NYACP
New York Chapter
American College of Physicians
Advancing Internal Medicine; Improving Patient Care

Your Chapter in Action

July 3, 2018

Practice Management

Provider Concerns and Barriers to Value Based Payment in NYS:
A Frank Discussion

With the changing landscape of state, federal and commercial Value Based Payment contracting, is your practice in a good position to achieve value based care? Please join us on a WEBINAR for a frank and open discussion which provides you with an opportunity to share your concerns, experiences, and any barriers you can identify.

Moderator: Marcus Friedrich, MD, MBA, FACP, Chief Medical Officer, Office of Quality & Patient Safety (OQPS), and the NYSDOH NYS PCMH Team.
Date: July 9, 2018
Time: 12:00 noon – 1:00 pm

Click here to register.

The Sunshine Act: CMS Posts 2017 Financial Data

The Centers for Medicare & Medicaid Services (CMS) has made available the Open Payments Program Year 2017 data, along with newly submitted and updated payment records for previous program years. The data is accessible here.

Open Payments is a national disclosure program that promotes transparency and accountability by making information about the financial relationships between applicable manufacturers and group purchasing organizations (GPOs) and physicians and teaching hospitals available to the public. Through this program, health care consumers have access to a more transparent healthcare system.

In Program Year 2017, applicable manufacturers and GPOs reported $8.40 billion in payments and ownership and investment interests to physicians and teaching hospitals. This amount is comprised of 11.54 million total records attributable to 628,214 physicians and 1,158 teaching hospitals.

Payments are reported in three payment categories: general payments, research payments, and ownership or investment interests. Payments in the three major reporting categories for Program Year 2017 are:

- **$2.82 billion in general (i.e., non-research related) payments**
- **$4.66 billion in research payments**

- **$927 million of ownership or investment interests held by physicians or their immediate family members**

Over the course of the Open Payments program, CMS has published 53 million records, accounting for $33.42 billion in payments and ownership and investment interests. For more information, please click here.

What's the Fastest and Easiest Way to Correct a Claim or Request an Appeal?

Recently, National Government Services (NGS) created a chart to assist the provider community in knowing the differences between an appeal Reopening and a Redetermination.

Understanding the differences and the process are very important for quick reimbursement.

- **A reopening is a reprocessing of a claim to fix minor mistakes.**
- **A redetermination is an examination of a claim that includes analysis of documentation.**

There is a substantial difference between a reopening and a redetermination and this guide will assist Part B providers in determining which to use. Please refer to the Reopening versus Redetermination guide to learn the fastest and easiest methods.

New Medicare Card Mailing Update – Wave 3 Begins, Wave 1 Ends

CMS has been mailing new Medicare cards to Medicare recipients who live in Wave 3 states: Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota and Wisconsin. They will continue to mail new cards to Medicare recipients who live in Wave 2 states and territories (Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon), as well as nationwide to people who are new to Medicare. Please note: New York will be covered in the upcoming Wave 4.

CMS has finished mailing most cards to Medicare recipients who live in Wave 1 states: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. If a Medicare recipient states they did not get a card:

- **Print and give them the "Still Waiting for Your New Card?" handout (in English or Spanish).**
- **Or tell them to call 1-800-Medicare (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.**

All Medicare Administrative Contractor (MAC) secure portal Medicare Beneficiary Identifier (MBI) look-up tools are ready for use. If you do not already have access, sign up for your MAC's portal to use the tool. Once we mail the new Medicare card with the MBI to your patient, you can look up MBIs for your Medicare patients when they do not or cannot give them. If the tool indicates the card has not been mailed for your Medicare patient who lives in a geographic location where the card mailing is finished, tell your patient to call 1-800-Medicare (1-800-633-4227).

To ensure people with Medicare continue to get health care services, continue to use the Health Insurance Claim Number (HICN) through December 31, 2019 or until your patient brings in their new card with the new number.

Check this website as the mailings progress. Continue to Medicare recipients to this website for information about the mailings and to sign up to get email about the status of card mailings in their state.

CMS will be mailing new cards to Medicare recipients through April 2019.

Information on the transition to the new Medicare Beneficiary identifier:

- **New MBI Get It, Use It MLN Matters® Article**
- **Transition to New Medicare Numbers and Cards MLN Fact Sheet**
- **New Medicare Card information website**

CMS Seeks Input on the Regulatory Burden of the Stark Law and Ideas for Possible Changes

Article courtesy of Nixon-Peabody

On June 20, 2018, the Centers for Medicare and Medicaid (CMS) issued a Request for Information (RFI) relating to many aspects of the federal physician self-referral law, commonly known as the Stark Law. This is part of an ongoing initiative by the Department of Health and Human Services to assess issues in the current regulations that may be acting as barriers to coordinated care.

The list of topics CMS requested information about is quite extensive. The RFI asks for details of any alternative or novel payment models or financial arrangements involving entities providing certain designated health services regulated by the Stark Law and referring physicians. In connection to these models, the request seeks information on how the current Stark Law exceptions help or hinder coordinated care, as well as whether any new exceptions would be useful to protect the new or alternative payment models.

The RFI also seeks the public's thoughts on more specific items, such as the utility of the risk-sharing exception, suggestions of definitions for several important terms, and costs associated with compliance. It even poses the question of whether a referring physician providing transparency of their financial relationships, price, or other related data to a beneficiary would "reduce or eliminate the harms to the Medicare program and its beneficiaries that the physician self-referral law is intended to address."

CMS encourages the public or any interested parties to provide responses to the topics put forward. "We are looking for information and bold ideas on how to change the existing regulations to reduce provider burden and put patients in the driver's seat," said CMS Administrator Seema Verma. Public comments are due by August 24, 2018.

The full RFI can be found in the Federal Register here.

This RFI comes only a few years after CMS made many significant changes to the Stark Law, all of which went into effect on January 1, 2016. The 2016 revisions included two new exceptions, revisions to several existing exceptions, and clarifications of some regulatory terminology. The new exceptions related to Federally Qualified Health Centers, Rural Health centers, and some specific timeshare agreements. CMS also simplified or clarified some of the signature requirements, as well as allowed expired leases and personal services arrangements to continue indefinitely on the same terms as long as they were otherwise compliant.

A more detailed analysis of the 2016 changes may be found in Nixon-Peabody's previous alert here.

Advocacy

Recent ACP Campaign to Ameliorate US IMG Visa Applications Issues A Success

A recent advocacy campaign in which ACP brought together other medical organizations to advocate for fixing an issue with visa applications for non-U.S., international medical graduates who are starting their residencies in July was a resounding success. The administration quickly acknowledged the problem and the need for a fix.

In a recent statement, a USCIS spokesman said the agency "recognizes the use of valid private wage surveys by petitioners to establish the prevailing wage for an H-1B petition, however, USCIS will continue to issue RFEs (Requests for Evidence) or denials, if appropriate, when officers determine that the petitioner has not established eligibility for the benefit sought."

An estimated one-fourth of non-U.S. international medical graduates are working here on H-1B visas, which are affected. "For at least one internal medicine training program, 60 percent of incoming medical residents are on H-1B visas so the impact of a delayed start and possible denials would be devastating to their physician workforce capacity," said ACP and multiple other physician groups in a joint June 30 letter to the director of the US Center for Immigration Services (USCIS).

You can read the rest of the article here.

- **The ACP letter to USCIS is here.**
- **ACP's statement regarding the resolution is here.**
- **If you want to be more involved in ACP's Advocacy efforts, find out how here.**

Membership

MLMIC's New Online CME Modules Address Diagnostic Errors

MLMIC has recently announced that a new series of CME modules addressing diagnostic errors is now available online.

High Exposure Liability: Errors in Diagnosis – Parts I & II **feature a physician expert and a defense attorney discussing high exposure liability claims associated with errors in diagnosis. The top medical factors that contribute to diagnostic errors are reviewed, and strategies to prevent claims are outlined. A case study analysis illustrates the key medical and legal issues that impact the outcome of a diagnostic error claim. Risk management strategies to help physicians improve the quality of patient care and reduce their potential liability risk are also provided.**

To learn more about MLMIC's CME modules, including how to register and view them, please click here or call 1-888-998-7871.

Notice of a Public Hearing on MLMIC's Plan of Conversion and Acquisition by Berkshire Hathaway

A public hearing has been scheduled by the New York State Superintendent of Financial Services to consider the Plan of Conversion that was adopted by MLMIC's Board of Directors.

To view a digital copy of the entire notice of public hearing, click HERE.

To view a digital copy of the Plan of Conversion, click HERE.
For additional information about the transaction, visit MLMIC's FAQ or call 1-888-7871.

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To learn more about MLMIC's CME modules, including how to register and view them, please click here or contact MLMIC at (518) 786-2700.

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