both the payer and the provider side in most instances. So, (Frank)?

(Frank): One other point I would really encourage you to look at this issue not just form the point of (HICKRA) but from the point of view of the other laws that these facilities have to consider when they're structuring their faculty practice plan such as the (Stock) Law and the Internal Revenue Code. You know, there are plans - I am sorry.

There are providers out there that have structured their faculty practice arrangements so that they're in compliance with both of those laws. And it would terribly unfair for them to be in compliance with those laws and then get trapped in a category where they may end up being subject to (HICKRA) surcharges.

Man: I think we should track that down as an action item (Chris). All right guys I think we're (up parallel), good. And going to be - this is a good summary anyway which is that moving forward whether it's the modifier approach or maybe even a more fundamental statutory change. Those would be good but there are a lot of people in the middle of audits struggling right now. And that was the point made by one of your colleagues.

But I would just add to that that sometimes the - what has been the rigidity and I recognize that you and the Department have become a bit for flexible. But some of the rigidity of that establishing that has really been a challenge. The letters are somewhat mushy way for lack of a better word. A mushy way to sort of disprove the burden of proof. And I would just ask that you continue to be open to some creative and flexible approaches on being able to show you that, you know, what's otherwise a physician claim, you know, is in fact non surchargable particularly in a case where someone might be able to show without letters or 1099s that that physician is not salaried.

Man: I think that's a fair (unintelligible). I think it's also fair to say we've progressed quite a bit probably within the last 18 months or so. So I think, you know, creativity is a good thing. We're always willing to listen. So I don't think that's a problem. All right guys I think we want to wrap up this section. We do have a fair number of action items that we need to take into account.

You know, a pretty good long term solution. You know, if you have any other - more ideas and you need to filter them through if anybody has any, you know, to the way

(Harold) to sum that up here. There are some short term ideas, we will definitely be willing to listen to those as well. So that takes us through private practicing physicians and moves us on to historical membership data.

I would say that probably almost as much of a nettlesome issue as private practicing physicians. I have been on these reviews for the better part of seven years. And we struggle to this day with historical membership data. The three questions that were generated from the survey, do all assessable and non assessable subscribers/ members need to be included in the data provided?

How should retroactivity be addressed in the data? And what is the impact of the review if historical data is not available? Those are not questions for me. Those are questions for you. So let's think about the first one. Do all assessable and non assessable subscriber members need to be included in the data provided? I am curious. Does anybody think that the non assessable side should not be included?

Any thoughts about that? (Unintelligible).

Man: They must be included. Otherwise we will give you - list of ten people. We will say these are (a body). And then that's it, we're done. You know, go...

Man: By the way - yes...

Man: So they have to be included for completeness.

Man: Yes. They absolutely do...

Man: Result...

Man: And when we test for deficiencies the testing goes both ways. It's to look for places where you have failed to pay the assessment but also where you over pay it as well. So giving the yeses has a tendency to lend it's to the over payment side (of the world) and not necessarily the under payment side. The next question - I think that was pretty straight forward. Good question but a pretty straight forward question.

We actually do still have some instances where we only get the yeses or people are only holding the yes part of the assessment back. And you need to hold both. I think is the way the kind of think that through. The next one is, how should retroactivity be addressed in the data? This is problematic. We have, you know, we could be whipping along on a review and - in fifth gear and this one is down shifting into reverse sometimes.

And we get to the retroactivity issue. So how should we handle retroactivity in the data? (John) why don't you explain the issue about retroactivity?

(John Kanitennis): (Unintelligible) in terms of all of the yeses and no's being maintained as one file. And sort of go to the description of historical. What constitutes historical? Obviously we've seen (in) industry membership data lends itself to being over written in terms (if) somebody moves their address gets updated. You know, they move from Rochester to New York City.

You know, you go back and your run that as of 2010. You're taking a look at say 2005, they're showing up as New York City even though back in 2005 they lived in Rochester. So just to further clarify what historical is and I think a number of you to (Roy)'s point, we've had this conversation. The files that we need are all the yeses and no's. But also with the non over written data.

So anytime there is, you know, say there is a marriage that occurs. You know, now you have a family. We need to see in 2005 that you were just a single guy living alone in your apartment there and you hadn't moved in with your wife yet, that type of thing. So to kind of round out that whole historical thing, I think what we're seeing in some instances is (back stats) of all of the yeses but to (Rory)'s point, that doesn't get us to where we need to be.

So the snapshot at the end of the month for who was active during that month, that's what we are looking for. In terms of the retroactivity (and) any given month there is, you know, terminations and additions that are going back to the previous month. Modifications that are going back to the previous month. And on the payer report itself

there is the lines for prior period adjustments because, you know, the Department and the statue allows for, you know, there is going to be some pluses and minuses going on.

So it - that's the opportunity for the payers to document that. I think the question that we sort of wanted to broach with everybody here and sort of brainstorm through is, how is - how are those additions and terminations, those modifications that are occurring, how are those documented by your system? And how are you factoring that into remitting the assessments? At various reviews we've seen it handled various ways.

It's been the trouble spot. So I think we just kind of wanted to get it on the radar and open it up for brainstorming in terms of if somebody out here in the audience or even on the call has an idea. And, you know, if there is an easier type solution or at least a path that maybe we should take a look at. I think we're open to hearing that solution.

Man: Back out there to the folks. Back out there...

Man: We're (moving) out on the Webcast. What is - how should retroactivity be addressed in the data? So basically I can tell you from a review perspective we need to see what you've done. So I don't know if that helps you at all. But what should it look like?

Man: I deal with an employee health and welfare organization, (risk of funds). The way those funds address eligibility is by monthly records. So for every month (I have eligibility) I know that that's the status of the employee. I know the address as it comes from the detail. The problem is some system override information some don't. So I can tell who is eligible in a particular month. What their status and what their address is harder to tell. And what region they live in is harder to tell.

However what I do tell my clients is retain those records historically. And support the back up - support for yourself the backup of what supports the summary forms that you are submitting to the Web site to pay the covered (license) assessment and so on. So it (boils) down (dedication). It boils down to telling clients this is - this has to be part of your process.

Man: That definitely sums it up. Does anybody have anything else? I mean if you - (Harold)?

(Harold Issm): I think for payer who have been through an audit and have had this problem they probably figured out some solutions. But I still would say for payers who haven't been sometimes the consequences of not having kept the data are enormous. And because, you know, you - I think in the past of sometimes defaulted to a - well if you don't have it. There have been the, you know, the settlements with the Department and some other ways of looking at it.

And I would say maybe you've stated to do this. But that there may be some sampling approaches from other years to try to figure out what a - what the impacts of these life changes are. So it is people moving, you know, the zip code issue. It's maybe people went from single to family as was said. And there may be a way to sort of figure out a proxy (rate) that says okay that the changes are - come to this much.

You know, rather than - I think a harsher approach that at least in some audits may have been taken to the lack of the - the historical data. I don't know if you want to repeat that because I know people...

Man: (Unintelligible) it should have worked there. I think (Rory) mentioned creativity and - we're always kind of listening for sort of - and it goes to I think (Ugala) have made the comment about understanding the payers processes and taking that into account. I think the number of instances, you know, if there is a way to get there, you know, we've gone down some fairly long paths to get that alternative procedure up and running.

You know, (bedding) it through the Department and stuff to make sure that we can gain comfort over what's being done. And I think when we can gain that level of comfort we've been able to do that. So to your point I think that a lot of the entities who have gone through it have kind of taken measures to account for that going forward. I don't know...

Man: I also had a comment about the treatment part of it. I mean we don't get involved in the settlement of the treatment part of it. We just report back the results. I understand what you mean in terms of, you know, maybe some sort of sampling or things like that. We

are trying to do a lot of that to make sure that we get the answer as close to as, you know, as close to as possibly we can.

So there is no more - I think it's safe to say, no more taking everybody. Calling them family, moving them into the New York City region. We work a heck of a lot harder than coming up with that solution. So (Amanda) was there a few more questions from the Webcast people?

(Amanda): We do. I (unintelligible) retroactivity exactly but it does relate to some of the address and storing the information. The question is how should members without addresses be addressed?

Man: You know, I (unintelligible) to be the guy who answers the question. What's the question, but how would you figure out what region they were in if you didn't have the address? Somebody (said to get their map). I think in that instance the treatment in the past has been - and again and I don't want to kind of pontificate. But it, you know, we try to take some sort of reasonableness or allocation approach.

If we're - you know, if you're out in Western New York and, you know, it looks like you basic business is primarily in that western region. We do try and take that into account if we've got a bunch of black addresses in regions and stuff like that. So we're not going to dis-arbitrarily dump them all in to the New York City region and (hammer you) for that number.

So, you know, if we can see from a reasonable (list) perspective year round Rochester, Buffalo we will make sure we allocate to those regions. More? And for those of you who haven't notices we're actually in New York City. You can hear all of the background noise. There is apparently an angry motorist right outside the window. Yes.

(Nick): To the last point, a person who doesn't give us the address does not make them uninsurable. So we can have enrollment without addresses. And we also can't do anything - (two) members that decide not to give us their current address or update their address. So that's one thing. The other problem is when our annual financials and quarterly financials tie out to the membership.

And those - (our) records are audited and then the Department of insurance also audits and confirms our enrollment. And then as a result of these audits we wind up with a different determination about total enrollment. So all of those records are inconsistent. And what I don't understand is, do we have to restate enrollment after one of these audits?

And that is an issue and we should be - also, you know, as an auditor, right? If our enrollment ties out and then because of the data issues you discover that there is a different total number then I think you should reconsider that. And I haven't seen that happen in the audits I've experienced.

Man: (Nick) - hold on to the microphone (Nick) for just a second. So can you - I apologize, can you be a little more specific without being too specific?

(Nick): Well what I am saying is that the - because the data, the results indicate a very different count of total membership than is indicated in the stat financials and the audited financials. Okay, and then we go back and forth KPMG will insist on their number and not reconsider the results to reflect the (stat) financials and the audited financials of the company. Get what (I am) saying? So in those instances where the data is short or larger than what the (tile) is either - what, 5500 to an audit financial statement.

We take the number off of the data, fair enough. We can take that down as an action item. I am not really sure what we would do there (Nick). I mean if you're turning the data over and it doesn't tie I am not so sure what I am supposed to do. But I can - I - you know, we can work it through. Okay - so - I am sorry we have time for like one more question. We have got to move on to the next thing.

Man: (Unintelligible) Department (or) paradigm shift all together. Right now you're auditing organizations going back as much as six years back or seven years back. Historical data is very hard to come by. So that process can go forward in whatever wobbly way it's going to go forward. Some data, some not, why not get the data contemporaneously from the payers who are actually trying to do the right thing?

But they don't know that they're doing the right thing if they don't hear about it in time. So instead of trying to audit them three years back and try to find out who is the person who did the work and where is the data and the switch of systems and switch of, you know, mergers and what not. Get the data contemporaneously when you submit it. And have all of - unique IDs so you don't have a HIPAA violation and you have everything that you need right then and there.

It will include - it will (report) the Department of a huge database but the database will have no identifying information other than ID and zip code basically.

Man: (And) as an action item. The last item on there is what is the impact to the review if the historical data is not available?

Man: (Want to talk that one)?

Man: Sure. You are required (whether you have) historical data, okay? We have the right to assess a civil penalty for failure to comply. What we've always done in the past, keeping in mind that we want future compliance as opposed to crucifying you for not having the data for the prior periods. What we are doing with the civil penalty is settling for ten cents on the dollar.

Okay, so if you get hit with a $72,000 penalty in fact we're going to assess $7200. Okay, in addition to that we have - and (Rory) you can speak to this better than I can. But we have used alternative procedures also.

Man: Very close to what (Ugala) mentioned here. In instances where we can get a later year or we can imply some other way - some sort of alternative procedure to come up with an answer that is a little bit more reasonable. I mean if you think about it, if we go and test overwritten data we get error rates that usually hover between 40% to 60%, 65% which creates all sorts of problems.

It's just a faulty test, right? So we try to take the nearest term year. Well in certain instances we'll take the nearest term year that we can get that has not been overwritten and then use that. And then use that error rate and go back over the years that are under

review. We have done that in the past. Okay, so let's move on to the next slide. This is all good conversation. The next one up to bat is Medicare.

There were a number of questions, it looks like there were six total. How should records related to instances of this - instances of Medicare be identified within the data? Which is actually kind of like a holistic question, we've got a lot more questions about that than just Medicare. What is considered sufficient supporting documentation for the criteria identified? How should claims - should claims for Medicare eligible members be excluded from the surcharge?

How instances of exhausted benefits or non covered services be identified? And what type of evidence is need to support this issue? Does Medicare have to pay the claim to exclude the claim from the surcharge? Are co pays or deductibles related to Medicare? Medicare claims and surcharge - are surchargables. Why don't we go back and why don't we start with the first one.

How should records related to instances of this be identified within the data? (John) or (Pat) why don't you just give us some background on how we've seen this in the past.

Man: Well I think to your point this is kind of holistic overview kind of question. And you will see that question is for a number of the exclusions. I think this goes to understand - that's one of the points for - that's one of the reasons that has driven sort of all of the communication we have up front with the reviewee's in terms of the kick off, the onsite, the follow up data calls. And even implementation of the (tempting) methodologies.

Again, to (Ugala)'s point about understanding the processes or procedures that are in place. If there are criteria specific fields that contain those criteria, during the discussions it just needs to be communicated to the review team, to KPMG team. Usually there is test work, some sampling, some test work around those criteria, you know, to give us the comfort as the reviewee - as the reviewer.

That the codes and such are being assigned consistently and completely and accurately for those instances. So I think there is not necessarily an easy quick answer for this. We've seen a million different types of fields. A million different types of criteria used

for that one. It's really something that each entity, you know, should be aware of that, you know, Medicare is a potential issue - is potentially excludable.

And so, you know, line to business, product type, there is a lot of different ways to (attack) that one. It is actually relatively simple if everyone can agree. I think it depends on how you identify it when you're making an exclusion. And as long as we can see that - I think it is a little different for some. I mean if you're relatively, you know, a relatively small non complex entity this is pretty straight forward.

Like (John) said, product code line of business is usually easier. Some of the larger ones, it's a little harder for them. There is an awful lot of possibilities shall we say. You know, if you have industry standard codes or the difference between that and proprietary codes, that kind of plays into it. But for the most part, if you show us what you did and we can do some testing to get us comfortable with that.

And if we don't have any exceptions then we are there. Criteria is usually provided to us in what we call the questionnaire. So, you know, when you are under review, the reviewee does complete our questionnaire. And you actually provide the codes that you use to identify Medicare paid claims. I think the third one - (unintelligible) for Medicare eligible members.

Medicare eligible members, be excluded from the surcharge.

Man: (And) question number five as well.

Man: (Unintelligible) the difference between eligibility and actually Medicare making the, you know, Medicare coverage making the payment. So Medicare eligibility is defined in a lot of different ways. (Ugala) absolutely wants it to be Medicare eligibility, why? Can we give (Ugala) the phone? Not the phone the microphone? The phone, the mic.

(Ugala): It's not what I want it's what health and human services say. The answer is yes. We researched this quite extensively and the Department came back and agreed to that. If somebody is eligible for Medicare regardless if they are participating in Medicare you have a potential of the state taxing the federal. I will give an example.

Somebody becomes Medicare eligible in August they decide not to apply until October, the insurance company (or the) fund pays the claim for September. And then Medicare kicks in and could retract (unintelligible) just because they didn't participate you will have a situation where Medicare benefits are being taxed by the state, because of that the law says that Medicare - and I am not an attorney.

The law says that Medicare eligibility - not Medicare participation is a criteria. I will give another example. (Enstradrinal) disease which makes somebody Medicare eligible under certain conditions makes them eligible whether they are getting benefits from Medicare or not. At that point they're not subject to (HICKRA) and the covered (lives) of their families is excluded as well. So I think the answer is yes.

Man: All right. Anybody else have any other comments? Let's take that down as an action item. (Unintelligible) discuss or review the possibility of eligibility being a determination for (HICKRA) (announce) the chargeability because I think it - to go along with that I think one component that - and that's I think the question - bullet number four is related to instances of exhausted benefits or non covered services.

I think that that certainly does kind of - it is a potential issue that needs to be addressed. And yes, (Ugala) is shaking his head. So certainly it's not as clear cut as everyone would like it to be. So as, you know, allowing - given - if the payer is able to make those - to distinguish between those and like sort of what would be covered by Medicare. I think that that allows us to get a little bit deeper with that one.

Well that's interesting because if we go by what we just, right? So let's play it all the way through. So if we make the determination about Medicare eligibility then there really is no such thing as exhausted benefits or non covered services, right, because if it states ineligibility the way it was just described then they're out. There is no such thing.

Man: So I guess the question - and, you know, I - again, I am just sort of brainstorming with all of the other folks in the room here. I think if, you know, Medicare would not cover the service, you know that wouldn't be federal dollars. And so that would fall in to the surchargable bucket. And again, yes just sort of brainstorming with all of the folks here.

So I mean as long as that can be identified I think it becomes an issue. And again, putting as an action item for further discussion is key. You know, which side, you know, which approach is to be taken? I think yes, the further discussion certainly (warranted).

Man: (I think it answers) the bottom two questions depending on which way you go here, right? So if the answer becomes eligibility is the determination then does Medicare have to pay the claim? The answer would be no because it states ineligibility not - who pays. And then the co pays and deductibles would (make) - related to Medicare claim surchargable.

I don't know what the answer to that (unintelligible) assume - but again it's all based on this one idea that we're going to change it around to be just eligibility driven only.

Man: I seem to be the barer of at least complicating news. Certainly to determine Medicare eligibility there are several factors that come in to play with that as well is my understanding. So, you know, satisfying each one of those criteria would be needed.

(Ugala): (Unintelligible) what I said before was the basic beginning of the rule. There are actually several rules that are involved. The first one is somebody has to be Medicare eligible by having 40 quarters of at least $7000 earned during their employment which is hard thing for insurance companies and welfare funds to substantiate because we're not the employers. We are just giving them insurance.

So that is a bit of a thorny issue when it comes to auditing that. The other rule is that the Medicare benefits have to be - the (funds of the) insurance company benefits have to be the same or less. In other words giving less than Medicare in terms of benefits. So if we allow - I don't know, brain implants and the Medicare doesn't allow brain implants then that is surchargable.

And the third one is of course exhaustion of benefits under Medicare is surchargable. That is absolutely right. The principle is not eligibility for Medicare, the principle again, I am not an attorney. The principle is that the state can not tax the federal. That's the concept.

Man: Okay. We are going to move on to one that has popped up just recently. And has gotten an awful lot of attention, the concept, the responsibility for applicable surcharges on co pays and deductibles. Who is responsible for applicable surcharges on co pays and deductibles? What level of documentation should be maintained to support the determination of responsibility?

What type of communication is necessary between the payer and provider? The third one is the million dollar question clearly. So let's go back to the first one which is causing angst for just about everybody in this room. So who is responsible for the applicable surcharge on co pays and deductibles? (Pat) what's going on right now with this? How does this work?

(Pat Bliend): Well the way it works on the payers side, you know, the co pays and deductibles. You can go about it one of two ways. You can voluntarily remit on the co pay and deductible or you can not. And we've seen both ways, you know, on the payer's side.

Man: (Unintelligible).

(Pat Bliend): That's correct. (Blended to) - depending on the system (unintelligible).

Man: When you (elect) to remit that, that means they're voluntarily electing to remit it directly to the pool?

(Pat Bliend): Directly to the pool, yes. Directly to the pool so they're actually paying the entire surcharge on both the co pay and deductible.

Man: (Unintelligible) so why would not - why wouldn't we just remit ourselves? Why would we pass that on to the providers? Because clearly the providers are having a problem with this, they are having a huge problem with this actually. (Noreen)?

(Noreen): We would need to pass it on to the providers when the entire claim went to the deductible. So for example, take $100 claim, apply surcharge, $109.63. The entire claim goes (for) the deductible. Then that's really the member's responsibility to submit the $109.63 to the provider and then they need to remit the surcharge to the state.

So in cases where you've got deductibles and co pay that take up most of the - (stats) claim benefit amount, then that's really the member's responsibility.

Man: Okay.

(Noreen): Do you understand that - what I am talking about?

Man: Yes I got it. So let's think about that from the provider's point of view. They're going to say that they have instances on their side where they can't figure it out from their side because there is no communication back and forth between the payers and the providers. So the idea here being well we know pretty well that there is a problem. How do we go about fixing this problem?

(Noreen): Looking in to that right now at Excellus. But there are a couple of ways you could do it. One is just tell the provider how much you remitted to the pool for that claim. So for that claim your remitted nothing. So then they would know that they have to remit the remainder of the claim. Or you could tell the provider how much they need to remit.

Man: (Group), it sounds like would advocate let it be almost like on a case by case basis. Is that what we're saying?

(Noreen): (Unintelligible) liability that surcharge. It is the member's liability.

Man: Okay.

(Noreen): It's the members (bought) a contract that has deductibles (on) coinsurances and co pays. And so they need to - in that case where the claim - there (was) extra money that would be paid to the provider. The claim then - (is) the member is where the surcharge is coming from not from (Excellus) or...

Man: Okay. So let's back up for just a second because this is actually kind of - it's kind of important. And then when we do the provider session I guarantee you that this will be able to attract conversations. So what we see on the reviews is everybody pointing the

finger at each other, right? So they're saying that they didn't know they were supposed to pay because they can't tell from what the, you know, from what's being submitted back to them.

And they are getting instances where it's being handled one way in one system and another way on another, blended for a third. So they feel kind of caught. So of course on our side we're looking and we're saying, well it's not my liability we have a lot of instances where it's not our deal. How do we simplify this?

(Noreen): One potential solution would be a recommended remit, what should be on the remit. A uniformed remit if that's possible.

Man: We - let me give the microphone to (Ugala). I think he's going to talk about an explanation of benefits.

(Ugala): Okay. Not to use a specific example but I went to the doctor to hospital and I got a bill for the deductible amount. And sure enough the (fine), you know, cost below lapped on (HICKRA) surcharge right on top of that. And I am expected to pay that. So it's not like they can't do it. The second thing is there is communication it's called an EOB. And they know very well, the hospitals know very well to send it over to the patient as soon as they get the EOB.

So I don't understand why there is even a question of what type of communication. We have communication and it's generally summarized sometimes electronic. It's not a burden. It's just a matter of - the issue is of that the patiently ultimately can or can not pay it and the hospital gets stuck with the bill of remitting it. But it should be a like a sales (tax). If you don't collect it you don't pay it.

You don't pass it on. That would be my position.

Man: (Unintelligible) they're just having trouble getting, you know, getting communication from the payers whether or not they're remitting the surcharge. That's been the issue. I think, you know, they tried to follow up with the payers as far as, you know, their

treatment and I think, you know, a lot of the hospitals have only heard from certain payers.

So, you know, it's like (Rory) said, it seems like both the payers and providers are pointing fingers at each other. So we're just trying to figure out the, you know, the best way to fix this.

Man: (Unintelligible) leave it the way it is. Then the action item has to be to clean up the communications because we can't keep going where everyone is asking each other what's going on, right? But if we're going to do some sort of uniform remit or we're going to make sure that one industry or the other is responsible and that's neat and clean. But it doesn't sound like anybody wants to get there. (Meg) or (Harold)?

(Harold Issm): I don't want to get there. But we talked earlier this week about developing a series of examples. And that I think (Rory) does need to be the next step because there will be cases where it is probably pretty clear who should - where the liability is and who should be remitting which are two separate questions. And so I think the next step is develop those with the Department and input from the payers and obviously with you guys.

And then after we see that series of examples, go back and figure out where the problem is. The - I though the two comments - one in the - where the patient hasn't met the deductible at all is a perfect example. Again, there is no liability at all. So it's not really a - who is paying on that? I mean it's clear who pays. And the EOB should explain that.

But, you know, that's work so they have to do a little work on their side. But until we get all of those examples knocked out I think it's going to be hard to figure some of this out.

Man: (Unintelligible) is on the provider end, okay? The way a lot of providers have been handling this is they're assuming that if an insurance company is an elector that the insurance company was automatically voluntarily submitting the surcharge to the public goods pool through their monthly cost report filings, okay? As far as the Department goes where we stand on it, we have given the option to the electing payer.

They can either pay it to the pool through their public pool submission or they can pay that piece over to the provider in which case the provider is responsible for remitting, okay? And because the assumption was made on the provider end that the elector was turning the money over to us, obviously we're auditing providers now and being hit with an underpayment as a result.

Woman: (Unintelligible) complex parts of that too. This isn't (hairy) enough, is that some payers who have been responding to the providers as to how they are as (Rory) mentioned either remitting it directly to the public goods pool or remitting it to the provider themselves have not been consistent. Based on either product line or various, you know, entities within the payer system itself. So from that perspective it adds complexity to auditing that because we can't just apply it to a particular payer down the lines.

It is product based or it's actual specific entity based. So that's created an additional kind of complexity to the whole issue.

Man: Payers also, are there cases where you have a planned participant that has a fixed co pay that you are picking up the surcharge on? That you're actually remitting the surcharge on that co pay? Okay, and is that just for ease of administration?

Woman: (Unintelligible). It depends on the system. So if you have what I will call a back end calculation then you remit for the deductible and the co pay when it's not a zero paid claim or there is a small amount left over. You will remit the entire amount. And this - if you implemented a system like what's provided in the billion examples on the Web site then you would not - we - you would not remit the co payer deductible in general.

Man: (Unintelligible) insurance company is the ultimate payer on that, the surcharge piece of the co pay? Or...

Woman: We would remit it to pay it to the provider who would then in turn pay it to the state.

Man: And you wouldn't go after your planned participant for the surcharge piece of the co pay?

Woman: Right, no. We do not go after this - the member. Right, so that would be an administrative nightmare if we had to actually - if - like the example of the entire claim going to the deductible. Having to go back to the member, bill the member for that surcharge piece. We - in general we don't bill members for claims. We bill members for premiums. So we don't have systems that would handle that kind of activity.

Man: Some plans do remit the surcharge related to the co payment and deductible to the provider so that the provider doesn't bill the member. The - when an EOB or rather when the hospital bills a member with an added line (HICKRA) surcharge - we get the calls. And to avoid that we are trying to make sure that they don't bill that extra line. But no matter what - there is that miscommunication and they ultimately - automatically bill that amount.

And we get the complaints. And whatever solution, we should consider the member concern too. If they don't understand that bill from the hospital and they resist paying that surcharge. They think that that is - they're not responsible.

Man: So - okay so the action in there is actually clarifying the billing part of it. So...

Man: How is that communicated to the provider?

Man: In the remits. But the typically - and I understand how the hospitals will have an automated system and they may not adjust it by payer. And they have their difficulties in billing too.

Man: Absolutely. So I think (Chris) we have a few action items. I will tell you what, there are a few things that have - I think raised- risen to the heat of this one over the last couple of years. So we're definitely going to give this one some pretty decent attention. Let's move on, we're actually kind of - the conversation has been great but we're rapidly - you know, were about 40 minutes before the end and we had actually added a couple more things.

You know, we have to still get through risk sharing arrangements, medical home pass through and somebody added ambulance on there as well. The next one is service line

exclusions. And again, this one - relatively holistic question. It, you know, you could have said it about Medicare, you could have said it about (just about anything else). The question comes out as, what are the service line exclusions that are recognized by the Department of Health?

And how should records related to the service be identified within the data? What is considered sufficient supporting documentation for the criteria identified? So let's put the second and third one to the side. So why don't we - (Pat), (John) talk about what the service line exclusions are?

Man: I think we say service - sort of service line I think we're talking sort of service level in terms of obviously the first component of determining whether or not a claim is surchargable or not is the facility that it is provided at. I, you know, meaning in Article 28 or a Non Article 28 facility. There are certain services that even if provided in an Article 28 environment should - can be excluded.

And so, you know, here hospice, home health, (skilled) nursing facility just to name a couple of examples. I think that there is, you know, just questions around that. And so - I think we wanted to bring it up to have the discussion around, you know, what are thoughts from your guys' perspective. I know two - sort of still on topic - two large items that we typically see on reconciliation are dental and vision.

Reconciling items, I think it's key to identify - sort of clarify the definition of those items as reconciliations are being prepared in terms of not so much at this service level but at the facility level in terms of dentists' office or, you know, going to Pearl Vision. That type of thing, so I think the question out there is just, you know, what are these exclusions I guess (Rory)? And what, you know, what questions are there from the group here in terms of - you want to (vet) it?

You know, kind of get those on - get a discussion going.

Man: The facility code should be the field that you use for that. The facility codes for hospice, home health, and so on. So with that you can pretty much exclude them right off the bat. The complicated part is ER which I believe is not excluded. I believe it's not

surchargable. I don't remember. It is surchargable? Okay. So that is not an issue. But for hospice and visiting nurse and all of those there is a facility code that will be part of the claim.

Again, if the payers - if the providers will include those modifiers we won't be talking about that. And I will make it tit for tat we - (give us) the modifier we will give them back EOB's with a surcharge (information) on the deductible. And I think we've got a good deal going. So that will be my response.

Man: You make a very good point. And I think to address this it goes to, you know, I mentioned again the level of communication in the on sight - those data calls. You know, understanding the processes that are in place. It, you know, if - it's not a facility code but there is, you know, a few other codes that can be used. That's - at a given review, you know, as long as, you know, there is sort of clear identification of those.

And we can work through the support and how that's (a sign) I think we're certainly opening to listening, working through that with you. And going ahead and making those - there are certain exclusions. It doesn't matter what it is or where it was given. It's just an exclusion and there are other ones where it's more about where the service was provided. You know, the physician component is not non surchargable. It is surchargable.

(Only accept) in the instances of discreet physician or private practicing physicians. The rest of it is surchargable. So that's an indication of, you know, a different type of exclusion. Medicare is, you know, flat out excluded on some level.

And there are some of them, you know, depends on where the service was provided. Does it provide it in Article 28? That's going to stay in, it's not provided in Article 28? It's coming out. I mean that is the way to kind of think of it. The exclusion, I mean I am not so sure the service level type idea (kind) of captures holistically what's going on.

And we do have people who make the - who have confusion between a facility exclusion or a service exclusion and I think that causes some friction at times, so.

Man: Yes (unintelligible) a little bit was some of the reconciling (honors) that we do so often that I think some of the payers do believe is not surchargable. They actually are provide that Article 28 facility. Would be the vision, dental and pharmacy. So I just wanted to, you know, just re - you know, echo that because I think that is often, you know, (unintelligible).

Man: If it's done under the Article 28 the exclusions you have are hospice, SNF and home care. Outside of that, that's it.

Man: Okay. Let's move on to the next one. The last one - well not the last one but the last one on the slide is referred out patient labs. Three quick questions. What are the criteria that need to be met to establish a claim as referred out patient lab service? What should records related to the instances of this be identified - oh sorry. How should records that relate to the instances of this be identified within the data?

What is considered sufficient supporting documentation? So (Pat) or (John) why don't we walk through - let's go real, real quickly what the rules are for referred outpatient labs.

Man: I think the referred out patient labs it's basically - the intent of this is if a lab service is being provided at an Article 28 facility. However it's done on an out patient basis. It's referred to that facility by someone other than the facility itself. And it's not part of preadmission test work. I believe it's within ten days of an admission. Then that claim is to be treated as if it was being performed by a free standing laboratory.

So then the 10-1-2000 date comes in to play. If it is on or after that then it can be excluded. And so I think, you know, that was four criteria I just kind of listed quickly. I think, you know, where we've had some difficulties is identifying those initial three criteria. And so, you know, the reason that - it obviously made the discussion today is what's available in order to prove those types of things and sort of what is available to you guys that can be provided? And we are trying to prove...

Man: Yes. Well what happens is - often when we go to test these referred out patient labs. The tax ID number is (falling) under the Article 28 facility. So I think that is real issue

occurred. So I think we just wanted to put it back out there to understand, you know, what type of criteria is available from the payers that we can truly identify referred out patient labs.

Man: Anybody?

Man: I don't think it's as big a problem as we've had in the past, right? I think everyone has sort of found their way a little bit more on this one. We have - we know, recently like you said I think within the last 18 months we've made some headway in terms of working through the processes and procedures and what fields are available at any given reviewee to prove different components. But just a point to keep on the radar - similar to my comments I have echoed a couple of times.

You know, open to communication what ever is available we can walk through and if we can get two out of three right off the bat and then kind of work to get that third component proven. You know, I think we're open to that, so.

Man: Okay. Does anybody have any questions about that? All right, so why don't we move on? I think earlier when we asked if there were any other topic items that you wanted to discuss, risk sharing arrangements came up. I can't remember who put their hand up. Do you have a specific question? There is a...

Man: Actually more accurate would be risk transfer as opposed to risk sharing. For example if a health plan globally capitates a hospital transfers full risk for all of the in patient and out patient care. How do you determine the value of services that are surchargable? Is it decapitation payment? Is it the proxy price value of the service performed? And of course, there is a variety of pricing methodologies to determine the value of the services.

And it seems like there is a lack of clear guidance on how to determine the amount that's surchargable.

Man: (Tony) I hate to sand bag you on this one. You want to...

(Tony Negliari): I guess the best way to answer that is that really (HICKRA) - keep it in mind that it's a provider tax. Okay, and it's accessible on the revenue received by the provider, okay? So in that case, you know, you are turning over X number of dollars to the provider correct? That's the part that would be subject to the surcharge.

Man: Even if the provider loses money on that arrangement, you get - because they don't receive the money. It can not be surchargable. And conversely if they had a positive arrangement where the proxy price value of the care was less than the amount of the decapitation payment you'd still be obligated to pay the surcharge on the full capitation payment if I understood you correctly?

(Tony Negliari): (Right) (what)'s surchargable, (Harold)?

(Harold Issm): I think there has been a lot of confusion created on this topic. And it is sometimes because depending on the particular arrangement and the way the question is asked, you can get answers that may not be completely consistent. And - so I would maybe suggest that this is a good topic for Q&A - or Q&A clarification because these arrangements - it's like the physician stuff can really vary.

And you can have a risk transfer to a hospital but you have risk transfers to IPAs and how do those get handled? Because those are also risk transfers and again, who is responsible there? And I think some of that we had figured out was in the agreement - had to be worked out in the agreement. But I would just say there is confusion created when there is one answer given but you've got 100 different risk transfer arrangements.

And some of those may have different qualities. And, you know, we just want to make sure that nobody gets trapped where they think they're not paying and then they have to pay on audits or vise versa. So...

(Tony Negliari): (Unintelligible) then is if anybody has a specific question related to a certain type of arrangement to send me an email and, you know, give me the specifics on what the arrangement is and we can give you an answer.

Man: Yes. We've - I mean to (Harold)'s point we do - when we conduct our reviews we do dig down on to the contract level to understand, you know, where the - basically the flow of the money or who is on the hook. That is what we're trying to make a determination as to whether something is (interact). So we're - on our level we are doing that. And you're right there is a million little options out there for how things should be determined.

And then what the treatment is under review as well, whether it's in, you know, in the surchargable bucket or out. (Nick)?

(Nick): If you have an agreement with a hospital where - for a category of service, let's say it's heart - interventional heart treatments. And you say its 70% facility and 30% professional discreet billing. Then that - the whole revenue is not surchargable, only the 70% part is surchargable. That is our understanding.

Man: Like I said, it depends on the physician, right? Is - I guess and that makes the assumption that the 30% is private practicing right?

Man: It's private practicing and discreetly billed.

Man: Yes, absolutely. In that instance we would try to take the 70%. We would ask you to - whenever you're not using the claims data in order to do the risk sharing you have some sort of methodology. So you are either using per member per month or something along those lines to make a determination. You have some sort of allocation or percentage you're using. We just ask you to prove that out to show us what you did.

And that's, you know, in the places where we can't. You know, you're saying 70/30 and we get back and it's like 80/20, that's when we start to run into problems. So as long as it approximates what you say, we're usually in a pretty good spot.

Man: To add on to that, you know, there are definitely a number of different categories in terms of how the risk is transferred and what dollars are truly driving the surcharge. Whether it be the per member per month payments in terms of certain capitation agreements or the actual claims data. In instances whether there are methodologies that are sort of stipulated in the contract between the payer and, you know, the other entity.

Where as the methodology, you know, the 70/30 break out, I believe those methodologies do need to be (vetted) with the Department of Health. So that, you know, when we come in to there, there should be an established, you know, sort of (vetting) that has already occurred between yourselves and the Department. And say, we're going to do 70/30, is this okay? There should probably some back and forth and, you know, ultimately, you know, as long as it is proven out I imagine (it) says, yes that works.

And then so when we get in there, there is already, you know, pretty good documentation for us to follow as reviewers.

Man: Any other questions on risk sharing? (Meg)?

(Meg): I actually just wanted to acknowledge from the folks on the Webcast we are receiving a number of your questions. A lot of them to discreetly (bill prior) to the practicing physicians and other topics that we've covered in great detail. We did just want to, you know, clarify that we're not ignoring them. If they haven't been covered or addressed in the conversation that's happening here in the room certainly we're going to work with the Department of Health to post kind of a formal Q&A after today's session.

This session obviously being Webcast it's also being recorded. So that information will be available as well as we move forward. So just look for that, and please know, you know, keep them coming because we will be responding to them. If not today certainly in the future, thanks.

Man: Anything else about risk sharing? Okay. Medical home pass through.

Man: Good morning. My plan is currently being audited by KPMG for the (HICKRA) surcharge and there has been a lot of good dialogue between us and KPMG. And KPMG with the Department and we really appreciate that. Earlier this week we found out that the Department intends on applying the surcharge to the medical home payment. Our understanding from the Department is that the medical home will be a pass through.

So in this (sense) the plans just got slapped for lack of a better word with a 7% tax that we're not being funded for. Is there anyway that the Department could get together with the other?

Man: Again, if you could send me an email we will funnel it through the Department to the right people.

Man: If you could possible (tell) that that would be great. We are starting to start the pay out for the medical home. So, you know, (expand) (unintelligible).

Man: That's (unintelligible).

Man: (Unintelligible) I think this was on somebody from the Webcast they asked about ambulance.

Man: (Just send me) an email. That's how we received it, just that ambulance so I am not sure what the issue is.

Man: Are there ambulance services that are surchargable and non surchargable? I mean if I was them that's what I'd ask.

Man: (Unintelligible) back to what we talked about earlier. The amounts for surchargable services, as far as right now, the ones that are excluded are hospice, skilled nursing facility and home care. So I...

(Tony Negliari): Yes, really. As far as ambulance goes and we get this question a lot. Who ultimately ends up with the revenue? You know, is it done within the Article 28 umbrella where the Article 28 actually ends up with the revenue? If so it's surchargable, but in most cases I believe it's done through outside contracts, okay? So in which case the, you know, the surcharge wouldn't apply to that contract payment, okay?

Man: (A perfect example) where something is not a service line exclusion but may be excluded depending on how the revenue is recognized. Dental and vision are two other possibilities as well.

Man: Okay, excellent. We have quite a number of action items. Hey (Chris) can you - I can't read your writing from here I am getting really old. Why don't you grab the mic and we can through our action items very quickly.

(Chris): Okay. For discreetly billed private practicing physicians we have an action item to understand the impact that the change would have to other regulations. Regarding - I am sorry there are also the potential use of the modifier. And understanding the ground rules and the - also understanding the unique structure of the providers. Understanding that the 1099 won't necessarily provide the discreetly billed private practicing physician exclusion.

So basically in summary for the private practicing physicians, the modifier (was) a potential solution and understanding the impact of the payer and provider policies to any changes around discreetly billed private practicing physicians are really the two key areas. Regarding the historical data, we are going to potentially look at the membership on the financials.

Man: It came from (Nick). You know, we have data that doesn't tie to the financials we want some consideration given to, well the audited financials have the number. And when we're making the assessment, can we use that number as opposed to the one out of the data? That will be a tough one but we can take a look at that.

(Chris): And the other option presented was receiving the data that was used to calculate the membership. Receiving that data on an ongoing basis so it's captured at the time of the payer report.

Man: (We also) talked about the possibility and instances where an entity has overwritten (next) data. May be taking some near term data and using that as a basis to conduct the reviews. So we have that action item as well.

(Chris): As far as Medicare goes, one of the key things that was identified was understanding what the individual processes (at) the payer because that is a key component. So what is

it that you do to identify Medicare covered services and you Medicare exclusions? It's important to communicate that to the reviewees - to KPMG.

Man: I think the second one is the biggest one. I think everybody in this room would love to have this one become reality as eligibility as becoming the Medicare exclusion as opposed to the way it is handled right now. So if someone is eligible but not necessarily drawing payment through Medicare that their eligibility status would be an indication as - to non surchargability.

Certainly it would help in terms of non covered services and exhaustion of benefits, co pays all that kind of stuff. It would clear some of that stuff up. So we will take that as an action item as well. We will look into that with the Department.

(Chris): As far as the service level exclusion goes there were two action items. One was considering the use of the facility code as well as the modifier. And the second one was a better communication around what are those specific exclusions. Understanding that everything within Article 28 is considered surchargable except for hospice, home care, SNF I think that's the three.

Man: (Unintelligible) and for us when we put the Q&As out I think we could probably take this down as a question. I think there is some general confusion about what exclusions are. You know, whether they're either facility based or whether they're overall, you know, some are where you have the service and some are just the type of service they are.

That they are going to excluded no matter where they are. So I think we could put a question out and verify all of that for everybody.

(Chris): Regarding the co pays and deductibles we're going to look at - evaluate the possibility of using a uniform remit. And then also as far as communicating, understanding who has the liability and who is making the payment or what the payment requirements are for co pays and deductibles between the payer and the provider. And then also potentially providing some examples of what the payer and provider communities are doing around remitting the surcharge for co pays and deductibles.

Man: I would that - when we have the provider session, they're going to disagree. So we're going to have to look into this one really deeply because they got their back up a little about this. And it is kind of a - it's a tough issue at the moment, it really is.

(Chris): And moving on to the RSAs and the risk transfer. There is an action item, I think we've asked the payer community to provide the Department of Health some questions around RSAs as well as KPMG will capture some of the questions that we have receiving along the way and provide them to the Department as well. And I think that covers it.

Man: To repeat what (Meg) said a little bit earlier. Anybody who has been asking questions through the Webcast we apologize for not answering all of them. We thought where they were being answered as part of the general conversation. But there are some that were a little bit more specific. We will definitely answer those again through a formal Q&A. So those are our action items.

We will start working on these obviously right away.

Man: As it relates to next steps what - as I indicated in my opening remarks. What we're going to do is consolidate all of the feedback we have received here today. Present the feedback to the Department, work with them as it relates to a certain level of action items. Certain ones will get implemented. Certain ones may need - require analysis and thought behind it as well as to getting it implemented.

I am not sure exactly what - how it will be shared with the community. Just to reiterate worries, closing comments. The Q&A will be finalized and be posted and shared with everyone, you know, probably within the next two to three weeks depending Department of Health approval. With that I do appreciate everyone participating via Webcast as well as the folks who actually traveled here to the New York City area to participate.

And hopefully this was a meaningful exercise for you. It definitely was for us and I will speak on behalf of the Department it was also a great process to go through. With that...

Man: Category of boy do I have a deal for you, okay? You may or may not know, but there is an amnesty provision that was passed recently, okay? Where by the depart will waive interest and penalty on any under payments for reporting periods 12-31-09 and prior that are received with certified reports or estimated reports by 12-31-10, okay? There are a couple of little stipulations within that, okay?

The first one you really don't care about it. But the 1% state wide assessment is not included in that, okay? That's more a provider issue obviously. Does not apply to any interest in penalty amounts which have been paid or collected previously by the Department. Does not apply to any under payments which is discovered during the course of a (public goods) pool audit conducted by the Department or it's designee. And I really want to speak to that one.

Okay, because what we're looking at is we will allow the waiving of interest and penalty even if you're currently undergoing an audit until that final audit report is issued. And what we mean when we say the issuance of the report is actually the formal report coming to you on Department letter head, okay? So even if you're in the final stages of a HICKRA audit it would certainly behoove you to consider submitting payment prior to finalization of that audit report, okay?

And then it doesn't apply to any delinquent amounts that have been referred for - well Medicaid (re-coopment) or collection proceedings to the attorney general's office, okay? So it is a great opportunity if you're sitting out there and you think that you have an under payment either as a result of the audit or just in general. Audits don't even have to play into it. You know, if you've discovered a system type problem where you've been under paying the surcharge or covered lives assessment, now is a golden opportunity to submit the payment to us.

Again, it's got to be on a public (good) pool report. A reporting period prior to 12-31-09, okay? But again it can be based on an estimate in which case we wouldn't ask you to sign the formal certification but simply check off a form that we have electronically that says it's based on an estimate, okay? So again I can't stress to you enough that this honest provision is out there. And you may want to take advantage of it, alrighty (sic)? Thank you.

Man: Thanks again on behalf of KPMG and the Depart of Health. Thanks so much for participating. Anybody in the room if you haven't filled in the CPE form please do, and we will make sure you get your continuing professional education credit. Thanks so much everybody have a great day.

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