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DMEPOS CB ROUND 2/NATIONAL MAIL ORDER (NMO) RECOMPETE (PAGE 2)

Important ICD-10 Resources

With the October 1, 2015, ICD-10 compliance date less than one year away, now is the time to prepare for the transition. To support the health care community, the Centers for Medicare & Medicaid Services (CMS) offers resources that explain ICD-10 for providers, payers, vendors, and non-covered entities. These resources are as follows:

Medscape Continuing Medical Education Resources
CMS has created two videos and one expert column to help educate health care professionals about ICD-10. Beyond providing tips and advice, these free resources offer continuing medical education (CME) and nursing continuing education (CE) credits. Anyone who completes the modules can earn a certificate.

- Video 1: ICD-10: Getting From Here to There -- Navigating the Road Ahead
- Video 2: ICD-10 and Clinical Documentation
- Column: Preparing for ICD-10: Now Is the Time

"Road to 10" Tool for Small Physician Practices
Information regarding this resource is available on the Provider Resources page at cms.gov/ICD10. The "Road to 10" tool is an online resource built with the help of providers in small practices. The tool is intended to help small medical practices jumpstart their ICD-10 transition and can help practices:

1) Understand the basics of ICD-10;

2) Build an ICD-10 action plan to map out the transition;

3) Answer frequently asked questions; and

4) Learn how ICD-10 affects your practice with tailored clinical scenarios and documentation tips for Family Practice and Internal Medicine, Obstetrics and Gynecology, Orthopedics, Cardiology, and Pediatrics

CMS.gov Resources
To support the health care community with the transition to ICD-10, CMS has developed a variety of resources available at cms.gov/ICD10, including fact sheets, guides, and webinar presentations. CMS also distributes regular Email Update messages with information about ICD-10. Subscribe today to stay up to date on the latest news and resources from CMS.

Inside this Issue:

Understanding the AFFORDABLE CARE ACT

Health Insurance and Your Taxes

2015 Physician Value-Based Payment Modifier Policy

Section 1848(p) of the Social Security Act (Act) requires that Medicare establish a value-based payment modifier (Value Modifier) that provides for differential payment under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared to cost during a performance period. Section 1848(p) requires that the Value Modifier be applied to specific physicians and groups of physicians the Secretary determines appropriate starting January 1, 2015, and to all physicians and groups of physicians by January 1, 2017.

Beginning in calendar year (CY) 2015, CMS will apply the Value Modifier to all groups of physicians with 100 or more eligible professionals (EPs). Our overall approach to implementing the Value Modifier is based on participation in the Physician Quality Reporting System (PQRS), with the performance period being two years prior to the year in which the Value Modifier will be applied. For example, for those physicians who will have the Value Modifier applied in 2015, CMS will look at PQRS performance of these physicians in 2013 to determine how the Value Modifier will be applied.

The Value Modifier will be applied to groups of physicians with 10 or more EPs starting in 2016, based on 2014 PQRS performance, and in 2017 to groups of physicians with 2-9 EPs and solo practitioners based on their performance in PQRS in 2015. CMS intends to apply the Value Modifier to all EPs (including non-physician practitioners) starting in 2018, pending future rulemaking. CMS strongly urges all EPs to continue participation in the PQRS program, as that program will continue to be the mechanism for the application of the Value Modifier.

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Open Payments Updates

The Open Payments Rule is designed to enhance public visibility into industry and physician financial relationships by making these relationships transparent on a national scale. A key program objective is to provide consumers with information they need to ask questions and make more informed decisions about their health care providers. Collaborations between physicians and the medical industry can be beneficial by promoting discovery and development of new technologies that improve health and/or lower costs

The law requires CMS to collect and display information reported by applicable manufacturers and applicable group purchasing organizations (GPOs) about the payments and other transfers of value these organizations have made to physicians and teaching hospitals.

The first Open Payments reporting period covered transactions from August 1, 2013 through December 31, 2013. Future Open Payments data will be published annually and will include a full 12 months (January through December) of payment data, beginning June 30, 2015. You can review CMS Open Payments website to learn more about the Open Payments program, including how to access the 2013 data currently posted.

When viewing the data, one can see information about individual payments and transfers of value; the physician or teaching hospital that received the payment or transfer of value; the applicable manufacturer or applicable GPO that made the payment; payment dates; physician or teaching hospital location and specialty information; nature of payments; type of payments; and payments or transfers of value for general, research and ownership/investment activities.

Finally, on October 31, 2014, CMS published four revisions to the Open Payments final rule in the Federal Register as part of the 2015 Medicare Physician Fee Schedule provisions. Details about the four revisions can be viewed on Law and Policy web page of the Open Payments website. The most significant change affects the Open Payments reporting requirements for payments or other transfers of value provided at continuing education events; these requirements for payments will change for data collected in 2016 and reported in 2017. This policy change was made in response to public comments, to create a more consistent reporting requirement and provide more consistency for consumers who will ultimately have access to the reported data.

DMEPOS Rd 2/NMO Recompete

CMS recently announced the bidding timeline for Round 2 Recompete and the national mail-order recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program, as required by law. CMS also launched a comprehensive bidder education program. This program is designed to ensure that DMEPOS suppliers interested in bidding receive the information and assistance they need to submit complete bids in a timely manner.

The DMEPOS Competitive Bidding Program changes the amount Medicare pays for certain DMEPOS while maintaining beneficiary access to items and services and quality of care. The program replaces the outdated, inflated fee-schedule prices Medicare paid for these items with lower, more accurate prices to help Medicare and its beneficiaries save money while ensuring access to quality equipment, supplies, and services. This program also helps limit fraud and abuse in Medicare.

The Medicare DMEPOS Competitive Bidding Program has saved more than $580 million in the nine markets at the end of the Round 1 Rebid's 3-year contract period due to lower payments and decreased unnecessary utilization. Additional savings are being achieved as part of the Affordable Care Act's expansion of the competitive bidding program—at the end of the first year of Round 2 and the national mail-order programs, Medicare has saved approximately $2 billion. Furthermore, the monitoring data show that the implementation is going smoothly with few inquiries or complaints and no changes to beneficiary health outcomes.

CMS is required by section 1847(b) (3) of the Social Security Act to recompete contracts under the DMEPOS Competitive Bidding Program at least once every three years. Suppliers must then compete to become a Medicare contract supplier by submitting bids to provide certain items in competitive bidding areas. The new, lower payment amounts resulting from the competitions replace the fee schedule amounts for the bid items in these areas.

The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders and the focal point for bidder education. The CBIC website, www.dmecompetitivebid.com, features an array of important and helpful resources for suppliers, including the bidding timeline, bidding rules, short instructional videos, user guides, fact sheets, checklists, and bid preparation worksheets. To sign up to receive important competitive bidding announcements and reminders, suppliers are encouraged to subscribe to E-Mail Updates on the CBIC website.

In addition to viewing the information on the CBIC website, suppliers are encouraged to call the CBIC customer service center toll-free at 1-877-577-5331 with their questions. During registration and bidding periods, the customer service center will be open from 9 a.m. to 9 p.m. Eastern Time.

Provider Outreach Staff:

Region III Provider Line
Phone: (215) 861-4154
ROPHICFM@cms.hhs.gov

Patrick Hamilton
Phone: (215) 861-4097
Patrick.hamilton@cms.hhs.gov

Lindsey Massuda
Phone: (215) 861-4320
Lindsey.massuda@cms.hhs.gov

Tom Robinson
Phone: (215) 861-4270
Thomas.robinson@cms.hhs.gov

Philadelphia Regional Office:

150 S. Independence Mall West
The Public Ledger Building, Suite 216
Philadelphia, PA 19106

Phone: (215) 861-4154
Fax: (215) 861-4243
Email: ROPHICFM@cms.hhs.gov

Medicare-Medicaid Demonstrations Continue in 2015

Various states across the country are participating in financial alignment demonstrations to coordinate care for dually eligible Medicaid and Medicare beneficiaries. Virginia is one of those states. The state launched its Commonwealth Coordinated Care (CCC) demonstration in April 2014.

The program serves approximately 26,000 Medicare-Medicaid beneficiaries in five regions of the Commonwealth: Tidewater, Central Virginia (Richmond), Northern Virginia, Roanoke, and Charlottesville.

The CCC aims to better integrate Medicare and Medicaid. Beneficiaries participating in the demonstration receive their Medicare and Medicaid coverage from a single, integrated Medicare-Medicaid plan (MMP). By integrating benefits, CCC aims to address the gaps and overlaps in care that result when Medicare and Medicaid operate separately. CCC is a demonstration jointly administered by CMS and the Virginia Department of Medical Assistance Services (DMAS).

To be eligible for CCC, beneficiaries must be 21 or older and be receiving Medicare Parts A, B, and D, as well as full Medicaid benefits. CCC is available to individuals living in the community, to individuals receiving the Elderly & Disabled with Consumer Direction (EDCD) Waiver, and those living in nursing facilities. Eligible beneficiaries are being passively enrolled each month. Beneficiaries have the right to opt-out of CCC at any time and select original fee-for-service Medicare or a Medicare Advantage plan for their Medicare coverage.

More information about Virginia's CCC demonstration is available on DMAS's dedicated website. Virginia's CCC Quick Provider Reference Guide also contains valuable information about its program. Information about this and other state demonstrations is available on CMS' Medicare-Medicaid Coordination Office website.

Suggestions for Potential PQRS Measures

CMS is accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System (PQRS) for future rule-making years. Quality measures submitted in this Call for Measures may also be considered for use in other quality programs for physicians and other eligible professionals (e.g. Value Based Modifier, Physician Compare, Medicare Shared Savings Program, etc.).

The PQRS Call for Measures is now conducted in an ongoing open format, remaining open indefinitely. The month that a measure is submitted for consideration will determine when it may be included on the Measures Under Consideration (MUC) list. Measures submitted prior to June 15, 2015 may be considered for inclusion on the 2015 MUC list for implementation in PQRS as early as 2017.

CMS will give priority to measures that are outcome-based, answer a measure gap and address the most up-to-date clinical guidelines. Measures submitted for consideration will be assessed to ensure that they meet the needs of the PQRS. As time permits, feedback will be provided to measure submitters upon review of their submission. When submitting measures for consideration, please ensure that your submission is not duplicative of another existing or proposed measure. Additionally, CMS is *not* accepting claims-based only reporting measures in this process. Note that measures already included in previous PQRS MUC lists may only be re-submitted for consideration if the measure has undergone substantive changes.

Each measure submitted for consideration *must* include all required supporting documentation. Documentation requirements and the submission timeline are posted on the Measures Management System Call for Measures web page Questions about this Call for Measures or the required documentation may be submitted to C4M@wvmi.org.

Note*:* Suggesting individual measures or measures for a new or existing measures group does not guarantee the measure(s) will be included in the proposed or final sets of measures of any proposed or final rules that address the PQRS. Additionally, measures submitted for consideration are not guaranteed to be put forth on the MUC list for Measures Application Partnership (MAP) review.

CMS will determine which individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for the PQRS.

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ACOs Moving Ahead: Medicare Shared Savings Program

CMS recently announced that 89 new Accountable Care Organizations (ACOs) will be joining the Medicare Shared Savings Program (Shared Savings Program). With today's announcement, CMS will have a total of 405 ACOs participating in the Shared Savings Program next year, serving more than 7.2 million beneficiaries. When combined with the Innovation Center's 19 Pioneer ACOs, CMS will have a total of 424 ACOs serving over 7.8 million beneficiaries.

ACOs are one part of this Administration's vision for improving the coordination and integration of care received by Medicare beneficiaries. ACOs are groups of doctors, hospitals, and other health care providers that work together to give Medicare beneficiaries in Original Fee-For-Service Medicare high quality, coordinated care. ACOs can share in any savings they generate for Medicare, if they meet specified quality targets.

Since ACOs first began participating in the program in early 2012, thousands of health care providers have signed on to participate in the program, working together to provide better care to Medicare's seniors and people with disabilities. In 2014 alone, existing Shared Savings Program ACOs added almost 17,000 healthcare providers, and the 89 new ACOs will bring approximately 23,000 additional physicians and other providers into the ACO program starting January 1.

The full text of the announcement is available on the CMS blog issued December 22, 2014.

2015 Value-Based Payment Modifier (cont'd)

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The statute requires the Value Modifier to be budget neutral. Budget-neutrality means that, in aggregate, the increased payments to high performing physicians and groups of physicians equal the reduced payments to low performing physicians and groups of physicians.

CMS also anticipates that we would propose to increase the amount of payment at risk for the Value Modifier as we gain additional experience with the methodologies used to assess the quality of care, and the cost of care, furnished by physicians and groups of physicians.

The Value Modifier applies only to physician payments under the Medicare PFS. The Value Modifier does not apply to payments that are not made under the Medicare PFS, including those for physicians providing services in Rural Health Clinics, Federally Qualified Health Centers, and Critical Access Hospitals (CAHs) (for CAHs electing method II billing). Additionally, for 2015 and 2016, the Value Modifier does not apply to groups of physicians in which any of the group's physicians participate in the Medicare Shared Savings Program Accountable Care Organizations (ACOs), the testing of the Pioneer ACO model, or the Comprehensive Primary Care Initiative. However, the Value Modifier will apply to these groups starting in 2017, based on their quality reporting in 2015.

Please read CMS's complete 2015 Value Modifier Policy Fact Sheet for details regarding the

CMS Enhances Provider Oversight

CMS recently announced new rules that strengthen oversight of Medicare providers and protect taxpayer dollars from bad actors. These new safeguards are designed to prevent physicians and other providers with unpaid debt from re-entering Medicare, remove providers with patterns or practices of abusive billing, and implement other provisions to help save more than $327 million annually.

CMS is using new authorities created by the Affordable Care Act to clamp down on Medicare fraud, waste and abuse. CMS currently has in place temporary enrollment moratoria on new ambulance and home health providers in seven fraud hot spots around the country.

The moratoria are allowing CMS to target its resources in those areas, including use of fingerprint-based criminal background checks. These and other successes continue to protect the Medicare Trust Funds.

CMS has demonstrated that removing providers from Medicare has a real impact on savings. For example, the Fraud Prevention System, a predictive analytics technology, identified providers and suppliers who were ultimately revoked, and prevented $81 million from being paid.

The new changes announced today allow CMS to:

1. Deny enrollment to providers, suppliers and owners affiliated with any entity that has unpaid Medicare debt; this will prevent people and entities that have incurred substantial Medicare debts from exiting the program and then attempting to re-enroll as a new business to avoid repayment of the outstanding Medicare debt.

2. Deny or revoke the enrollment of a provider or supplier if a managing employee has been convicted of a felony offense that CMS determines to be detrimental to Medicare beneficiaries. The recently implemented background checks will provide CMS with more information about felony convictions for high risk providers or suppliers.

3. Revoke enrollments of providers and suppliers engaging in abuse of billing privileges by demonstrating a pattern or practice of billing for services that do not meet Medicare requirements.

A fact sheet regarding the safeguards is available on CMS's webpage. To see the final rule visit: https://www.federalregister.gov/public-inspection

Physicians Must Start Using Revised 855R Applications

Medicare Administrative Contractors (MACs) will require the use of the revised CMS 855R (Reassignment of Benefits) application as of May 31, 2015.

The revised CMS 855R will be available for use on the CMS website as of December 29, 2014. However, MACs may accept both the current and revised versions of the CMS 855R through May 31, 2015. After May 31, 2015, MACs will return any newly submitted CMS 855R applications on the previous version (07/11) to the provider/supplier with a letter explaining the CMS 855R has been updated and the current version of the CMS 855R (11/12) must be submitted.

The revised CMS 855R has been streamlined and some sections have been re-ordered for clarity. It includes an optional section for primary practice location address. This information is shared with other programs, such as Physician Compare to help beneficiaries identify where their physicians are primarily practicing and must be an address affiliated with the group/organization where the benefits are being reassigned.

Get Enrolled! ***The last day to enroll in a 2015 Health Insurance Marketplace plan is February 15, 2015.***