



# The Pulse of CMS

**“A quarterly regional publication for health care professionals”**  
Serving Delaware, Maryland, Pennsylvania, Virginia, West Virginia and the District of Columbia.

## VP Biden Announces \$1.2 Billion in Grants for Electronic Health Records

Vice President Joe Biden has announced the availability of grants worth nearly \$1.2 billion to help hospitals and health care providers implement and use electronic health records. The grants will be funded by the American Recovery and Reinvestment Act of 2009 (ARRA) and will help health care providers qualify for new incentives that will be made available in 2010 to doctors and hospitals that meaningfully use electronic health records.

The grants made available include:

- Grants totaling \$598 million to establish approximately 70 Health Information Technology Regional Extension Centers, which will provide hospitals and clinicians with hands-on technical assistance in the selection, acquisition, implementation, and meaningful use of certified electronic health record systems.

- Grants totaling \$564 million to States and Qualified State Designated Entities (SDEs) to support the development of mechanisms for information sharing within an emerging nationwide system of networks.

The Extension Center grants will be awarded on a rolling basis, with the first awards being issued in fiscal year 2010. Grants to States will be made in fiscal year 2010. Those interested in applying for these grants may visit <http://HealthIT.HHS.gov> for more information.

The Department of Health and Human Services will also provide additional assistance to health care providers through the Health Information Technology Research Center (HITRC). The HITRC will gather relevant information on effective practices from a wide variety of sources across the country and help the Regional Extension Centers collaborate with one another and with relevant stakeholders to identify and share best practices in EHR adoption, effective use, and provider support.

## CMS Details Plans for H1N1 Prep

On June 11, 2009, the World Health Organization confirmed that a global outbreak of H1N1 has occurred and raised the Pandemic Level to the highest Level of 6. For the health care community, this means preparation for community outbreak at the local level. For updated information on Pandemic Preparedness and other emergency events, you can sign up for [e-mail alerts](#) from the CDC Physician registry. The site has a new link for physician offices to prepare for Pandemic including a [medical officer checklist](#).

CMS issued information on Medicare fee-for-service policies and procedures in an H1N1 flu pandemic. The [22-page document](#) addresses issues related to H1N1 vaccination, flexibilities available in an emergency or disaster, waivers of certain Medicare requirements in a declared emergency or disaster, and payment policies and billing procedures for various types of health care services and providers.

CMS will issue further information that informs the public and contractors concerning payment policy for the H1N1 vaccine and its administration under Medicare fee-for-service. The information presently available to CMS is that the H1N1 vaccine will be made available without charge to hospitals, physicians, and other entities that immunize patients. If the vaccine is made available to providers free of charge, then Medicare will not pay for the vaccine itself. However, Medicare will pay for the administration of the vaccine.

For providers, CMS said the payment amount for the H1N1 vaccine's administration will be the same as the payment for administration of seasonal flu vaccine.

Additionally, CMS has established a [Preparedness website](#).

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## Provider Enrollment Just Got Easier

CMS wants to remind all providers that the Internet-based PECOS system is up and running for your Medicare enrollment needs. To view the [“Getting Started Guide for Physicians and Non-Physician Practitioners.”](#) go to the CMS website. For all information related to PECOS, visit the [PECOS page](#) of the website.

## Website Available for Part D Extra Help

HHS wants to remind providers that extra help is available to their patients. Medicare beneficiaries with limited income and resources could take advantage of a program where they would pay no more than \$2.40 for generic drugs and \$6 for brand name drugs.

For those who qualify, this program helps pay for prescription copayments, as well as monthly premiums and annual deductibles. Individuals who make less than \$16,245 and married couples who make less than \$21,855 may qualify. Resources must be limited to \$12,510 for individuals and \$25,010 for married couples.

To help your patients find out more, please direct them to the [Social Security Administration website](#), or have them call 1-800-772-1213. They should ask for the *Application for Help with Medicare Prescription Drug Plan Costs*. Medicare beneficiaries may also visit [www.medicare.gov](http://www.medicare.gov) for more information.

## Shingles Vaccine Update: How Is It Paid?

CMS wants to reiterate the policy for coverage of the shingles vaccination. As of January 1, 2008, Medicare pays for the vaccine and the administration of the vaccine for shingles under Part D. Beneficiaries can receive the vaccination in one of two ways:

- 1) At a network pharmacy (except for the state of Maine), which would bill the beneficiary's Part D plan directly; or
- 2) At the beneficiary's doctor's office.

If the beneficiary opts to receive the vaccination at a doctor's office (outside of the Part D plan's network), the physician would administer the vaccine and then bill the beneficiary for the entire charge, including both components (vaccine and administration). The beneficiary should submit a paper claim to the Part D sponsor for reimbursement of plan-allowable costs for both the vaccine cost and the administration fee.

See the attached [MLN Matters article](#) for more information.

## Attention Durable Medical Equipment Suppliers: The Time is Now to Prepare for Round One Bidding

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program Round 1 Rebid is beginning in the fall of 2009.

If you are a supplier interested in bidding, prepare now – don't wait!

**UPDATE YOUR NSC FILES:** All suppliers must notify the National Supplier Clearinghouse (NSC) of any change to the information provided on the Medicare enrollment application (CMS-855S) within 30 days of the change. Information and instructions on how to submit a change of information may be found on the [NSC Web site](#) and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

**GET LICENSED:** Suppliers submitting a bid for a product category in a competitive bidding area

(CBA) must meet all DMEPOS state licensure requirements and other applicable state licensure requirements, if any, for that product category for every state in that CBA.

**GET ACCREDITED:** Time is running out to obtain accreditation by the September 30, 2009 deadline or risk having your Medicare Part B billing privileges revoked on October 1, 2009. Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations may be found at the [CMS website](#).

**GET BONDED:** Certain suppliers will need to obtain and submit a surety bond by the October 2, 2009 deadline or risk having their Medicare Part B billing privileges revoked. See the article below.

Visit the [CMS website](#) for the latest information on the DMEPOS competitive bidding program.

## DMEPOS Supplier Accreditation and Surety Bond Requirement Deadlines Coming in October

Medicare suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), unless exempt, must be accredited and obtain a surety bond by October 1, 2009 and October 2, 2009, respectively.

If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. You can voluntarily terminate your enrollment with the Medicare program by completing the sections associated with voluntary termination on page 4 of the Medicare enrollment application (CMS-855S). Once complete, you should sign, date and send the completed application to the National Supplier Clearinghouse (NSC). By voluntarily terminating your Medicare enrollment, you will preserve your right to re-enroll in Medicare once you meet the requirements to participate in the Medicare program.

If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier.

For additional information regarding DMEPOS accreditation or the provisions associated with a surety bond, go to the [CMS website](#). Frequently Asked Questions (FAQs) on the surety bond requirement can be found on the [NSC's FAQ page](#).

### HHS Website Available for Health Insurance Reform

The Department of Health & Human Services has a comprehensive website for information relating to the Administration's health insurance reform. Located at [HealthReform.gov](http://HealthReform.gov), the website includes news from the DHHS Secretary, links to information offered by the White House, and an up-to-date listing of events relating to health insurance reform. This multi-media-intensive website should be consulted for all official information and statements relating to the Administration's efforts at reform. As a reminder, CMS will not comment on pending legislation and will refer those with questions to this website.

### Reminder about Contractor Provider Call Centers

Medicare Provider Call Centers across the nation have been receiving an increasing number of calls each month from beneficiaries referred by the provider community. CMS would like to remind providers that provider call centers are not equipped to serve the beneficiary community and will have to refer them to 1-800-MEDICARE. Please remember to refer Medicare beneficiaries to 1-800-MEDICARE, or to the Medicare website at [www.medicare.gov](http://www.medicare.gov).

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## CMS Announces Proposed Changes to the Medicare Physician Fee Schedule

CMS has announced proposed changes to policies and payment rates for services to be furnished during calendar year (CY) 2010 by over 1 million physicians and non-physician practitioners who are paid under the Medicare Physician Fee Schedule (MPFS).

CMS is making several proposals to refine Medicare payments to physicians, which are expected to increase payment rates for primary care services. The proposals include an update to the practice expense component of physician fees. For 2010, CMS is proposing to include data about physicians' practice costs from a new survey, the Physician Practice Information Survey (PPIS), designed and conducted by the American Medical Association.

As part of health care reform, the Administration supports comprehensive, but fiscally responsible, reforms to the physician payment formula. Consistent with this goal, the Administration announced in the FY 2010 President's Budget that it would explore the breadth of options available under current authority to facilitate such reforms, including an assessment of whether the cost of physician-administered drugs should continue to be included in the payment formula. CMS is proposing to remove physician-administered drugs from the definition of "physician services" for purposes of computing the physician update formula in anticipation of enactment of legislation to provide fundamental reforms to Medicare physician payments.

CMS is also proposing to stop making payment for consultation codes, which are typically billed by specialists and are paid at a higher rate than equivalent evaluation and management (E/M) services. Practitioners will use existing E/M service codes when providing these services instead. Resulting savings would be redistributed to increase payments for the existing E/M services.

CMS is proposing to increase the payment rates for the Initial Preventive Physical Exam (IPPE), also called the "Welcome to Medicare" visit to be more in line with payment rates for higher complexity services. Subsequently, Congress extended the time period for the IPPE benefit to within one year of the beneficiary's enrollment in Part B.

The proposed rule contains a number of provisions to promote improvement in quality of care and patient outcomes through revisions to the Electronic Prescribing Incentive Program (e-Prescribing Program) and the Physician Quality Reporting Initiative (PQRI). Eligible professionals or group practices that meet the requirements of each program in CY 2010 will be eligible for incentive payments. CMS is proposing to simplify the reporting requirements for the electronic prescribing measure and to provide eligible professionals with more reporting options.

CMS will respond to all comments received in a final rule to be issued by November 1, 2009. Unless otherwise specified, the new payment rates and policies will apply to services furnished to Medicare beneficiaries on or after January 1, 2010.

For more information on the proposed rule, please see:  
[www.federalregister.gov/inspection.aspx#special](http://www.federalregister.gov/inspection.aspx#special)  
or  
<http://www.archives.gov/federal-register/public-inspection/index.html>

## In the Spotlight... Two Additional CMS Websites



[Resources for Medicare Caregivers](#)

[State Health Insurance Program Offices](#)

## Turning Up the “H.E.A.T.” on Fraud & Abuse

Fifty-three people have been indicted for schemes to submit more than \$50 million in false Medicare claims in the continuing operation of the Medicare Fraud Strike Force in Detroit. The Strike Force in Detroit is the third phase of a targeted criminal, civil and administrative effort against individuals and health care companies that fraudulently bill the Medicare program.

The Medicare Fraud Strike Force is a multi-agency team of federal, state and local investigators designed to combat Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing.

The Strike Force operations in Detroit are part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT), a renewed effort announced in May 2009 between the Department of Justice and HHS to focus their joint efforts to prevent fraud and enforce current anti-fraud laws around the country. The HEAT taskforce is made up of top-level law enforcement agents, prosecutors and staff from both Departments and their operating divisions.

The Strike Force operations in Detroit have identified two primary areas – infusion therapy and physical/occupational therapy providers – in which schemes were allegedly orchestrated to defraud the Medicare program.

According to the indictments, the defendants charged participated in schemes to submit claims to Medicare for treatments that were in fact medically unnecessary and oftentimes, never provided. In many cases, indictments allege that beneficiaries accepted cash kickbacks in return for allowing providers to submit forms saying they had received the unnecessary and not provided treatments. Collectively, the physicians, medical assistants, patients, company owners and executives charged in the indictments are accused of conspiring to submit more than \$50 million in false claims to the Medicare program.

Since its inception in March 2007 with phase one in South Florida and expansion to phase two in Los Angeles in May 2008, the Strike Force has obtained indictments of more than 250 individuals and organizations that collectively have billed the Medicare program for more than \$600 million.

To learn more about the HEAT team, go to: [www.hhs.gov/stopmedicarefraud](http://www.hhs.gov/stopmedicarefraud)

## Medicare Demonstrations Show Paying for Quality Health Care Pays Off

Demonstrations being conducted by the Centers for Medicare & Medicaid Services (CMS) continue to provide strong evidence that offering financial incentives for improving or delivering high quality care increases quality and can reduce the growth in Medicare expenditures.

CMS has announced new results from three of these demonstrations, one for large physician practices, one for small and solo physician practices, and one for hospitals. CMS has also announced the start of three additional value based purchasing demonstrations.

The CMS value-based purchasing (VBP) initiative is designed to tie Medicare payments to performance on quality and efficiency and is part of CMS' effort to transform Medicare from a passive payer to an active purchaser of higher quality, more efficient health care.

Entering its fifth year, the Hospital Quality Incentive Demonstration (HQID) shows continued quality improvement among participating hospitals. In addition, physician practices participating in the Physician Group Practice (PGP) Demonstration continue to improve quality for patients with chronic illnesses or requiring preventive care.

And more than 560 small and solo physician practices participating in the Medicare Care Management Performance (MCMP) Demonstration are being rewarded for providing high quality care in the delivery of preventive care and care for patients with chronic illnesses.

New demonstration programs include the Nursing Home Value-Based Purchasing Demonstration,

the Medicare Hospital Gainsharing Demonstration, and the Physician Hospital Collaboration Demonstration.

The nursing home demonstration program will reward facilities that can improve or deliver high quality care in four specific areas: staffing, resident outcomes, avoidable hospitalizations and reductions in deficiency citations.

The gainsharing and physician hospital collaboration programs will evaluate whether gainsharing leads to improvements in quality and efficiency. The demonstrations provide a promising opportunity for hospitals and physicians to join forces to improve quality and efficiency of care, establish effective means to govern use of inpatient resources, reduce costs, and share the rewards.

Overall, demonstrations give CMS the opportunity to work closely with providers to improve quality and efficiency and serve as a vehicle to test various VBP methodologies.

To view the full press release, go to the [CMS Media Center](#) on the website. For additional information on value based purchasing demonstrations, visit the [demonstrations webpage](#).

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#### Information Disclaimer:

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#### Links to Other Resources:

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