



The Pulse of CMS

“A quarterly regional publication for health care professionals”

Serving Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming.

LAST CHANCE TO SUBMIT COMMENTS ON THE MEDICARE PROPOSED RULE FOR ACCOUNTABLE CARE ORGANIZATIONS...JUNE 6, 2011 DEADLINE (SEE PAGE 2)

Coverage for the Uninsured: Pre-Existing Condition Insurance Plans Now Available

If you know of patients or family members who have had a hard time finding health insurance because of a pre-existing condition, or if they have been turned down for insurance coverage and feel like they are out of options, they are not out of luck. They may now be eligible for a new program created by the Affordable Care Act – the *Pre-Existing Condition Insurance Plan*.

This transitional program is available for children and adults in all 50 states and the District of Columbia who have been locked out of the health insurance market because of a pre-existing condition. In 2014, Americans – regardless of their health status – will have access to affordable health insurance when the nation transitions to a new marketplace. Under this new program, participants will receive health coverage for a wide range of medical benefits including physician’s services, hospital care, and prescription drugs. All covered benefits are available — even to treat a pre-existing condition. Those enrolling in these plans will not be charged a higher premium because of their medical condition, and eligibility is not based on income. Like standard health insurance plans, enrollees will be required to pay a monthly premium, a deductible, and some

cost-sharing expenses. Premiums may vary depending on where they live, their age, and which health plan they choose.

The Pre-Existing Condition Insurance Plan is already getting results that are changing the lives of Americans across our nation who don’t have health coverage and need medical care. To qualify, enrollees must: be a citizen of the United States or residing here legally, have been uninsured for at least 6 months before applying, and have a pre-existing condition or have been denied insurance coverage because of their health condition.

Each state may use different methods to determine whether a pre-existing condition exists and whether potential enrollees have been denied health coverage. To find out more about the Pre-Existing Condition Insurance Plan, including eligibility, plan benefits and rates and how to apply, visit www.pcip.gov and click on “Find Your State” and select your state from a map of the United States or from a drop-down menu for details.

You can also dial the Call Center toll free at 1-866-717-5826 (TTY 1-866-561-1604). The call center is open 8 A.M. to 11 P.M. Eastern Time.

June 15, 2011: National Version 5010 Testing Day

The Version 5010 compliance date – Sunday, January 1, 2012 – is fast approaching. All HIPAA-covered entities should be taking steps now to get ready, including conducting external testing to ensure timely compliance. Medicare Fee-for-Service (FFS) trading partners are encouraged to contact their Medicare Administrative Contractors (MACs) now and facilitate testing to gain a better understanding of MAC testing protocols and the transition to Version 5010.

To assist in this effort, CMS, in conjunction with the Medicare FFS Program, has announced a National 5010 Testing Day to be held Wednesday, June 15, 2011. National 5010 Testing Day is an opportunity for trading partners to come together and test compliance efforts that are already underway with the added benefit of real-time help desk support and direct and immediate access to MACs.

More details concerning transactions to be tested are forthcoming from your local MAC. Additionally, several State Medicaid Agencies will be participating in the National 5010 testing day. More details will follow from them as well.

Again, CMS National 5010 Testing Day does not preclude trading partners from testing transactions immediately with their MAC. You are encouraged to begin working with your MAC now to ensure timely compliance. Note that successful testing is required before a trading partner may be placed into production.

For more information on HIPAA Version 5010, please visit the CMS website.

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Looking for a Certified EHR System?

To see if your electronic health record system is certified for HITECH meaningful use, or to see a listing of products already certified, visit the [Certified Health IT Product List](#) on the Office of National Coordinator for HIT website.



Accountable Care Organizations (ACOs)

Three New ACO Models Announced

CMS has announced three Affordable Care Act initiatives designed to help put doctors, hospitals, and other health care providers on the paths to becoming Accountable Care Organizations (ACOs) and improve health care for Americans with Medicare.

First, the Center for Medicare and Medicaid Innovation (Innovation Center) is requesting applications for a new [Pioneer ACO Model](#), which provides a faster path for mature ACOs that have already begun coordinating care for patients and are ready to move forward.

Second, the Innovation Center is seeking comment on the idea of an [Advance Payment Initiative](#) that gives certain ACOs participating in the Medicare Shared Savings Program access to their shared savings up front, helping them make the infrastructure and staff investments crucial to successfully coordinating and improving care for patients.

Finally, providers interested in learning more about how to coordinate patient care through ACOs can attend free new [Accelerated Development Learning Sessions](#). The Accelerated Development Learning Sessions will teach providers interested in becoming ACOs what steps they can take to improve care delivery and how to develop an action plan for moving toward providing better coordinated care.

Together with the [Medicare Shared Savings Program](#), these initiatives give providers a broad range of options and support that reflect the varying needs of providers in embarking on delivery system reforms.

These initiatives are part of a broader effort by the Obama Administration, made possible by the Affordable Care Act, to improve care and lower costs. For more information about all of these initiatives, visit the [Innovation Center website](#).

To read the CMS Press release, go to the [CMS Media page](#).

Proposal for Accountable Care Organizations to Help Better Coordinate Care and Lower Costs

The Accountable Care Organization (ACO) proposed rule creates incentives for healthcare providers to work together to treat an individual patient across care settings – including doctor’s offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower healthcare costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

The proposed new rules will help doctors, hospitals, and other providers form ACOs and are now available for public comment.

“The Affordable Care Act is putting patients and their doctors in control of their health care,” said HHS Secretary Kathleen Sebelius. “For too long, it has been too difficult for healthcare providers to work together to coordinate and improve the care their patients receive. That has real consequences: patients have gaps in their care, receive duplicative care, or are at increased risk of suffering from medical mistakes. Accountable Care Organizations will improve coordination and communication among doctors and hospitals, improve the quality of the care their patients receive, and help lower costs.”

By focusing on the needs of patients and linking payment rewards to outcomes, this delivery system reform, as part of the Affordable Care Act, will help improve the health of individuals and communities while saving as much as \$960 million over three years for the Medicare program.

Under the proposal, ACOs – teams of doctors, hospitals, and other healthcare providers and suppliers working together – would coordinate and improve care for patients with Original Medicare (that is, who are not in Medicare Advantage private health plans). To share in savings, ACOs would meet quality standards in five key areas: 1) patient/caregiver care experiences; 2) care coordination; 3) patient safety; 4) preventive health; and 5) at-risk population/frail elderly health.

The proposed rules also include strong protections to ensure patients do not have their care choices limited

by an ACO. If ACOs save money by getting beneficiaries the right care at the right time – for example, by improving access to primary care so that patients can avoid a trip to the emergency room – the ACO can share in those savings with Medicare. ACOs that do not meet quality standards cannot share in program savings, and over time, those who do not generate savings can be held accountable.

The new program will be established on January 1, 2012. Before the rule is finalized, CMS will review all comments from the public and may make changes to its proposals based on those comments.

CMS has worked closely with other federal agencies, including the Department of Health and Human Services Office of Inspector General (OIG), the Department of Justice, the Federal Trade Commission, and Internal Revenue Service (IRS) to ensure that providers and suppliers have the clear and practical guidance they need to form ACOs without running afoul of the fraud and abuse, antitrust, and tax laws. The Proposed Antitrust Policy Statement is posted at on the [Federal Trade Commission website](#); and the [IRS Guidance and Solicitation of Comments](#) can be found at this link.

The proposed rule and joint CMS/OIG notice are posted at: the [Federal Register website](#). For more information, read the [fact sheet](#) and be sure to [submit official comments on the proposed rule by June 6, 2011](#). CMS will respond to all comments in a final rule to be issued later this year.

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Provider Enrollment Fees for Institutional Providers

Section 6401(a) of the Affordable Care Act requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The fee is to be used by the Secretary to cover the cost of program integrity efforts including the cost of screening associated with provider enrollment processes. The application fee is \$505 for CY2011. The application fee is imposed on institutional providers that are newly-enrolling, re-enrolling/re-validating, or adding a new practice location, for applications received on and after March 25, 2011. CMS has defined "institutional provider" as any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

After completing the application (either through PECOS or by paper), you should then promptly pay the application fee through www.Pay.gov. Once you are on Pay.gov, type 'CMS' in the search box under "Find Public Forms" and click the "GO" button. Click on the "CMS Medicare Application Fee" link. Complete the form and submit payment as directed. You will get a confirmation screen indicating that payment was successfully made. This confirmation screen is your receipt and should be printed for your records.

If you have problems submitting your application fee, you should use the Help Tools available on the Pay.gov site for questions specific to the payment processing. Other questions regarding payment policies and procedures may be sent to the Medicare provider and supplier enrollment e-mail account at Dpse_admin@cms.hhs.gov.

For more information, please refer to the regulation published in the [Federal Register](#).

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E-Prescribing: Avoiding the 2012 Payment Adjustment

In November, CMS announced that beginning in calendar year 2012, eligible professionals who are not successful electronic prescribers based on claims submitted between January 1, 2011 and June 30, 2011, may be subject to a payment adjustment on their Medicare Part B Physician Fee Schedule (PFS) covered professional services.

From 2012 through 2014, the payment adjustment will increase each calendar year. In 2012, the payment adjustment will result in an eligible professional or group practice receiving 99 percent of their Medicare Part B PFS amount that would otherwise apply to such services. In 2013, an eligible professional or group practice will receive 98.5 percent of their Medicare Part B PFS covered professional services. In 2014, the eligible professional or group practice will receive 98 percent of their Medicare Part B PFS covered professional services.

The payment adjustment does not apply if less than 10 percent of an eligible professional's (or group practice's) allowed charges for the January 1, 2011, through June 30, 2011 reporting period are comprised of codes in the denominator of the 2011 eRx measure.

Please note that earning an eRx incentive for 2011 will NOT necessarily exempt an eligible professional or group practice from the payment adjustment in 2012.

Affordable Care Act Provisions to Help Fight Healthcare Fraud

HHS has announced new rules authorized by the Affordable Care Act which will help stop healthcare fraud. Specifically, the final rule creates a rigorous screening process for providers and suppliers enrolling Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to keep fraudulent providers out of those programs. Types of providers and suppliers that have been identified in the past as posing a higher risk of fraud will be subject to a more thorough screening process.

The rules also require a new enrollment process for Medicaid and CHIP providers. States will screen providers who order and refer to Medicaid beneficiaries to determine if they have a history of defrauding the government. Providers that have been

An eligible professional can avoid the 2012 eRx Payment Adjustment if (s)he:

- Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011 based on primary taxonomy code in NPPES;
- Does not have prescribing privileges (note: (s)he must report (G8644) at least one time on an eligible claim prior to June 30, 2011);
- Does not have at least 100 cases containing an encounter code in the measure denominator;
- Becomes a successful e-prescriber; and
- Reports the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure.

For group practices that are participating in eRx group practice reporting option (GPRO) I or GPRO II during 2011, the group practice MUST become a successful e-prescriber. Depending on the group's size, the group practice must report the eRx measure for 75–2,500 unique eRx events for patients in the denominator of the measure.

For additional information, please visit the ["How To Get Started"](#) webpage on the CMS website for more information or download the [Medicare's Practical Guide to the Electronic Prescribing \(eRx\) Incentive Program](#) under Educational Resources.

kicked out of Medicare or another state's Medicaid or CHIP will be barred from all Medicaid and CHIP programs.

Medicare and state agencies also will be on the lookout for trends that may indicate healthcare fraud. If a trend is identified in a category of providers or geographic area, the program can temporarily stop enrollment as long as that will not impact access to care for patients. Under the new rules, if there has been a credible fraud allegation, payments can be suspended while an action or investigation is underway.

The full text of the [press release issued on January 24, 2011](#) is available on the HHS website.

More than 150K Seniors Receive New Annual Wellness Visit

HHS has released a new report showing that in less than two months, more than 150,000 seniors and others with Medicare have received an annual wellness visit. This, along with many other recommended preventive services, is a preventive benefit now covered by Medicare free of charge when obtained by a participating health care professional, thanks to the Affordable Care Act. The report also shows that enhanced preventive benefits coverage will lower costs, including lowering Medigap premiums for employers, states, and people with Medicare.

The report shows that, thanks to the Affordable Care Act, an average of 2,800 people with Medicare have received an annual wellness visit *per day* between January 1 and February 23, 2011. Because Congress eliminated the Part B coinsurance and deductibles for the annual wellness visit and many other preventive services, the report says that the use of these services should increase. This will make a big difference for people with Medicare who, like most Americans, tend to use preventive services at roughly half the recommended rate.

The Affordable Care Act encourages beneficiaries to use more preventive services by waiving the usual coinsurance and deductible requirements for services recommended by the United States Preventive Services Task Force. If those recommended services are obtained from qualified and participating health care providers, there are no out-of-pocket costs.

Along with other efforts to improve care for people with Medicare, the Affordable Care Act will generate billions of dollars in savings for Medicare, extend the life of the Medicare Trust Fund by 12 years, cut costs for seniors, and keep people with Medicare healthy.

Visit the HealthCare.gov website to learn more about the [new Medicare benefits in 2011](#), and also [read the full report here](#).

Attestation for the Medicare Electronic Health Records (EHR) Incentive Program Has Begun

On April 18, 2011, CMS opened attestation for the Medicare EHR Incentive Program. Now eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that have registered for the program can attest that they have demonstrated meaningful use of certified EHR technology and be one step closer to receiving their Medicare incentive payments authorized by the 2009 Recovery Act.

Under the Medicare EHR Incentive Program, EPs, eligible hospitals, and CAHs must prove, or "attest," that they have met meaningful use criteria. Those who attest in the program's first year must successfully demonstrate meaningful use for a consecutive 90-day period in their first year of participation. In subsequent years, participants will need to meet meaningful use for a full year before attesting. Attestation for the Medicare EHR Incentive Program is different from the Medicaid Program and takes place at the state level. Visit the [CMS EHR Incentive Programs website](#) for information on attestation for the Medicaid Program.

Providers can visit the [CMS EHR Incentive Programs registration webpage](#) to register for the Medicare

program. Participants who have not previously registered can complete the registration and attestation process at the same time. Also, [EPs](#) and [eligible hospitals](#) should be sure to review the Attestation User Guides, which provide step-by-step instructions for login and completing attestation.

Before submitting their attestation, participants can enter information in the [Meaningful Use Attestation Calculator](#) to receive preliminary information on whether they should be able to meet all of the necessary core and menu measures and can successfully demonstrate meaningful use and qualify for an EHR incentive payment. CMS also has developed Attestation Worksheets for [professionals](#) and [hospitals](#) to help participants compile information on the numerators, denominators, and exclusions for meaningful use and clinical quality measures before beginning the attestation process.

For more information and resources on the CMS EHR Incentive Programs, please visit [CMS EHR webpage](#).

Extension of Exceptions Process for Medicare Therapy Caps

On December 15, 2010, President Obama signed into law the [Medicare and Medicaid Extenders Act of 2010](#), which extends the exceptions process for outpatient therapy caps (see Section 104). Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after January 1, 2011, through December 31, 2011. Follow manual policies that apply when exceptions are in effect.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on

January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses was \$1,860 in 2010 and is \$1,870 in 2011. For occupational therapy services, the limit was \$1,860 in 2010 and is \$1,870 in 2011. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

Information Disclaimer:

The information provided in this newsletter is intended only to be general summary information to the Region VIII provider community. It is not intended to take the place of either the written law or regulations.

Links to Other Resources:

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