This issue of the e-News will be made available in PDF format no later than 24 hours after its release, and can be found in the archive with other past issues.

CMS Medicare FFS Provider e-News

CMS Information for the Medicare Fee-For-Service Provider Community

CMS asks that you share the following important information with all of your association members and state and local chapters. Thank you!

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The e-News for Thu Feb 23 includes…

National Provider Call: Hospital Value-Based Purchasing Program – Last Chance to Register [↑]

Tue Feb 28; 1:30-3pm ET

CMS will be creating hospital-specific performance reports that simulate the FY2013 Hospital Value-Based Purchasing Program for each hospital to review; the simulated reports will employ hospital data from prior years to construct each hospital's baseline period and performance period scores. To prepare providers for interpreting the simulated report, this National Provider Call will discuss a sample report that shows what hospitals can expect when they receive their own reports.

Target Audience: Hospitals, Quality Improvement Organizations, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare Fee-For-Service providers

Agenda:

- Opening Remarks
- Program Announcements
- Overview of the Hospital Value-Based Purchasing Program
- Presentation and Walkthrough of the Hospital-Specific Report
- Question & Answer Session

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

Presentation: The presentation for this call will be posted at least one day in advance at http://www.CMS.gov/Hospital-Value-Based-Purchasing, in the "Downloads" section of the page.

Special National Provider Call Series: Physician Value-Based Payment Modifier Program: Experience from Private Sector Physician Pay-for-Performance Programs – Last Chance to Register [↑]
Wed Feb 29; 2:30-4pm ET

Section 3007 of the *Affordable Care Act* requires CMS to apply a Value Modifier, which compares the quality of care furnished to the cost of that care, to physician payment rates under the Medicare Physician Fee Schedule starting with specific physicians and physician groups in 2015 and expanding to all physicians by 2017.

This National Provider Call is in support of the efforts of CMS to implement the Medicare Physician Feedback and Physician Value-Based Payment Modifier Programs. This call is one of a series of calls CMS will hold to engage the public in dialogue about physician level value-based purchasing and obtain stakeholder input on how best to implement the physician value modifier.

This National Provider Call will include presentations from a panel of three private sector experts who have had experiences in implementing physician-level pay-for-performance programs. The second call in the series, scheduled for Wed Mar 14, will feature three additional private sector experts.

Target Audience: Medicare Fee-for-Service physicians, specialty medical societies, and other interested parties.

Agenda:

- Opening Comments and Background – Sheila Roman, MD, MPH; CMS
  - Background on the Value-Based Payment Modifier
  - Introduction of Speakers
- Using Physician Pay-for-Performance to Improve Care – R. Adams Dudley, MD, MBA; University of California, San Francisco
- Quality Measurement: Physician & Practice Performance – Ted von Glahn, MPH; Pacific Business Group on Health
- Physician Pay-for-Performance and Other Incentive Programs: Lessons From The Field – Francois de Brantes, MS, MBA; Health Care Incentives Improvement Institute
- CMS Questions and Comment
- General Question and Answer Session
- Closing – Sheila Roman, MD, MPH; CMS

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

National Provider Call: Medicare Shared Savings Program and Advance Payment Model Application Process – Registration Now Open [↑]
Thu Mar 1; 1:30-3pm ET

On Thu Oct 20, 2011, CMS issued a final rule under the *Affordable Care Act* to establish the Medicare Shared Savings Program, along with a notice for the Advance Payment Model that will provide additional support to physician-led and rural Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program. These two initiatives will help providers participate in ACOs to improve quality of care for Medicare patients.

On Thu Mar 1, CMS is hosting a National Provider Call, during which subject matter experts will provide an overview and updates to the Medicare Shared Savings Program application and Advance Payment Model application processes. A question and answer session will follow the presentations.

The Medicare Shared Savings Program Application and Advance Payment Model webpages have important information, dates, and materials on the application process. Call participants are encouraged to review the applications and materials prior to the call.

Target Audience: Medicare Fee-For-Service (FFS) providers

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

Pre-Existing Condition Insurance Plan Saves Lives – *Affordable Care Act* provides Coverage for Nearly 50,000 Americans with Pre-Existing Conditions [↑]

HHS Secretary Sebelius announced on Thu Feb 23 that the new healthcare law's Pre-Existing Condition Insurance Plan (PCIP) program is providing insurance to nearly 50,000 people with high-risk pre-existing conditions nationwide. The Department released a new report demonstrating how PCIP is helping to fill a void in the insurance market for consumers with pre-existing conditions who are denied insurance coverage and are ineligible for Medicare or Medicaid coverage.

Under the *Affordable Care Act*, in 2014, insurers will be prohibited from denying coverage to any American with a pre-existing condition. Until then, the PCIP program will continue to provide enrollees with affordable insurance coverage.

In many cases, PCIP participants have been diagnosed with and need treatment for serious healthcare conditions such as cancer, ischemic heart disease, degenerative bone diseases, and hemophilia. As a result of the new law, PCIP enrollees are receiving health services for their conditions on the first day their insurance coverage begins. Their critical need for treatment, combined with their lack of prior health coverage, has led to higher overall per-member claims costs in state-based PCIPs of approximately $29,000 per year, which is more than double the per-member cost that traditional State High-Risk Pools have experienced in recent years.

Enrollment in PCIP has seen a nearly 400 percent increase from November 2010 to November 2011. PCIP enrollment is anticipated to trend upwards of 50,000 enrollees within the coming month.

People who enroll in the PCIP program are not charged a higher premium because of their medical condition. Program participants pay comparable premium rates to healthy people in the individual insurance market. By law, premiums may vary only on the basis of age, geographic area and tobacco use.

PCIP provides comprehensive health coverage, including primary and specialty care, hospital care, prescription drugs, home health and hospice care, skilled nursing care, preventive health, and maternity care. The program is available in 50 states and the District of Columbia and open to US citizens and people who reside in the US legally (regardless of income) who have been without insurance coverage for at least six months *and* have a pre-existing condition, or have been denied health insurance coverage because of a health condition.

The new report can be found at http://www.cciio.CMS.gov/resources/files/Files2/02242012/pcip-annual-report.pdf. For more information on the PCIP – including eligibility, plan benefits and rates, and how to apply – visit www.PCIP.gov and click on "Find Your State."

The full text of this excerpted HHS press release (issued Fri Feb 17) can be found at http://www.HHS.gov/news/press/2012pres/02/20120223a.html.

January 2012 Updates to the Physician Compare Website [↑]

On Thu Jan 26, CMS released its quarterly enhancement to the Physician Compare website. Improvements were based on recommendations made during July 2011 testing as well as suggestions from users and stakeholders. This is part of the Agency's ongoing effort to improve the Physician Compare website's data accuracy and ease of use.

What's New?

- *Page updates:* Home, results, and profile pages were updated and content reorganized to make it easier for providers and beneficiaries to find information. For example, a new menu option, "Provider Resources," is a direct link providers can use to find information about updating their PECOS

information.
- *Improved feedback tool:* The tool now allows providers and beneficiaries to contact Physician Compare administrators directly with questions or concerns.

For additional information on future new releases and updates visit the Physician Compare website.

Only 6 Days Until the Covered Document Review Date for DMEPOS Competitive Bidding Round 2 and National Mail-Order Competition [↑]

Reminder: If you are a supplier bidding in Round 2 and/or the national mail-order competition of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, you must submit your hardcopy financial documents on or before Wed Feb 29, 2012, in order to be eligible to be notified if you have any missing financial documents. *Don't wait – send the required hardcopy documents TODAY!*

The covered document review process gives bidders the opportunity to be notified of missing required financial documents. The Centers for Medicare & Medicaid Services (CMS) urges all bidders to take advantage of this process. Under the covered document review process, we will notify suppliers that submit their hardcopy financial documents by the Covered Document Review Date (CDRD) of any missing financial documents. ***The CDRD for the Round 2 and national mail-order competitions is Wed Feb 29, 2012 – financial documents must be RECEIVED by the Competitive Bidding Implementation Contractor (CBIC) on or before Wed Feb 29, 2012, to qualify for the covered document review process.***

The covered document review process only determines if there are any missing financial documents. It does not indicate if the documents are acceptable, accurate, or meet applicable requirements. Suppliers that submit financial documents by the CDRD will be notified of any missing financial documents within 90 days of the CDRD. Suppliers will be required to submit only the indicated missing financial document(s) within 10 business days of the notification. ***Only those suppliers that submit financial documents by the CDRD will receive notice from CMS of any missing financial documents.*** Bidders that submit their hardcopy financial documents after the CDRD will not be notified of any missing financial documents. After the bid window closes, bidders may only submit the requested financial documents identified as part of the CDRD process and cannot submit corrections to any other required documents. We encourage bidders to review the Covered Document Review Date factsheet available on the CBIC website.

Here are some important things to remember when submitting your hardcopy documents:
- Review the Request for Bids (**RFB)** instructions carefully to be sure that your documents comply with all requirements. The **RFB** instructions contain complete instructions for compiling and submitting your documents.
- Put your bidder number on every page of every document. We need your bidder number to match your hardcopy documents with your electronic bid. You will get your bidder number when you complete the Business Organization Information screen in Form A in **DBidS**, the online bidding system.
- Submit all required hardcopy documents in one package.
- The Round 2 and national mail-order competitive bidding areas (CBAs), product categories, DBidS information, bid preparation worksheets, educational materials, and complete **RFB** instructions can be found on the CBIC website. Suppliers should review this information prior to submitting their bid(s). CMS will send important information via email during the bidding and contracting periods, so it is very important that you keep the email address registered in IACS current. To update an email address, go to the registration page on the CBIC website.

If you have any questions, please contact the CBIC customer service center at 877-577-5331 between 9am and 9pm Eastern Time during the bidding period.

It's Not Too Late to Give and Get the Flu Vaccine [↑]

Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention also recommends that patients, healthcare workers, and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine – Not the Flu.

Remember – The flu vaccine plus its administration are covered Part B benefits. CMS has posted the 2011-2012 seasonal flu vaccine payment limits at http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp. Note that the flu vaccine is NOT a Part D-covered drug.

For more information on coverage and billing of the flu vaccine and its administration, as well as related educational provider resources, visit http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp and http://www.CMS.gov/immunizations.

Physician Quality Reporting System Program Update – Measure #235 Claims Error [↑]

CMS has recently identified an error related to the submission of Measure #235, "Hypertension: Plan of Care," for the 2012 Physician Quality Reporting System. "Hypertension: Plan of Care" is a claims/registry measure with G-codes that are inactive due to an error found on the HCPCS tape. Consequently, this has resulted in claims containing the G-codes associated with the measure being rejected by the carrier/MACs or denied.

The codes G8675, G8676, G8677, G8678, G8679, G8680, and 4050F will be reactivated with the next update of the HCPCS tape in April 2012. For 2012 claims-based reporting, PQRS requires at least 3 measures to each be reported at a 50% reporting rate. In the interim, eligible professionals who had intended to report this measure via claims for the 2012 PQRS may want to consider taking the following steps:

- Eligible professionals may want to consider reporting additional measures to substitute for Measure #235, "Hypertension: Plan of Care."
- "Hypertension: Plan of Care" is a per-visit measure, which requires reporting for 50% of eligible patient visits. Therefore, eligible professionals could report the measure on more than 50% of eligible visits from April through December 2012 to increase the likelihood for successful reporting of the measure.

For additional information, visit the Physician Quality Reporting System webpage on the CMS website.

➢ Additional material related to the Physician Quality Reporting System in today's e-News… [next]

From the MLN: "Critical Access Hospital" Fact Sheet Revised [↑]

The revised "Critical Access Hospital" fact sheet (ICN 006400) is now available in downloadable format. This fact sheet includes background information, as well as information on Critical Access Hospital (CAH) designation, CAH payments, reasonable cost payment principles that do not apply to CAHs, election of Standard Payment Method or Optional (Elective) Payment Method, Medicare Rural Pass-Through Funding for certain anesthesia services, incentive payments, and grants to states under the Medicare Rural Hospital Flexibility Program.

From the MLN: "Role of the Zone Program Integrity Contractors, Formerly the Program Safeguard Contractors" MLN Matters Article Released [↑]

MLN Matters Special Edition Article #SE1204, "The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs)," has been released in downloadable format. This article is designed to provide education on the roles and responsibilities of the ZPICs, and includes an overview of the various program integrity functions that ZPICs perform and each of their seven designated zones.

From the MLN: "2012 eRx Incentive Program: Future Payment Adjustments" MLN Matters Article Released [↑]

MLN Matters Special Edition Article #SE1206, "2012 Electronic Prescribing (eRx) Incentive Program: Future Payment Adjustments," has been released in downloadable format. This article is designed to provide education on future eRx Incentive Program payment adjustments for eligible professionals and selected group practices that participate in the 2012 eRx Group Practice Reporting Option, and includes information about the applicable electronic percent for payment adjustments, eligibility criteria, and how to submit a hardship request.

From the MLN: "2012 Physician Quality Reporting System Claims-Based Coding and Reporting Principles" MLN Matters Article Released [↑]

MLN Matters Special Edition Article #SE1207, "2012 Physician Quality Reporting System Claims-Based Coding and Reporting Principles," has been released in downloadable format. This article is designed to provide education on claims-based coding and reporting under the 2012 Physician Quality Reporting System, and includes step-by-step instructions eligible professionals should take prior to participating in the program.

- Additional material related to the Physician Quality Reporting System in today's e-News… [previous]

From the MLN: MLN Provider Exhibit Program Schedule [↑]

Just a reminder to mark your calendars! The Medicare Learning Network will be exhibiting at the following healthcare provider conferences in the coming weeks:

- *American College of Preventive Medicine*
  Wed Feb 22 through Sat Feb 25
  Orlando, Florida
  Booth #11
- *American Medical Group Association (AMGA) 2012 Annual Conference*
  Wed Mar 7 through Sat Mar 10
  Manchester Grand Hyatt; San Diego, California
  Booth #802
- *American Medical Student Association*
  Thu Mar 8 through Sun Mar 11

Hyatt Regency Houston; Houston, Texas
Booth #12

- *National Association of Rural Health Clinics*
  Mon Mar 19 through Tue Mar 20
  Hyatt Regency; San Antonio, Texas
- *The American College of Cardiology's 61st Annual Scientific Session & Expo*
  Sat Mar 24 through Mon Mar 26
  Chicago, Illinois
  Booth #19076
- *National Hospice & Palliative Care Organization*
  Thu Mar 29 through Sat Mar 31
  National Harbor, MD
  Booth #625

Please make a note of these dates and locations and add them to your calendar! If you are interested in having a CMS Medicare Learning Network Exhibit at your event, contact us at MLNexhibits@cms.hhs.gov.

More Helpful Links…

Check out CMS on

Twitter, LinkedIn, YouTube, and Flickr!

The Medicare Learning Network
www.CMS.gov/MLNGenInfo
Archive of Provider e-News Messages
www.CMS.gov/FFSProvPartProg/EmailArchive