KPMG US KAUDIOKCONF

Moderator: Celeste Scavetta
October 22, 2010
12:30 pm CT

Rory Costello: Good afternoon everybody. Welcome to the afternoon portion of our all-day session here. This morning we had the HCRA session for the payer community -- very spirited discussion as you can imagine. We don't expect anything less for this afternoon.

Welcome to the HCRA session for the providers. Over the next two hours led by a few people on our team here we're going to be leading a facilitated session discussing some of the current issues, some the axioms that come from that, some solutions, should be spirited conversation I'm sure.

I am Rory Costello. I'm a Managing Director with KPMG. I've been on the HCRA engagement for the better part of seven to eight years so I do have a little bit of experience about what we're doing here today.

Before we start to get into administrative details and how the session's going to run and before I introduce the rest of the team I'd like to turn it over to Tony Naglieri from the Department of Health for a few opening words.

Tony Naglieri: Good afternoon everybody. I'm going to try to speak up. I was told this morning that I speak softly although I don't think my wife would buy into that.

But thanks for coming first of all. I know some of you had to travel to get here and we really appreciate it.

The whole impetus behind this session is just to have a real open conversation about some of the issues that, you know, you're seeing not only on the audits but also just in general, you know, any comments, issues you have in regard to the Health Care Reform Act, you know, bring them onto the table and, you know, we'll address them as best that we can come okay.

You know, we have had conversations earlier this week both for greater New York and (Hannies). And I just wanted to thank both associations for making yourselves available.

I don't know if you were at the session the other day but (Terry Cullin) kind of described HCRA as the perfect screwed up system.

So and I think in a lot of ways that's true. But (Dave Oakley) also made a good point in saying that, you know, for 99% of what we do it is working correctly. But so I guess that being said we're kind of here to talk about the other 1% and, you know, try to make everybody's lives as pain-free as possible again not only on the audit but also on a going forward basis. So that being said I'll turn it back over to Rory. Thanks again for coming.

Rory Costello: Thanks Tony. We have a couple of administrative details to go over. I have a couple slides to go through before I turn it over to our lead facilitator.

For those of you who are participating by phone there is a 1-888 number that you can use. The pass code is KPMG. It's the one on the top bullet there of your slide.

Questions, polling questions for CPE credit will appear on your media player on the left-hand side of your screen. So those polling questions must be answered if you intend to get CPE credit, Continuing Professional Education credit.

They will not appear if your presentation is viewed in slide show mode. So if you do that thing where it opens up, covers the screen, you're not going to see the questions, you're not going to get any CPE credits.

You can submit questions. For those of you who are the Web cast you can submit questions via the Ask a Question (vote) button located on your media player. Send those through.

We have some people going through those questions. If it's germane to the topic we'll bring it forward. If it's not if we get to the end and we've got a bunch of open questions we will have a formal QA where we answer those questions and hand it back - hand those - that information back to the provider community at a later date.

Any problems you can contact the helpdesk at the - help desk at the number below. Just a quick note there's a 30 second delay between the live conference call and the slides you are viewing on the Internet. We don't have a lot of slides. That shouldn't be all that big of a deal.

For those of you like we said, it is a facilitated discussion. For those of you in the room we do have microphones that we'll be traveling around.

All you have to do is put up your hand if you've got a question or you want to add to the conversation. We'll gladly get the mic over to you and we can hear what you have to say.

The reason why we have mics is obviously we want the people on the Web cast to hear the questions so we're not up here repeating every little thing that's being said.

So our agenda, you know, we'll walk through introductions very quickly. I'll walk you through your session objectives and ground rules.

We'll talk to you about the feedback received through the surveys. We'll get through our discussion topics and we'll talk about next steps.

So that may not seem like a lot but we do have a fair amount of topics, a fair amount of important topics to discuss as part of our day.

In way of introductions from the Department of Health obviously everybody knows Tony Naglieri. But also at the back of the room we have George Lengio and (Jackie DeRose). You guys can wave. There we go. You guys now know who to talk to.

Other KPMG team members here today in addition to myself is Megan Watson. She's a Senior Manager with KPMG. And she's a lead facilitator for today. So she'll be taken us through our topics.

Up on the podium here I also have (Pat Brian) who's a manager with KPMG. And I think that's James Hanrahan over there -- there we go -- who's also up on our podium. He's a senior associate with our group.

These three folks have, you know, already a couple thousand hours of experience on provider reviews. And they get it.

So we understand what's going on and we hope to kind of get ourselves all the way through and discuss these issues a little more or a little deeper.

Over there drinking the coffee is (Chris Poll)'s. And he's going to be the guy taking down our action items throughout the rest of the afternoon.

Just a quick - a couple quick things about session objectives and ground rules, obviously, you know, the way we've put this out in the invite and the way we've described it today, it is truly a facilitated session.

So you're going to see a list of topics that Meg will go through in a couple minutes. They're the topics that we were gathered - well from our work but also from the surveys that we sent out to all of you and you answered. And so these are the top things on our minds.

There's a series of questions underneath some of them. But the questions are only to just get the discussion started. It's not for us to sort of set up and pontificate and tell you what the answers are.

This is truly a session to talk through some of the things that are, you know, maybe not going so smoothly or not going well at all and to try to get action items or solutions brought out today.

We come up with a solution we agree to, we'll do our best to put it into effect. But more likely we're going to find ourselves, you know, working on action items over the next several weeks to get things rectified.

One of the things I have to stress is some things may not necessarily get resolved they way you want. We're not making any promises.

We're really just opening this up as part of our normal our reach process to gather more information from you folks about what you think is on your mind and what things you want to talk about and get out in the open.

Ground rules, do me a favor, refrain from specifics. You can be specific without saying the name of your hospital or your payer if there's any payers in here.

It's not really a session to talk about your individual issues. The issues are little bit more macro than that. They're a little higher. So please refrain from, you know, bringing specifics into it.

Ask questions. If Meg gets up here and nobody asks any questions I - we probably would be done by about ten to 2:00.

So it really is interactive. This morning we had the payer community in here, now not as large a group as this but we had four or five people especially that had a lot on their mind.

So we had an awful lot of to talk about. We had a ton of action items. They were sort of scattered up on the wall over there. So it was a truly good facilitated session.

As you can imagine they don't agree with some of the things you guys want to do so but that's what we're here for absolutely.

Limit complaints and be constructive. We didn't really have any complaining this morning. It was all very constructive. I'm sure it's all going to be that way.

I mean certainly there are things that are frustrating. That's perfectly okay. But be as constructive as possible.

And again to reiterate that this session will not necessarily resolve issues. Some of it is really just to identify them and bring them into light a little bit better.

So with that what I'd like to do is I'd like to turn it over to Meg Watson who will be your lead facilitator for today.

Megan Watson: Can you hear me? You can hear me on the Web cast but now you can hear me? Okay. I told them I didn't need this. I tend to have a teacher voice. But we're going to roll with it anyway just to make sure everybody out there in Web land can get the same value that you all in the room.

I've been working on HCRA now for over a year and a half and have solely been working on providers until recently when I've switched over and done a little bit of the payer side.

So I know a number of you in the room are going under review with me right now. Some of you have completed your review. So thank you all for your continued patience with us as we get this underway.

What we attempted to do for both the payer and the provider community was send out a survey. So many of you in this room had responded and for that certainly we give you thanks because I think what we attempted to do was try and facilitate or guide the focus of our discussion today.

So what you see up here on the screen and on your screens in your offices is a ranking in order of significance.

So we had put out to this community the six hot button issues that we have been hearing about again and again. And those issues that we've talked to the department about again and again.

And so what we've asked is that folks would go ahead and rank them in order of significance.

I'll be honest with you when I reviewed all of this information last night I was shocked at the variety of answers.

Between hospitals, between (Hannies) between all the folks who participated it was kind of interesting to see that the hot button issues that I thought were so big weren't necessarily the same for every hospital.

Now that may be because some of you have not gone under review yet and you don't know what your issue is - and you don't know what you don't know. But believe me, we'll have that conversation today, what it's all about.

But this - the one thing that did stand out was the issue of co-pays and deductibles. That did kind of lead the pack without question.

But other things we want to talk to you today about is the difference between a direct and a non-direct payer.

Hopefully some of you in the - most of you in the room understand what that means. We'll get into that a little bit.

Private practicing physicians, certainly that's been a hot topic for a number of our entities. And we'll discuss that.

Undetermined payments, and this really relates to a variety of things, whether or not you can parse out your Medicare or what, you know, the various exclusions that might happen.

And then penalties and interest. I know Tony had spoken this morning during the payer community session about the amnesty program that's ongoing right now. And certainly we'll have him relay that same information to this group as well.

And then lastly on the list that we have created was personal items and how they are to be treated whether or not they are subject to the surcharge and then certainly whether or not they're subject to the 1% statewide assessment.

So I see some of you nodding your heads at me like you know what I'm talking about and some of you looking at me like you have no idea.

So again we're going to get into this topic. But the first thing I want to do is kind of throw it out there, are there other items that perhaps are not on this list that you do want to cover today? And we should kind of throw that out there right away. We got them all?

Man: Elector list.

Megan Watson: Oh the elector list, absolutely. So I do think that that's something we're going to cover with the direct versus non-direct payer but more specifically maybe perhaps the administration of that list.

Man: I - my question was or my observation or issues with the elector list not only with its complexity which we are working with Department of Health over but we want and need to have once the issue is resolved for one facility it's resolved for all and to have carryover between the audits with regard to all of these items.

Megan Watson: So (crisp) comment to that also consistency across the reviews. I will say we've been trying to do that.

You know, our team internally within KPMG and then certainly communications with the Department of Health we're constantly revisiting how did we treat it at this hospital, was that appropriate?

And to be - I'll be honest with you, to the extent that we realized it wasn't we've gone back and made the changes as appropriate, you know, and done it retroactively.

So definitely that's something we're constantly considering but I would agree, you know, could use some continuous improvement.

Anything else anybody wants to add to the list? So - oh (Sean)?

(Sean): Who we talk about like carve outs like radiological services that are carved out?

Megan Watson: Okay so service exclusions, sure. Okay, so carving out specific items. And then certainly as Rory had mentioned, as we get into these discussion topics you're going to notice that the questions we have listed for you up here on the screens are just those kind of that have come to us in previous engagements and we want to put out to you.

But certainly they might not necessarily address what your issue with the topic is. So Rory mentioned it earlier, don't be shy.

We need to utilize this as an interactive session. For me to stand up here and talk for the remainder of the day would not be productive. And really we want to have a dialogue as opposed to us telling you what's going on.

So without further ado I think we'll get right into the first topic which is really the responsibility for applicable surcharges related to co-pays and deductibles.

Kind of the thought-provoking questions we came up around this, obviously who's responsible for those, what level of documentations should be maintained to support the determination of responsibility, and then certainly what type of communication is necessary.

You know, Rory threw it out there so I'll kind of tag on to it. As you might imagine the payers feel a little bit differently than you all as the providers as it relates to this topic.

So that being said, I'd like to open it up to the crowd if I may to kind of get your thoughts and feelings. Don't all jump up at once.

We do just as a reminder, we have (Ming) at the back of the room with a microphone. For the benefit of those folks joining us via Web cast we do ask that you just raise your hand and he'll come to you with the microphone and we'll do it that way.

(Elizabeth), (Ming).

(Elizabeth): Some of the complexity with this is really very difficult for the hospitals for the simple purpose of the carriers are paying the surcharge and the co-pay and deductible but some of them choose to pay the state directly.

And then a few of the carriers are beginning to pay the hospitals which are putting an administrative burden on us.

You know, we don't get the 2% for those and it really is very difficult in processing our payments and monitoring them.

Megan Watson: Absolutely. So first thank you for being brave enough to stand up and have the first comment. But as it relates to this you are right, you know, and Tony had mentioned earlier today during that payer discussion that that is in fact their option, right?

What had been happening I know is that a number of providers were anticipating that if they were a direct payer, in other words if they were on the electoral list they in fact were paying the applicable surcharges on co-pays and deductibles directly to the public goods pool.

To the extent that they weren't they were paying it to you. So as the department sees it those are their two options.

We did mention today that there’s some inconsistency around that. There's a lot of complexity as to not only to what you described, you know, I think we have to note that as (Chris) if you will, an action item just to figure out that administrative piece.

The 2% that you're not being able to charge through on having to track that, collect that, and move forward, you know, that's certainly something for the department to consider.

But I think also what we’re finding is that as payers are responding to you all as providers they're saying yes I do this except for when I do this, right?

And so for those of you who haven't been under review yet what you'll find is that as we as auditors come in we really don't have an opportunity to say okay well if then, you

know, if this then why or if - so the way we run our procedures on millions of transactions is we need to either have a code that's assigned to it or there has to be some indicator so that we can parse these things out as appropriate. So thank you (Elizabeth) for that. Tony did you want to say anything on that one?

Tony Naglieri: No outside of the simple fact is we do not mandate electing payers to pay the surcharge piece over to the pool. You know, as Megan stated they have the option of doing either. And that's how we've always portrayed it in the Q&As, okay.

Megan Watson: The other issue -- and I'll just throw it out there because I know some of you in the room of had this issue -- is as it relates to whether or not someone is a primary or a secondary payer and whether the coordination of benefits principles apply as it relates to this particular issue.

Have any of you found that that's going to be a problem for you? Or let me back up. Have any of you found that, you know, you're going to have an issue determining whether or not you're paying the co-pay, the surcharge and - or the applicable surcharges on the co-pays and deductibles?

Not much information. How many of you are reporting this on Line 17 of your hospital report every month?

Nobody, okay. This is your opportunity...

Man: (Unintelligible).

Megan Watson: Okay you might be okay so maybe go ahead?

Man: We need to take a poll of who’s actually remitting on the co-pays and deductibles versus who is not just to kind of get a feel.

Because I know for my experience I've seen it both ways where, you know, some hospitals have taken, you know, the stance that, you know, all direct payers remain the

surcharge directly on co-pays and deductibles. And when I say directly I mean directly to the state.

And I've seen the other stances as well where, you know, they're not remitting any on the co-pay deductible. So we've seen it both ways.

So as Megan said this is, you know, your chance to try to get this, you know, this process better and come up with some ideas. And that's really what we're looking for.

Megan Watson: Go ahead. Sorry.

Man: I've actually heard from our membership three ways. One way where they automatically do it regardless. They - the hospital takes the responsibility for automatically on assessing the surcharge and sending it directly whether or not they've determined that the insurer's actually paying.

I've also - and also think it's reasonable if the person is on - if the insurance company is on the elector list as you indicated, that the assumption is that they're also electing for everything not just that one component.

And then I've heard the other case too where they just are trying to contact the individual companies and trying to do the best they can to go through the weeds to figure it out.

But again just using the elector list as an example that's got thousands of lines on the elector list so theoretically there's thousands of options even within the same insurance company depending upon who's the processing center, what group they're talking about.

And I've heard from - also from members which individuals that they're dealing with within their - the companies themselves.

So we really need to have some type of uniform way of identifying what's going on to the provider community because truly we don't stand a fighting chance I feel in being able to determine whether or not or what the insurance company is doing.

Megan Watson: That being said I just kind of want to flip to the same opportunity we gave to the payers today what I'd like to encourage and I hear the issue loud and clear.

What I'd like to encourage is some dialogue around how do we fix that? You know, what is the potential solution at the end of the day?

Is it that, you know, at some point down the road -- and again going back to Rory's no promises? But is, you know, is that that we're suggesting they have to do it one way or the other or because I wasn't around back then.

But apparently there was a lot of dialogue when this originally happened and there was a lot of pushback on behalf of both communities that they didn't want that control taken away from them or having it dictated to them as to how they were to handle this.

But unfortunately I think what that does is it creates an issue now of some are communicating it, some aren't, what do we do? How do we handle it. (Stu)?

(Stu): Obviously we echo what (Bob) said from (Hannies) but I think this discussion here needs to focus on how KPMG is going to handle what's been going on for the last 17 years.

Going forward the associations are working very closely with officials at the Health Department to try and fix the situation.

But the fixes don't really reflect what's been going on for 17 years. And what the providers are faced with is audits for the last four or five years.

And you can't rely on okay well it's a broken system and we're going to fix it because you're holding them accountable to prove either that the payers handle this or the providers needed to handle this and documentation is scanty going back four, five years.

And I think that's what - that's the troublesome part of this. So we really need to focus on two things. And the discussions going forward are best served between the department and us representing our membership.

But what they want to hear today is what easements they're going to get on not being able to come up with this documentation because the payers won't give it to him.

Megan Watson: Absolutely. I kind of forgot to open with my joke about one of the hospitals that had just recently gone to review told me I should wear a poncho because I'm going to get a lot of stuff thrown at me during the session.

And so I think that was my first tomato if you well. So thank you. But from that perspective we completely understand your position, right?

On many conference calls we've heard we get it. We didn't do it properly or we didn't even track how we were doing it or whatever the case may be.

And as auditors that puts us and the department quite frankly, in a difficult position. Because at the end of the day I need to audit evidence that you knew or didn't know or did it appropriately or didn't do it appropriately.

So that being said, you know, I think you're right in terms of moving forward in the audits that are under review.

I think the department has made a lot of concessions as it relates to how we are handling these things and continues to do so in the ongoing reviews that we have.

I think the other thing that we've tried to do as kind of a proactive approach is to the extent that things are brought up on one engagement and we know for instance that this payer always remits directly to the pool.

We're at least sharing that information so with the next review or the next provider that comes under review we know just take it out. They're not even included. Take it out and we're addressing it that way.

Until we get more communication back from payers as it relates to what they are doing, how they are handling it and until the provider community starts to document this is how we understand whether we pay or we don't we're kind of in a hard spot.

So any comments or suggestions as it relates to what he's talking about?

Man: For the providers, what do you see mostly in terms of the surcharge piece being paid by the insurance companies? Is it small insurance companies also that are voluntarily paying this or is it the large insurers? From a financial impact where is the big hit is the question?

((Crosstalk))

Megan Watson: And I apologize. We can't have a conversation without the mic so if one of - thanks.

Woman: Hi. What I would like to mention, I don't know if this is only my problem as a provider, but if we follow the instruction when we fill the pool reports right, it has always been very specifically told that anything that's co-pay deductibles and self-pay as a secondary payer should be included and reported.

So from this point of view I think the Web site doesn't help in clarifying. It kind of really puts all the burden in - on the provider side.

It really - I mean it and also if you follow the examples, the building examples that the Web site provides they're very misleading in terms of who is responsible to pay the surcharge. And it feels like from if you read all of those all the burden falls on the providers.

Megan Watson: Well to use a term that came out earlier this morning it's certainly there is burden of proof on you as providers correct? And the same goes for payers quite honestly when we come in and review them as well.

In terms of at some point during the process you as a provider made a choice to not pay on co-pays and deductibles or to pay on co-pays and deductibles.

And to (Elizabeth)'s point earlier it does create an administrative burden as to when do I, when don't I. Is it EOB based? Is it, you know, whatever the case may be?

But I think that - that's why we're here, right? We need to understand how to better facilitate that discussion.

As it relates to the case studies that are on the Web site, you know, certainly that's been brought to our attention. We've had those discussions many times with Tony.

So maybe getting back to, you know, the purpose of today and recommended action items is we can look into those case studies to see are there more appropriate examples? Is there more detail that can be provided within the hospital report instructions and we'll go from there.

Thank you.

Okay I didn't mean to cut you guys off. I'm sorry. Do you guys want to - okay.

Tony Naglieri: Generally we're hearing it's a mixed bag. There are some small insurance companies that are picking it up and some of the big ones too correct? Okay.

Megan Watson: Okay considering the fact that this is the number one issue in the responses that we received, I'm a little surprised. But certainly if there's no more comments we'll go ahead and move on to the next discussion topic.

And for those of you on the Web cast I do just want to remind you that if you do have a question or a comment that you want to contribute those are in fact being tracked and relayed to us as necessary.

To Rory's point earlier, if we don't get them today there will be kind of a formal Q&A that comes out of this process. And the same goes for you all in the room. We'll communicate back out kind of what transpires today with actions are going to be.

Yes?

Man: (Unintelligible).

Megan Watson: No problem.

Man: Just a thought on that - just a thought on the co-pays and deductibles. You're obviously also auditing the payers, correct? Why aren't you getting it from that side?

Megan Watson: We actually have been asking that specific question...

Man: Right.

Megan Watson: ...now that we've, you know, if you think about the development of how this all works as far as I know this is not a hot issue a couple even months back to be honest with you.

So from that perspective now that we know we are tracking it at all of the reviews on the payer community side we're sharing that information between our teams internally with KPMG and quite frankly getting approval from the department to apply those determinations to the remainder of the reviews.

So that's happening. Unfortunately for the, you know, the folks who are under review right now it's not as real-time as they might like or it might not necessarily, you know, take care of the material payers from that particular entity.

So it's happening but it's not happening quickly enough to make a significant impact. Go ahead (Annika).

(Annika): (Unintelligible) my question is how is that information being shared with those hospitals that are currently under audit? And then I think we also need a plan for how that can be shared with the industry globally?

Because we're not just, you know, addressing the audits going back. Certainly there are hospitals in the room that aren't being audited today but may be undergoing audits starting, you know, next week. And that information would benefit them significantly.

Megan Watson: I think we'll definitely track that as an action item. But I can speak at least from my own personal experience with my reviews, to the extent that we kick off an audit this is one of the first things we discuss at the kick off entrance or kick off for entrance conference.

And primarily it is to share that information. To say here are the folks that we know we don't - you don't have to spend your time worrying about.

Here are the folks that have not been approved or otherwise at this point in time. And it is going to be on the providers unless a change is made.

And I'm sure will discuss this with the department going forward that we'll have to continue to receive letters essentially. That's what we're expecting, communication from the payers whether it come in the form of an email, a letter.

I've actually gotten on the phone with payers myself to try and, you know, figure out a couple. Because I'm hearing one thing in one email and I'm getting information in another that's a little different.

So we're tracking that information as best we can. Is there may be a better way to do it more systemically? Possibly, probably. So from that perspective we'll certainly look into that.

(John)?

(John): Is there a list somewhere as to those payers that you currently have that are paying on the co-pay deductibles...

Megan Watson: I can print...

(John): ...because we're only aware of one...

Megan Watson: ...it out and give it to you. And I know that's not the fair answer, right. But certainly that is something that we have created and we've shared with hospitals.

You know, we could talk to the department about presenting that as part of the Q&A after today's discussion. But that is something that is available.

Man: (Unintelligible).

Megan Watson: I'm actually sitting here thinking to myself how come you don't have it? So absolutely, as soon as a leave here. You're very welcome, tomato number two.

We have another comment or question. Thank you (Jessica).

(Jessica): Yes, this is from our Web cast. In light of the inconsistency and confusion that surrounds the payers remittance of surcharge on deductibles, co-payments, and coinsurance to providers can the payers provide information to either the state or to providers as to how and what the payer believes they paid in surcharge to the providers?

Okay I think the question's actually talking about in aggregate. And so from that perspective that really doesn't help us too much in our detailed test work when we're actually figuring out applicable surcharges on detailed transaction level information.

So although that might be helpful in terms of getting that number back down if, you know, we're being conservative and treating it an appropriate way, but that's certainly an approach that we could perhaps discuss.

I know sampling around this topic has also been something that's been thrown out there. And so we'll certainly start to consider that as well. But thank you whoever submitted the question on the Web cast.

Okay.

Tony Naglieri: I guess to sum it up, you know, we realize it's a big issue. We realize that the hospitals that are going through audits are obviously behind the eight ball.

Okay we're trying to be as reasonable as we could possibly be, you know, which is why we have gone to some of the big payers to see how they handle it.

And in cases where they tell us they consistently pay the pool directly we're wiping those right off the slate, you know.

It's kind of the mixed bags that we really have a difficult time being able to say well, you know, these are going to come out of the equation because some insurers handle it both ways, okay.

But again, you know, just in terms of reasonableness we're going to be pretty flexible, as flexible as we can possibly be and still fulfill our ministry of obligations.

Megan Watson: Go ahead (Ming) if you would.

(Bob): Would the Department of Health be willing to maybe send a letter from the Department of Health to each of the insurance companies so that we could take care of this in one fell swoop rather than the individual providers having to do it?

Tony Naglieri: (Unintelligible) respond.

(Bob): Well you have the authority of the state of New York behind you and hopefully that would help.

Tony Naglieri: Well I guess (Bob) if you're if you're telling me that if they don't respond you want it taken back. No, I thought so.

Woman: (Unintelligible).

Tony Naglieri: But we can't go that far. I can certainly look into something coming under department letterhead that requests them to provide us information, okay and put the caveat in there

that if it changes how they handle it they'll have to notify us. But that's certainly a potential solution.

(Bob): And then maybe put that - and maybe put that element of the audit on hold until we get the responses back, plenty of stuff to look at.

Megan Watson: We want to just have a dialogue here. So I think that the issue there too is it puts us in a difficult position because at the end of the day you made a decision to pay or not pay based on something.

But from that perspective really the something is what we're looking for. And in many instances we're not finding it.

So that's I'll be honest with you how this process evolved was that it became a compromise that the Department of Health would say okay this communication coming from the payer then will at least alleviate that particular payer from being included.

So I think to put it on hold completely is almost saying okay well, you know, let's stop HCRA and you really don't have to prove why you paid or why you didn't and...

(Bob): So you don't have to do it in each one of our shops. It's all for you.

Megan Watson: I like that approach. He's throwing flowers instead of tomatoes. So from that perspective...

(Bob): (Unintelligible).

Megan Watson: Yes I think that that' certainly an option and something that can be discussed with the department. And I think he's right though at the end of the day what's the impact if the answers don't come back.

Or how do we then even okay, so even this way, can you identify those folks in your data or in your systems to say yes this is the person, no it's not and do you even have indicators that can prove that out?

Because I - so from that perspective if you have, you know, commercial payers or generic payer codes that you're utilizing within your data to track these things, if you're not tracking whether they're not paying - whether they're paying the co-pay or deductible or not, at the end of the day I can't back it out unless you can prove to me that yes this is that payer or yes this is that instance that's reflected in the communication that came from the payer.

So it's not as cut and dry as believe me, I would love it to be. But unfortunately we're in kind of a predicament. But again go ahead.

(Bob): Just to follow-up on that with Tony, could you add a question to their certification or their monthly report?

Tony Naglieri: I'm actually thinking along the lines as we're talking this out perhaps during the questionnaire period okay, at the commencement of the audit if you can give me, give KPMG a listing of the insurers that are involved okay through your systems, we can at DOH perhaps trigger a letter that we sent to all of them.

Megan Watson: Well and I think what Tony's saying if you think about it this way there - I will tell you I've see a lot of these letters come through.

There are payers that will say for this provider I will certify that I'm doing X. That can't always apply to I can't take that of this particular hospital review and apply it over here unless they're going to confirm that I do it across the board regardless of the provider I'm dealing with.

So, you know, to your point that's why we do in essence have to think about this on an individual review basis unless to your point earlier, going forward something changes so...

Tony Naglieri: And that - and throwing that out as a potential solution is not the long-term solution I'm looking for. It's more to address the audits that we're in now.

(Elizabeth): I guess I would really caution us again using side letters of the solution to all of this because the side letter business for lack of a better term is really created its own mess.

And then the second thing I would just say is I think, you know, especially on this issue we really need to solve the overall policy issue of whether or not, you know, to the earlier point whether or not the payers are actually, if they're electing they're electing for co-pays and deductibles also. And I think that's a threshold issue that needs to be resolved before we get into...

Megan Watson: Tony if I could, I just need to kind of reiterate what (Elizabeth)'s saying only for the purpose of the Web cast.

So certainly you're a soft talker also. But what I'm hearing you say is the side letter issue might even cause more of a mess than it might actually help resolve.

And then the second issue is around it goes back to the fundamentals of electing or non-electing and what that really means as it relates to this particular issue. Is that accurate? Okay, thanks.

Tony Naglieri: And I don't disagree with any of that. You know, the only thing I'm trying to get at here is some sort of resolution on a short-term basis for the hospitals that we're currently (dinging).

You know but I agree, anytime we can get away from the whole side letter issue I think that's a good thing.

Megan Watson: Okay so in the interest of time I am going to go ahead and move on to the next fun and interesting topic which is private practicing physician.

This is certainly an issue that's been coming up again and again. And they're smiling already. And so from that perspective, you know, ranked number two on our survey but we're really looking here for what determines whether the entity's physician practice or clinical practice et cetera, is outside the scope and not subject to HCRA.

And there have been some very recent developments as it relates to this topic. And from the department's perspective I think that you all as a provider community really have two options.

At the end of the day originally this topic -- and Tony feel free to correct me if I'm wrong --- but originally this topic related to are those physicians employed by the hospital and does that revenue generated roll up to the financial statements of the entity under review?

Because if you think about it in again going back to the fundamentals of HCRA as it relates, it's a provider tact and therefore the revenue - and it's based on revenue.

So any revenue that rolls up to the hospital would then be subject to HCRA. But recently there are two options as it relates to this.

Certainly in terms of getting yourself out from under having your whole physician practice audited you would either have to state in the letter that you're - the physicians that are under the review or providing services in the Article 28 facility are in fact discretely billed and not employed by the hospital or you would have to go into creating a letter that would basically discuss although they're employed you'd have to explain how - that basically their hospital (unintelligible) reflected on their records are attributable to private practicing physicians and explain how the issue legally accounting - from an accounting perspective and from a billing perspective they don't really roll up in the hospital.

So most recently we have had reviews that have - we've essentially stopped reviewing their physician practice or their clinical practice for this particular issue because the department was satisfied with the information that was presented in a very formal document to the department.

It was raised to me that the questions and answers that are provided on the Department of Health Web site, you know, they pretty much state that if it's a private practicing discretely billed physician group then it's not subject to HCRA.

Well again going back to the burden of proof you're under review. So you need to be able to provide evidence of that. And in this instance the department's accepting formal documentation from your entity that would basically outline those three things.

(Stu)? Oh (Ming) sorry, making you run (unintelligible). I might as well just sit up there with these guys.

Man: Okay we're appreciative that the department is asking for A or B but it's nice that it's communicated here. But we don't have the entire membership or entire provider community here.

So are you guys going to send something out formally from the Department of Health, I'm sorry? Well if you give it to us we'll send it out but it's got to be on your letterhead.

So electronically send it to us and we'll communicate to them.

Tony Naglieri: Yes, certainly...

Megan Watson: Also updating the Q&A to that effect...

Tony Naglieri: Yes.

Megan Watson: ...would be helpful.

Tony Naglieri: Yes and just to speak to the whole Q&A revamping I know we had this conversation a year ago and I told you that we're in the process of revamping them.

I've been told by the person in charge of doing the revamping that she's done with the questions. Now we just have to get our counsel's office approval on them. But yes that question certainly will be revamped okay.

Woman: (Natalia)?

(Natalia): As it relates to the letters based on my, you know, prior experience with KPMG do we still, you know, is there a standard letter form in terms of have we develop that in terms of, you know, what needs to be included in the letter like the date, you know, TIN number, of the physician group and so on and so forth? Can we talk about that more, you know...

((Crosstalk))

Megan Watson: And I don't mean to cut you off but I think that that's what Tony's referring to. I know the logistics are being worked out.

There has been I believe two letters to date that have been approved by the Department of Health. Both have very similar language not surprising.

And so from that perspective I think they're reviewing that and will certainly be open to sharing that with the community to the extent that the department - that's the department's, you know, decision. But absolutely I think that would be helpful.

Man: (Unintelligible).

Tony Naglieri: The one letter with him. I'm going to ask him to just kind of go through some of the highlights that are included in this letter that allowed us to make the decision we made?

Man: Just for some past history I believe initially the department when HCRA started wanted to define what private industry practicing physicians would be.

But there was some resistance on the provider community because they said that there was so many possibilities that it really wasn't, you know, fair for the department to define it. And they said that the providers were in the best position to do that. So the department has pretty much, along with that.

And what we've expected in the letter is either A, yes definitely everything is private and discreet that we bill for or if you're uncomfortable with that, what we're asking for is, is an explanation as far as where the revenue is going whether it's part of the ICR or

separately just going to the financials and not flowing through the ICR and also explicitly showing that the building is discreet and also from the accounting position like I said that it goes through the financials but not necessarily into the ICR and that your legal department is in agreement with all that foregoing analysis.

So if you can give us those three areas and you're comfortable with that then, you know, we're willing to look at the letter and probably accept it.

Tony Naglieri: We'll try to get a sample letter out on the Web site too, okay?

Megan Watson: So again it's really those three components he mentioned -- legal, accounting, and billing. And so you're going to need to provide that.

So we'll certainly take it as an action item here but knowing that the department's following-up on that already.

Tony Naglieri: And one of the big changes recently we - I don't think anybody really had an issue all along with the discreet part of this whole thing.

It was in the definition of private practice, okay. And the more we've talked to the associations about the salaried physicians and the arrangements that are out there and we've actually talked to the health department's commissioner's office, you know, there's a whole move on to get these physicians salaried which, you know, is beyond my knowledge basically but certainly the move that's on out in the real world, you know, with the various models that have been done.

So all of that being said we are trying to make this whole thing work in terms of, you know, looking at salaried physicians and saying yes they are indeed under the umbrella of private. So we have made headway after 14 years.

Megan Watson: Okay. So we're going to move on to our next topic of the day which actually related to personal items. And from that perspective we were really looking at how should they be treated as it relates to HCRA?

And by personal items really we were talking about TVs, telephone, and private rooms. And I think what's happening is that there is some treatment that originally had varied as it relates to the hospital report instructions for both the 1% statewide assessment and then the HCRA surcharge.

So from that perspective, you know, just either by a show a hands or if you can talk to me a little bit about how your entity or how entities in general are treating personal items and whether or not they can be identified clearly as, you know, TV, telephone, private room, et cetera and then maybe how you have been treating it and then what you've been hearing obviously in the grapevine. So I'll open it up. Go ahead (Bob).

(Bob): Actually the association has done a survey on that particular item. The respondents to the survey pretty much universally have said that the - they had not applied the surcharge to that.

We did not consider it on the patient service revenue and believe the department has already opined on that.

And I know that we've notified the industry that, you know, this item is not subject to either the surcharge or the 1% assessment. So I guess is it - it’s sort of a moot? Okay.

Megan Watson: That is correct. I raised it here only because A, it was an item that didn't - obviously address it and discussed at great lengths. But I also, you know, from a perspective of again you go back to being able to provide evidence that it is in fact personal items, right?

So the department has in fact come out with information allowing us to not surcharge and not include in the 1% statewide assessment personal items.

The burden goes back to you all as a provider community that you need to be able to parse those out of your billing system and separate those from us.

Sorry to you folks who are on the Web site or the Web cast. There’s (kind of a bit of) background. Hopefully our building’s not on fire or maybe I'd get lucky and it was.

So from that perspective I appreciate your comments but this is kind of a done issue. I would imagine that either perhaps going forward the hospital report instructions as it relates to surcharge may be updated.

If you were to go to them now the 1% statewide assessment very clearly excludes telephone and television. It does not exclude that on the surcharge side.

So that's where some of the ambiguity came up. And it was being surcharged in some cases. So I'd imagine that the Q&A will certainly be updated to reflect this point.

Man: And the one thing just to add there too just, you know, from the reviews that we've done on the hospital side we have seen hospitals include personal items in their net patient service revenue. So it has been part of our data.

So the one thing that we, you know, we would ask if you are under review is to be able to identify those personal items with some type of criteria because we have seen it included online one with net patient service revenue.

Megan Watson: Thanks.

Man: (Unintelligible) it's the department's official position now that personal items including those and others like guest meals or other purchases that may show up on a bill are not surchargable and not assessable.

To the extent that hospitals been doing this for the last 17 years can they apply credits to the next pool report to recoup that money if they've paid surcharges...

Tony Naglieri: If they paid surcharges...

Man: ...or assessments?

Tony Naglieri: ...on them, sure, yes.

Man: Okay so will you indicate that officially either through the Web site or on...

Tony Naglieri: Yes...

Man: ...the report?

Tony Naglieri: ...we certainly can. But it was my understanding that they weren't paying surcharges on these items that they were including them as other operating revenues.

Man: To the extent that somebody did it and I think...

Tony Naglieri: Yes then they can...

Man: Is this data - is it being applied retroactively...

Tony Naglieri: Yes.

Man: ...they should...

Tony Naglieri: Yes.

((Crosstalk))

Man: (Unintelligible).

Tony Naglieri: Yes they can take a credit for that.

Megan Watson: Okay so moving on to the next item. And I think somebody - (Bob) had kicked this off with regard to the elector list being an issue.

The direct versus non-direct payers, for those of you who might not be as familiar with this basically, you know, the direct payers pay directly into the public goods pool whereas the non-direct payers are not paying applicable surcharges and therefore leaving the burden of proof on you or the burden of payment rather on you all.

So from that perspective, you know, what determines whether a payer is treated as direct for the purposes of calculating an entity's HCRA obligation?

How are the mergers and acquisitions being handled? And then are they effective in termination dates for a particular payer considered when calculating an entity's HCRA obligation?

I feel like I'm doing a lot of the talking but on this particular, you know, piece, there is and so many of you have not gone under review I just want to give you some quick background.

Essentially when we come into your organization we're requesting the data, the detailed transaction data from your billing system from all of your cash payments.

So when that comes to us we do, you know, run a series of queries to identify all of the unique payers that you're dealing with on a day to day basis.

What we do with that information is then turn around and compare it to the state's elector list to say whether or not these folks are direct or non-direct.

At that point in time you'd have an opportunity to review that list and our determinations to then figure out okay because they're direct they're paying in. If the obligation leaves the provider I don't think you're going to come back and argue those with me because obviously I've told you, you don't have to pay.

Where it gets a little tricky is when we tell you that we either could not determined based on the payer name you gave us or we actually could not find the (NC) on the elector list.

We will let you know that those would be treated as non-direct.

And for those of you very close to it which I know you all are, then you will be charged a non-direct surcharge rate which is I believe about 31% as opposed to an 8% or so rate depending on the timing and the service dates, et cetera.

So from that perspective this becomes a major focal point of our review. So, you know, from - what we're really looking for you all to do is to start to think about how are you tracking that?

So for those of you out there, if you could just kind of bear with me to do some of the talking for a little while, how are you tracking that? What are you doing on a regular basis to identify whether or not you should pay a HCRA surcharge or not?

Woman: You both understood before that everybody who does business in New York State as a payers should elect and pay the surcharge to the board. So kind of every insurance company does - doing business in New York State was kind of excluded from that. It's considered a direct payer. So we focused more on the out of state payers.

Megan Watson: Okay.

Woman: And now I think we've been asking the state for a while to provide, I understand the list of those who did not elect to pay the pool is much smaller than the list of those who elected to pay.

So why not have that on the Web site and make it very easy for us to really look into who is not really paying?

Tony Naglieri: Can I ask you how we would know that population?

Woman: I'm sorry?

Tony Naglieri: Can I ask you how would we know that population? There's no way for us to know every single entity in the United States or in the world for that matter who provides self insurance to their employees?

The only way we know about the self insurers that we do is through the election process. But I can tell you whether it's a New York company or a non New York company the election process is voluntary. There's no mandate on a new your company that they file an election, okay?

Woman: Okay.

Tony Naglieri: I mean you would hope that anybody that has a presence in New York State would, okay? But really that's a business decision they have to make. You know, because really if they employee a lot of young 20 somethings that are a healthy population they may choose not to and take the hit on the hand surcharge instead of being on the hook for a covered lives obligation on every one of those insureds.

So it really is a business decision they have to make. But there is no mandate for New York State companies.

Megan Watson: Just from our experience, I mean some of the entities that we've reviewed, some actually do it on a payer by payer basis or an EOB by EOB basis and they're making those determinations.

Some entities actually go through the process of figuring out are they on the elector list? Are they not coding them as HCRA surchargable or not and going through it that way?

There's a variety of methods out there. I think what's important at the end of the day you need to be able to prove your decision why it was made and whether or not you can tie back to the elector list.

Two of the other questions that came up, one was related to mergers and acquisitions. So obviously the insurance companies, you know, there's a lot of mobility in terms of who's acquiring who and who now belongs with this system and what have you. And so we're doing our best that we can to keep up with that.

I know the department has maintained a database. KPMG has added to it. As we become aware of entities that are either related or what have you that we're accepting their election status because they were merged with another company.

So that's something that still, you know, goes back to how you're treating it on a day to day basis and paying the surcharge or not paying the surcharge based on their election status.

Tony Naglieri: (Unintelligible) clarify a couple of misunderstandings that are out there too about the elector list.

And that is number one it is historical in nature in that if an elector came on board and then they termed their election for whatever reason. They might've gone from self-insured to fully insured or they might've merged with another company.

These start and end date of the election period is always reflected on the elector list. So that if somebody was an elector and they're no longer an elector they remain on the elector list but they're end dated. Okay that's the first point I want to make.

The second point is it is a real-time list okay, generally. What happens is every night or every morning at 2:00 am any transactions for the previous day as far as somebody electing in or electing to opt out is then reflected by the next business day on that list. So it is an up to date list and it is historical.

Along the lines of it being historical we are in the process of making an enhancement to it because right now if you have somebody that merged with another fund in the status column it will simply say merged.

What we're going to do there is -- and this is probably within a couple weeks -- I know the program is in place but we're just testing it now, you can actually click on the link and it'll tell you who the company merged with, okay.

Man: Can you talk a little bit about governmental payers?

Megan Watson: So the question in the audience was could you talk about a little bit about governmental payers. So...

Man: (Unintelligible).

Megan Watson: ...and yes.

Man: (Unintelligible) that we actually Medicare is not surchargable, but out of state Medicaid programs I know that we've come to an understanding.

Tony Naglieri: Out of state Medicaid programs the surcharge percentage is based on their election status. So if you have New Jersey Medicaid okay, what we would look for, they don't specifically have to elect in for Medicaid okay.

We've always taken the position that when a company elects in they're electing in for all lines of business.

So as long as the state of New Jersey in some way shape or form elected into the pool we're taking that election and carrying it over to every governmental payment for the state of New Jersey.

Megan Watson: But this actually gets to an interesting point right? And that's how we've applied it. What's happening is at various entities, I don't know how many of you are - all are tracking out of state Medicaid as a particular payer and can then put that forward and show us that.

So if you just have, you know, a general category out of state Medicaid or if it just says Medicaid, we would have to dig down and figure out then you're going to have to start pulling samples of the lake to say it's actually New Jersey Medicaid or its Georgia.

I mean there are believe it or not, I mean you're in a highly - even people come to travel to New York City, the chances are you will have Medicaid payments from out of state.

And so that's the approach we've been taking to the extent that you can show us that they are an electing payer as Tony mentioned, they have to elect then just like everybody else, then certainly we're willing to remove that from the population just as we would Medicare. Thanks (Bob).

We have a question in the back?

Just for the folks in our room here we are sending around a CPE roster. If you wouldn't mind signing it whether you need the CPE credits or not, it does just give us an attendance of who joined us today. We'd appreciate it.

Those CPE credits will then be rolled out to you via email. I believe you'll get notification.

Tony Naglieri: May I clarify something?

Megan Watson: Sure.

Tony Naglieri: Back to the out of state Medicaid. They wouldn't be exempt like Medicare is exempt. What they would be is either the direct pay rate or the non-elector rate, okay.

Megan Watson: Thanks. Sorry about that.

Tony Naglieri: I know it's being recorded.

Man: Just out of curiosity though, Medicare is a federal program so clearly that's exempt. Medicaid is half funded by the federal government. Why wouldn't that be exempt?

Megan Watson: You got me there. I mean no, in all honesty I just believe it's not part of the exemptions in original statute.

Maybe - I mean that's it. It's just - yes it's part of the law and it wasn't excluded so therefore it is included and we do it based on whether or not they've elected in.

Any other questions? Yes in the back.

Man: Just have a question on international insurance companies like from South America or Europe.

We've been having a lot of pushback from them. They don't say - think they should have to pay at all.

I point them to the Web site and they still come back and say that they're not subject to it so...

Megan Watson: So the question really relates to international insurance companies who obviously are responsible for payments made to you all as providers in New York State.

And we understand that this is an issue and they are getting push backed or you all are getting pushback as it relates to whether or not they have an obligation to pay.

At the end of the day essentially they do but unfortunately the burden's on you to go after that money. I don't know Tony if you want to...

Tony Naglieri: It's the same thing, we, depending upon their election status okay? And believe me I realize that these are international companies and, you know, are we really going to go out and go after a company operating out of France? No.

But the only exemptions that really apply are for foreign diplomats, okay and in the case of foreign governments where the foreign government is actually the payer, okay?

They would be deemed to be an unspecified payers and pay at the same percentage as the election rate is.

Man: (Unintelligible) Q&As to be a little bit better?

Tony Naglieri: Yes we are - yes we're revamping all the Q&As yes. And let me just speak to that too.

As far as any specific Q&A's that you feel are lacking, please feel free to send me an email and I'll make sure that the person that's been working on this project has address that particular Q&A, okay?

Megan Watson: (Ming) if you could, a question (unintelligible) or if you just want to ask the question (unintelligible).

Man: (Unintelligible)?

Megan Watson: Yes to the...

Man: (Unintelligible).

Tony Naglieri: From the front end?

Man: From the front end of (unintelligible)?

Tony Naglieri: On your end? They would have to present something to you that tells you that there are foreigners.

((Crosstalk))

Man: And that's a question we would have to ask the patient...

Tony Naglieri: Yes.

Man: ...if they were a foreign diplomat?

Tony Naglieri: Yes.

Megan Watson: So the question in the audience was actually related to a foreign diplomat and how you would know at the point of registration whether or not they were. And basically it has to do with your intake process and understanding if they are or they're not.

It's come out on a number of reviews. Some hospitals may not experience it. Some more specialized hospitals, this is a major issue. So but you'd have to be able to prove that...

((Crosstalk)).

Man: (Unintelligible). You'd get lucky if you get paid at all from (unintelligible).

Megan Watson: The comment in the room was related to getting lucky if you get paid at all.

Man: (Unintelligible).

Megan Watson: Yes. Right, if you don't get the revenue you can't be surcharged on it.

So one other - (Natalia) has a question. But one other thing I just wanted to address and we'll get to your question, is the effective and termination dates.

Tony certainly touched on this. This is something that is absolutely considered when we go under review.

The point being is that if they don't elect in till let's say, you know, April of 2004 and we're reviewing service dates from April of 2003, to the extent that they were a non-elector at the time that the service was provided they are in fact deemed as a non-direct rate. So that is something that's consider during the course of our review.

So what we attempt to do is when we provide you back the information it really is provided in such a way that you can see whether or not they were deemed or what transactions were deemed out of scope or, you know, in that non-direct grouping. (Natalia)?

(Natalia): I just wanted to go back to a question about the diplomats. I don't think it - you know, potentially hospitals would be able to provide support.

Because when you do go to the hospital they normally ask you about what it is that you do and, you know, like, you know, you put your occupation. So potentially hospitals would be able to provide support.

Where it gets a little bit more challenging is I believe the international patients, identifying them and how, you know, I'm - right.

I, you know, based on my experience I know there have been a lot of issues or hospitals would just not pay any surcharge on claims for international patients. And I think that's more of a gray area as well.

Megan Watson: And to Tony's point, the issue is that if you have an international patient, if somebody from France comes and visits New York and ends up at a hospital in the city they're not exempt from paying the HCRA surcharge.

The revenue is still generated in the hospital. There's no exclusion because that individual's not a foreign diplomat and therefore the entity is responsible for paying.

It's not about the person accept for if they are a foreign diplomat. So but you're right, I mean it - and so certainly if you think that you're serving a lot of foreign diplomats then, you know, certainly this is something you need to consider.

But to the extent that, you know, you have to think from a business decision whether or not you need to be tracking this. But certainly we would need evidence of that, you know, if you were to be subject to the review.

Sue? (Ming) if we can have the mic please?

Man: Tony can you remind us why diplomats are excluded? We...

Tony Naglieri: (Unintelligible) we got a convention agreement and the Vienna convention too I believe.

So our official policy on it is not that we agreed but we chose not to contest it.

Megan Watson: (Bob) (Unintelligible).

(Bob): Actually too I just want to bring up one point when it comes to foreign diplomats, Medicaid, out of state Medicaid patients.

The discussion with Department of Health and the associations really centered on the ability for the hospitals and the - whether or not it was fair for the hospitals to have to pay 30% or is 35% of whatever they were able to collect which in most cases for out of state Medicaid was very, very small.

And truly the discussions and the agreements to exclude out of state Medicaid really revolved around that, that the facilities have no wherewithal to encourage out of state Medicaid programs to pay directly into the pool and why should the providers be left holding the bag for 30% to 35% of whatever tiny amount of money that they get from out of state governments?

And we actually did have a discussion with New York State and, you know, tried to see if there was any way that the state could intervene with their counterparts in other states.

Again it's mostly an issue in New York City, the border - obviously the border areas. And that's really I think what was motivating the decision to exclude those programs.

Man: (Unintelligible) as far as the neighboring states go who elected and who didn't?

Man: They all did.

Woman: They all did.

Man: I was going to say I think...

Tony Naglieri: They all did.

((Crosstalk))

Megan Watson: New Jersey, Connecticut, Pennsylvania.

Man: Pennsylvania, yes.

((Crosstalk))

Megan Watson: (Unintelligible) definitely were. It was the Floridas, the Californias, the Texas that we...

Tony Naglieri: Not really an (agency).

Megan Watson: Typically, being recorded so can't quote me on that.

Man: That's obviously something that we believe (unintelligible).

Megan Watson: Okay absolutely. (Chris) I think as it as an action item. And certainly we'll definitely consider that.

So it's really you're focusing on the Medicaid, out of state Medicaid and whether or not that's an appropriate thing to move forward with?

(Bob): (Unintelligible) Governments for them to pay a 35% fee. That's something New York State would have to negotiate I would think. And to have the providers being left holding the bag for that really is not fair.

Megan Watson: (Bob)'s comment just for the benefit of those folks on the Web cast is really that it's not on, you know, on the providers to negotiate that.

But, you know, that might be something the department or really the State of New York attempts to negotiate or figure out going forward. Thank you.

Any other further discussion on the directs versus the non-direct? Everyone's going to go back to their hospitals and figure out how to set up a HCRA indicator going forward?

Man: The only other thing I was going to mention which I think is worth bringing up now is, you know, one of the issues that KPMG has and I imagine the providers have this as well is, you know, actually determining direct versus non-direct.

Because, you know, right now currently it's an alpha to alpha match and we don't have a unique identifier as on the payer side we get the provider's tax IDs. So it makes it a much easier process.

So I figure that was at least worth bringing up to see if anyone had any recommendations on how this process could be more efficient or if you have a process in place at your hospital, you know, what exactly are you doing other than an alpha to alpha match?

Megan Watson: (Unintelligible).

Woman: Yes I got it. For the non-direct payers is there any way you can put in the Q&A exactly how to itemize the bill? Like do we have to add line per surcharge one, line for GME and how much is a percentage? What makes this 30 something percent or when does the penalty apply, the 28%?

Tony Naglieri: We do have in our HCRA Web site we do have a section that will give you the surcharge rates, the penalty if you will, the added percentage and also any alternative GME. That is out on our Web site okay, by region.

Megan Watson: Does that answer your question? I think - no. You're shaking your head. Can you? Difficult in what sense, difficult to figure out how to format your bills to get payers to pay in or to understand whether they are electing or are not?

Man: No get the calculation. They keep on, you know, it's not in all one spot. You have to go to different places and pull the information I think.

Megan Watson: Okay but I guess I'm...

Tony Naglieri: No frankly it is all in one spot...

Megan Watson: Yes.

Tony Naglieri: Just send me an email and just remind me I can send you the link, okay?

Megan Watson: Okay any other issues? Consistency was something that (Bob) had brought up in the beginning. I just want to address that for this purpose. And to (Pat)'s point, this is on an alpha to alpha match.

And so one of the other things that becomes an issue for you all is providers is to the extent that you are using generic payer codes to track, you know, as Tony mentioned, the amount of entities that are out there in terms of paying these claims is infinite as far as I'm concerned.

So from that perspective we understand system constraints. We understand you're not going to have a unique identifier for every particular payer.

But it's just something to consider in terms of what level of support are you maintaining to then be able to dig down into the detail and figure out who actually paid the bill at the end of the day.

So is that a problem for anyone out there in terms of how you're currently tracking it? Have you made changes to it recently, knowing that this is all coming?

Man: Here's another tomato.

Megan Watson: Thanks. You've been throwing them all day. Why stop now. Can you just wait for - yes?

Man: As we said in the past, the audits are spanning four or five years. So to the extent that hospitals were doing something back in 2004, 2005 they may have realized over the years that they need to better manage their business not only for HCRA but for other cost report issues where they need to drill down into payer types.

So I think that's what's hamstringing a lot of hospitals that you're going back to '05 or '06 and they may have been doing something differently then and you can't find an alpha match.

One thing that comes to mind is maybe there's an out of state Medicaid plan that has a fiscal agent and the fiscal agent sends the money in and the hospital records it coming from that fiscal agent rather than Arkansas Medicaid.

So you may be looking for Arkansas Medicaid and it's really coming from whoever the agent is. So I think that's really some of the problems that we're faced with.

And moving forward people are probably adjusting their systems so that they're not caught up in this type thing.

And I thought I heard Tony say I don't know about today, but other times that you're basically electing in all out of state Medicaid plans now. So then they should be off the table. And wouldn't that go retroactively?

Tony Naglieri: It is.

((Crosstalk))

Tony Naglieri: So when we're talking about election states, they have elected in. There's no enhanced surcharge and no commitment on the hospitals to collect those.

So Jersey Medicaid, Connecticut Medicaid, you have no obligation on those.

Megan Watson: But...

Man: Just Medicaid if they...

Megan Watson: So for them well you may be seeking to (something) - they would have to elect in. I think what you might be referring to is on particular instances the department may -- and this really goes for a lot of things -- but on this one instance if to the extent that the hospital is unable to provide the detailed breakout as I'm, you know, telling you that we need to review it.

We've come to the department with this is, you know, this is the percentage of dollars we're talking here. It's really immaterial in the scheme of things and therefore they may have made a decision.

That was a specific instance again, on a case by case basis. I don't believe at this point that there has been a determination from the department to say all out of state Medicaid is excludable at this point or not surcharged at the right rate, right.

Man: Okay the converse on this is New York State Medicaid sends patient out of state to services. To the extent that another state has a similar provider tax is New York State obligated - is New York State paying that tax or are they ignoring it also?

So it's, you know, I think it goes both ways and a state is going to say well if you don't pay my tax I'm not going to pay your tax and yet the provider is held, you know, accountable for this.

So perhaps in our discussions moving forward we can collectively come up to some agreement on how to deal with 50 Medicaid programs and the territories.

Megan Watson: So and I think (Chris) we got the out of state Medicaid thing pretty much documented there for an action item. So we'll certainly follow-up with that.

A couple of things you did talk about I just want to touch on. You know, yes I understand on a go forward basis you can improve your processes because you know these things are going to be audited.

I will say that yes we're going back. We've always - the department always reserved that right to do that.

And so, you know, but that's what today is all about, you know, to try and make the - improve the process to try and get feedback from you as to your pain points and to see what the department can or cannot do as it relates to those.

The other thing I will say is that they do tend to compromise quite a bit. So they're, you know, I know it sounds - and some of this people under review are looking at me like not really.

But certainly I will say and I think those folks in the room can even own up to this that there is a lot of discussion, there is a lot of back and forth and there is, you know, we bring a lot of evidence to the department and they make determinations. And so we can only move forward in that regard.

And then the last thing too that I think you were starting to touch on is related to who bears the risk at the end of the day. Is that where you were headed with that comment?

And I think that that's true. You know, but it goes back to the point about the data.

So if you're capturing a third party administrator in your data and really the risk there who's actually responsible for making that payment is somebody else, we need to get to that level of detail.

So okay, so moving on to the next topic is penalties and interest. I'm actually going to have Tony talk about this.

But really what is the entity's exposure as it relates to potential penalties and interest on any related HCRA payments? And then certainly I don't know if any of you are aware but there is a current amnesty program that talks about interest and penalties and what you can pay now to kind of alleviate the issue going forward so...

Tony Naglieri: Right now the way the law reads is that interest will apply to any underpayments that are greater than 10%, okay.

So KPMG comes in and determines for a particular month that you only gave us 80% of what you should have gave us for a particular month, you're going to get hit with interest.

The public health law states that the interest is 12% per annum, okay. What we generally use instead of the 12% is the New York State tax and finance corporate tax rate which pretty much brings the interest down to probably about a 9% level, okay.

In addition to the interest there's also penalty involved for payments that are less than 70%, okay? So that's 5% a month up to a maximum of 25%, okay.

So what you're hearing is basically these rates are a little under what loan sharks are charging right now, okay,

So it brings me to the next issue and that's amnesty, okay. If you don't know it there's an amnesty provision that just got put into legislation okay, so that for any report periods 12-31-09 and prior which are received by the department by 12-31-10 along with payment and certification okay, we will waive interest and penalty in full okay?

And this doesn't always apply to audit. It applies to any underpayments you feel you have out there. And the good news is you'll be able to estimate these payments, okay.

So if you're sitting there thinking, you know, I remember that system problem where (were) already taking this up on the surcharge. Now's a golden opportunity for you to become whole and not get hit for the interest and penalty, okay.

As far as signing a certification I know that a lot of payers and providers will be very hesitant to file a formal certification based on an estimate, okay.

So what we've given you the ability to do through the electronic application is actually fill out a different form that tells us it's an estimate, okay, so that you're not signing the formal certification, all right?

But again we need to receive the report, the payment and either the certification or estimate form signed for report periods 12-31-09 and prior by 12-31-10, okay.

Now for those of you that are under audit, you know, if you feel that you're going to get hit on audit okay, that the bottom line is going to be an under payment, it may behoove

you to submit the payment prior to 12-31-09 okay, by filling out a prior period adjustment line on a 12 - by 12-31-10 filling out a prior period adjustment line on a 2009 report sending us the payment.

Then when we actually go and calculate the bill we'll take that piece that you've paid under the amnesty period out of the bill and not subject it to any interest and penalty, okay?

And, you know, I would really ask - I mean we've gone out with notices on this. We continue to go out with notices and email blasts.

But I would also ask the two associations also to spread the word as much as you can because it's a great opportunity for people to get out from under the interest and penalty.

A couple of things, there are a couple of exclusions here. The first one I know I'm going to get a tomato but it's the amnesty period does not apply to the 1% statewide, okay.

Any interest and penalty which has been paid or collected previously by the department you're not getting back, all right?

Now any under payments which are discovered during the course of an audit conducted by the department or its designee okay, basically what we're using there is if you're about to wrap up an audit okay and a final audit report is prepared it's - we're looking at it as not until we actually send you that final report along with a letter from us that it becomes final and removed from the amnesty equation, okay?

So we're willing to work with you here. Hold on to the final report. But you've got to let us know you're making an amnesty payment okay. And then once we receive the amnesty payment then we'll go out with the final report, okay?

And the fourth one is it doesn't apply to any delinquent amounts that have been referred to New York State Medicaid recruitment or to the attorney general's office. So if we already have a facility in collection okay, the amnesty does not apply to that.

Man: Is all this information on your Web site also...

Tony Naglieri: Yes.

Man: ...somewhere?

Tony Naglieri: Yes. Plus we - yes. Yes and we've sent letters out and we've sent email blasts out to our contact people.

Megan Watson: Just to reiterate Tony's...

Tony Naglieri: Yes.

Megan Watson: ...confirming that all of the information that he just went over is available on the Department of Health Web site.

And there were specific notices actually set out to the various entities. And this does apply for payers as well as providers.

Tony Naglieri: You'll find it on the both What's New (Frank). You'll find it under both What's New and also under correspondence and notifications, okay. And let me just ask, is everybody familiar with our Web site? Okay.

Megan Watson: Okay. So a lot of estimated payments going at a later time. So moving on unless there's any other questions as it relates to penalties and interest, I know this came up as a topic because some entities were actually shocked at how large it can get and how quickly it can grow.

So as Tony mentioned it's almost a gift, you know, right in time for the holidays. So you might want to take advantage of it. (Bob)?

(Bob): Megan, how are you netting out the...

Megan Watson: That's a good question. So as it relates to the reviews you mean?

(Bob): Yes.

Megan Watson: So the question is how are we netting that out as it relates to the reviews? And although we haven't spoken about this directly, essentially I don't believe it will impact the review we take under. Essentially we would go through the process, we would complete our audit and then after the fact once the report is delivered to the states the state would then consider that in whatever invoice or credit memo's being issued back out.

So certainly they'll have the ability to take information from us or data from us in order to help calculate what that all means as it relates to, you know, the individual specifics.

But as far as I know we're not going to be adjusting our audit procedures to take into consideration any estimated payment.

Because if you think about it if we did you'd have to provide me with transaction level detail that I could back out versus just an amount. Is that fair?

(Bob): That's fair. The other question I have is when you accrue an interest penalty and you do have overpayments and during that time period, are you adjusting the latest, you know, the latest years hit if you will, with any overpayments that you made?

Megan Watson: (Unintelligible) and I'll let Tony speak to that. But keep in mind that the KPMG or any designee of the department, the report that's issued as it relates to the audit doesn't apply interest and penalties specifically.

It basically talks about specific underpayments related to service dates. All of that calculation is done at the department level after the report.

Tony Naglieri: You mentioned (you only get) from KPMG in the draft report and the final report broken out would be, you know, the amount that was paid into the pool as opposed to what KPMG determined that amount to be in simply a difference, okay.

Then what we do at the department...

Man: (Unintelligible).

Tony Naglieri: Yes actually...

Megan Watson: Yes...

Man: By month.

Tony Naglieri: By month.

Megan Watson: By month...

Tony Naglieri: By month.

Megan Watson: ...you do that.

Tony Naglieri: Okay? Then we take all of that information, put it on a bill and then we apply the 90%, 70% threshold to see if interest and penalty apply, okay?

So we'll go through that whole gyration there. And then when all is said and done any payments we got during the amnesty period we would net out against that.

Man: So the underpayments, overpayment? I'm assuming it’s fluctuating by month?

Tony Naglieri: Yes.

Man: So there's one month were you may have underpaid one month where you overpaid. Your finding overpayments for the latest period, correct?

Tony Naglieri: Well the overpayment would just show up.

Man: The penalties - the interest could be astronomical and be netted out.

Tony Naglieri: Doing it by month.

Man: This is you.

Man: Yes this is the way - how are you going to apply when you assess the interest penalty?

Tony Naglieri: The net overpayment or underpayment for the audit, okay.

Megan Watson: No but he said because there's different interest rates that are applied based on the month that it's actually being calculated.

Tony Naglieri: Yes.

Megan Watson: And so does then that net out - do you get the benefit of the interest rate that you overpaid also...

Tony Naglieri: Exactly.

Megan Watson: ...as a benefit of the interest of the underpayment?

Tony Naglieri: Right.

Megan Watson: I believe the answer is yes but we'll definitely put that as an action item as a follow-up for today. I don't want to put Tony on the spot as it relates to the...

Man: (Unintelligible).

Megan Watson: So because the monthly overpayment or underpayment, the percentage of interest that's applied at that point in time relates to that month, it varies slightly. I mean at the end of the day is it material? Probably not or maybe it is.

Man: It depends if you're 2004 on your 20%.

Megan Watson: Okay good point. So, right.

((Crosstalk))

Man: It should be netted against (unintelligible).

Megan Watson: Right.

Tony Naglieri: Well we're actually doing it by month so that KPMG determined it's underpayment is (unintelligible) 2004 that's where the underpayment is going to show up on the bill and we're going to look at that month.

((Crosstalk))

Megan Watson: Yes, so let's table it but yes, I don't want to force the issue so we'll table that one. But I also don't think you'd be paying interest on - he's asking if he's getting the credit for when they overpaid?

Man: Well they're getting the credit for the overpay.

Megan Watson: Overpayment.

Tony Naglieri: He's not getting interest on his over payment.

Megan Watson: Right, right.

Tony Naglieri: The state only works one way...

((Crosstalk))

Megan Watson: Right. (Bob) I guess that's really the answer to your question. If you think about it from a logistics perspective you overpaid the state's not giving you interest back is your point.

(Bob): But I want to offset any underpayments by overpayments but have that, you know, in the...

Megan Watson: Okay.

((Crosstalk))

Tony Naglieri: So if you've got an underpayment of one month and then an overpayment the next month we're applying the overpayment against the underpayment when we calculate the bill, okay.

Megan Watson: Okay so we'll still leave that. Maybe we can help clarify that in terms of the Q&A but...

Man: I think that...

Tony Naglieri: Let me have (Jackie) just send you an example.

Megan Watson: Perfect.

Tony Naglieri: Okay?

(Bob): Yes I mean...

Tony Naglieri: Yes.

(Bob): ...the facility...

Tony Naglieri: Yes.

(Bob): ...worked it out.

Tony Naglieri: Yes.

(Bob): I just want to make sure that that workout...

Tony Naglieri: Yes.

(Bob): ...works for...

Tony Naglieri: Yes we do net it. We do net it out.

Megan Watson: Okay the last item for our listing today was really this topic of undetermined payments. I'm going to let (Pat) speak to this a little bit and then we'll answer any questions.

I do want to leave sometime just so we're all aware of agenda, I do want to leave sometime at the end where we can just kind of rehash some of the action items we took today. I appreciate the, certainly the conversation to this point though.

So as it relates to the undetermined payments, really here what we're talking about is what is the potential impact if you all as providers are not able to distinguish among different types of self pay and other payments? And (Pat) if you could just talk on that a little bit to get them started.

(Pat Brian): Sure so, you know, when KPMG does get the data obviously we do take a look at, you know, the, you know, who the payers are.

And certainly to, you know, trying to determine who actually made the payments has been challenging at times.

For example we've come across generic payer names which, you know, we've pretty much seen that each of the hospitals where they have for some of their smaller payers you'll run into like commercial payers or miscellaneous payers and so forth.

But as you can imagine if you're under audit KPMG needs to be able to see who actually did make the payments.

And if we can't determine who made the payments you potentially could be a, you know, they could be potentially identified as not direct.

Another instance is, you know, co-pays on Medicare primary payments. So for instance I can tell you at some reviews we see payments come across as self pay but they truly are co-payments related to Medicare primary payments.

So we're just - what KPMG is trying to get at here and an issue that we've seen is we're just trying to understand who the true payer is and have enough information in the data that's provided to us.

So certainly we wanted to open this up as a discussion point as to, you know, how we can hopefully mitigate this going forward, this issue as far as, you know, to get more, you know, more of the upfront payer information or to, you know, I guess, you know, at this point we just want to open it up to see, you know, what the community has to say about this.

Megan Watson: That much?

Man: So this is something that we're seeing in hospitals especially the big one is the generic payer names.

We have used sampling and, you know, that has, you know, that has worked to a point. But, you know, this is something that, you know, going forward we would like to be able to change.

And this might be - you know, as far as you might be changing your process to actually identify who the true payer is.

But as you know, we do go back and, you know, take a look at, you know, years in the past. And we have had this, you know, generic payer issue on pretty much all the reviews to date.

Megan Watson: (Dean) if you could?

(Dean): I would think by linking the primary payer to the data set that is being sent to you, even if it's a self pay if you can tie it back to as I say a Medicare, then you would be able to

say okay is Medicare paying? That payment that's his coming in is usually a co-pay. And in this case we've done that and we've, you know, got the benefit of that.

(Pat Brian): Yes and seems like that would solve, you know, co-pays as far as identifying Medicare primary or (champus) as primary or so forth.

So that is definitely a good recommendation as far as letting us know up front how that we can identify those types of payments.

Megan Watson: And we have updated the questionnaire actually to reflect kind of a lesson learned there. So thank you.

(Pat Brian): Anything on the generic payments? I mean I can tell you that it has been challenging for the hospitals to drill down to the transaction level for some of these generic payers.

Some of the amounts have been pretty significant. But as I said we have done sampling if we're able to do so. But other than that that is something that has been an issue.

Megan Watson: Okay, so just in terms of next steps and what we hope to gain from today I think certainly what I've noticed at least in the folks in the room there's certainly some good conversation.

I think it's evident that some folks have gone under review have a lot more to say or questions to ask or perhaps, you know, if you're going forward and thinking okay, how is this going to impact me?

So I would challenge you all to keep thinking in that vein and certainly reaching out to the department, you know, with questions and as Tony offered many times today.

In terms of next steps for what happens after today, certainly the Q&A because it's being Web cast we have a full transcript that will come out.

You won't get the full transcript because I do want my tomato jokes on there. But you'll get the Q - the significant Q&A that will be coming back out to you after we sat down and discussed it with the department.

You know, in terms of action items to echo Rory's opening comments, some of these are might very well be things we can start to implement, you know, as the department agrees.

Others will need further analysis and discussion on what is the best approach and how to move forward especially on those issues where the payer provider communities might not be seeing eye to eye.

(Chris) if - would you mind walking us through? You might have to take that one. And I'll try to chime in but I can't read your writing.

(Chris Polls): It's really not that bad is it?

Megan Watson: I'm sure Rory (unintelligible).

(Chris Polls): So as far as action items go I think the common theme here is communication one between the payer and provider community, updating the Q&As, and the Q&As as well as some upfront communication maybe within the questionnaire.

But I'll go through each one of the areas. And as Megan said this is recorded and we will be providing a transcript.

So in any event, for the co-pays and deductibles issue certainly discussions are going to occur around the administration - administrative burden between the payers and the providers.

And as part of that discussion it's important to address, you know, particular case studies or examples that are involved. And in order to do that we will gather information from both the payer and the provider community.

Also as previously discussed we are tracking how the various payers are submitting the surcharge for the co-pays and deductibles.

We will be - and we do communicate that to the department as well. We'll continue that process and we'll also identify a process to share that information with the entire provider community.

In addition, you know, it was discussed that these are potential solutions so I don't want anybody to think that we are going to do this.

But however, potentially payers can provide the process that they're using to the state and/or the providers whether it's via the upfront certification process through the issuance of a letter, et cetera.

And then the overall thing as discussed by the associations is, you know, addressing the policy and really not having maybe one off scenarios and ultimately addressing the policy and revisiting that.

For the private practicing physicians again, there is a process that has been set up. Tony and George did discuss the letter that is available.

One of the action items is to post a sample letter to the Web site and to communicate what a potential letter, acceptable letter is.

And again, communicating the particular process out to the entire provider community either through a Web site email communications, et cetera, obviously to be determined as far as how that communication is going to occur.

The third area addressed was the personal items. As discussed personal items are not subject to 1% assessments or the surcharge. And the Q&As are expected to be updated and reflect that information.

The next area is the direct verse non-direct. We talked about a lot of issues here. I think, you know, certainly the out of state Medicaid needs to be re-addressed.

The fact that when we're performing our reviews there is certain proof that the provider community needs to provide.

So I think it's important that as the provider community you think about what documentation is available and what is available within your - in your systems specific data elements.

And as far as education goes around that area once again consider updating the Q&A that's posted to DOH's Web site.

Megan Watson: And I think that was a theme you heard Tony mention many times. If you have questions or if you really do need clarification over a specific Q&A, you know, let the department know so they can work on updating those so that it is at least a little bit more clear or the like.

And sometimes you're not going to like the answer they give back, right? You're not going to like the fact that it's part of the statute it is what it is and that's what has to happen moving forward.

But at least the department can attempt to clarify if there is, you know, we talked about case studies or if there's better examples that can be provided.

Having gone through a number of these reviews at this point, you know, certainly there's more information that we have available to us that we're also able to share with them.

Are you okay? I think the only other thing I did notice and I apologize to (John) is that one of the things we did when we opened up is talk about other topics that perhaps were wanting to be considered.

So I just want to go back to the service level exclusions for a second. And if you could - don't - if you don't mind just expanding on what exactly are you looking for, what are the issues and then we can talk through what the resolution might be.

Man: A prime example is we have a contract with a company that does radio - radiology services for a vendor. And we've been going back and forth whether they're direct or not direct because they are CIGNA, really CIGNA patients. And there's been a lot of back and forth then just how can we get some better clarity on this?

Tony Naglieri: The system needs more information as far as what the arrangement is, okay. So they're CIGNA insureds correct?

Man: Correct.

Tony Naglieri: Okay. Then there's basically a middleman if you will that provides...

Man: Radiology services.

Tony Naglieri: ...radiology services, okay. And...

Megan Watson: And I think the idea here is -- this is what we discussed the other day -- is that the radiology services are not - or are being provided at the (Article 28) facility.

In other words are you being paid by that service provider for things that happened at their facility or yours? And so from that perspective the revenues being generated in an (Article 28) facility and therefore would be surchargable.

I don't think it's surchargable on behalf of you would expect the service provider to pay it. You'd expect the insurance company to pay it.

Tony Naglieri: Well again keeping in mind that it is a provider tax. So the surcharges assessed on the surchargable revenue, okay?

Megan Watson: Which is what you're - from the insurance provider or the radiology provider?

Man: We're providing the services. It's being paid by...

Megan Watson: CIGNA.

Man: ...AIM which are CIGNA patients.

Megan Watson: Okay and so maybe what we do need to do is - well this is certainly an issue. But and I do think it would be a broader issue, not just a, your entity issue. So we - we'll follow-up.

And to the extent that we can update any related Q&A to give more guidance we can certainly discuss that. But...

Man: Because the payer would be direct. I guess the only thing would be the 1% whether it's outpatient or inpatient it sounds like to me. I mean based on what I'm hearing. Obviously I haven't seen the...

Megan Watson: (Pat) let me talk. No, he's saying he likes your answer.

Man: But I'm hearing...

Megan Watson: And it is - and not for anything. You know, to be honest Tony had pointed out as we started today is that HCRA's kind of the perfect, what was it a perfect mess?

Tony Naglieri: A perfect screwed up mess.

Megan Watson: And so from that perspective there are going to be these intricacies that we really have to sit down and figure out.

At the end of the day KPMG and I know certainly the Department of Health, we want to get to the right answer. So that really is part of the message.

Tony Naglieri: A situation like that we really - we need to be careful because there are a lot a different contractual arrangements out there.

So it's very difficult to sit here and kind of give you an umbrella answer without knowing all the specifics.

You know, so certainly if, you know, if you - either Meg can bounce the - it sounds like you're familiar enough with that particular scenario where we can talk?

Megan Watson: Yes. Okay that being said for the folks that are here in the room with us in New York City there is a CPE sheet going around. As I mentioned earlier if you could just make sure you get a hold of that and sign it we'd appreciate it.

For those of you who are on the Web cast hopefully you've gone ahead and answered the questions that have been pushed through to you so you will get your due CPE as well.

You know, certainly on behalf of KPMG I just wanted to thank everybody for your time today. I don't know if you have any closing remarks?

Tony Naglieri: No just to really thank everybody. We really find these forums to be very helpful. You know, we realize it's a very convoluted law with twists and turns. And I know that the audit impacts are significant. And we're trying to make the process better going forward.

So the fact that you people took the time out to come join us today is greatly appreciated. Thank you.

Megan Watson: And actually this whole entire Web cast will be available for rebroadcast. So if there are folks within your entities or certainly you want to share it across it should be available in the Department of Health Web site as early as probably Monday.

Man: And the association...

Megan Watson: We can - Tony assuming it's okay with you what we will do is send it to the complete list of registrant's and invitees. So they'll get it and certainly that would include you. So thank you all very much.

END