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COMPETITIVE BIDDING CONTRACT SUPPLIERS SELECTED (SEE PAGE 2)

Affordable Care Act: Year Three

By Kathleen Sebelius, Secretary of Health and Human Services

Three years ago, the Affordable Care Act ushered in a new day for health care. Since then, more than 6.3 million seniors and people with disabilities with Medicare have saved more than $6.1 billion dollars on prescription drugs. Nearly 71 million Americans got expanded access to preventive service at no charge through their private insurance plans, and 47 million women now have guaranteed access to additional preventive services without cost sharing.

More than 3.1 million young adults who were uninsured were able to gain coverage by being able to stay on their parents' insurance policies until they turned 26. And parents no longer have to worry about insurers denying coverage to their children because of a pre-existing condition.

Americans are getting more value for their health care dollars due to the health care law. Affordable Care Act initiatives are promoting coordinated care; paying for quality, not quantity; and dramatically reducing fraud and waste, contributing to the slowest growth in national health spending in 50 years.

Consumers also saved $2 billion in 2012, because of programs to review premium rates and to require insurers to provide rebates if they do not spend at least 80% of premiums on care, rather than overhead, such as executive pay and marketing. And the law's initiatives have extended the life of the Medicare Trust Fund by eight years.

But that's only the beginning. Thanks to the health care law, starting October 1, 2013, qualified individuals will have access to quality health insurance through the new Health Insurance Marketplace. With the Marketplace, there'll be a whole new way to find health insurance that fits consumers' needs and budgets, with less hassle. Individuals, families, and small business owners in every state and the District of Columbia will be able to shop in the Marketplace for private insurance coverage that begins in January 2014.

For the first time, you'll be able to go to one place to learn about health insurance; get accurate information on different plans; and make apples-to-apples comparisons of private insurance plans, including costs and benefits.

You'll get a clear picture of what you're paying and what you're getting before you make a choice. You'll also be able to learn, with a single application, if you qualify for a free or low-cost plan, or a new kind of tax credit that lowers your monthly premiums right away.

Inside this Issue...

Pre-Existing Condition Insurance Plan: Enrollment Suspensions

The federally-run Pre-Existing Condition Insurance Plan (PCIP) has suspended the acceptance of new enrollment applications until further notice. PCIP will continue providing coverage to more than 100,000 people currently enrolled nationwide. We encourage you to visit **http://finder.healthcare.gov** to explore your other health care options.

Please note that i*f you lost PCIP coverage during the past 6 months because you moved out of state, you may be eligible to re-enroll in PCIP in your new state of residence. Please call 1-866-717-5826 (TTY: 1-866-561-1604), Monday – Friday, 8 a.m. to 11 p.m. EST, if you believe you are eligible.*

PCIP is a temporary program for those locked out of the current insurance marketplace. The program has a limited amount of funding from Congress. Based on program experience and trends since the start of the program, PCIP enrollees have serious and expensive illnesses with significant and immediate health care needs. This suspension will help ensure that funds are available through 2013 to continuously cover people currently enrolled in PCIP.

Starting next year, the Affordable Care Act guarantees that all Americans, regardless of their health status or pre-existing conditions will finally have access to quality, affordable coverage. People will be able to apply for affordable health insurance coverage choices in Health Insurance Marketplaces when open enrollment begins on October 1. The Health Insurance Marketplace will offer a choice of quality, affordable health plans. Coverage begins on January 1, 2014. Visit **www.healthcare.gov** to learn more about the Marketplace.

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Mandatory Payment Reduction in the FFS Program: Sequestration

The *Budget Control Act of 2011* requires, among other things, mandatory across-the-board reductions in Federal spending, also known as sequestration. The *American Taxpayer Relief Act of 2012* postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013. The Administration continues to urge Congress to take prompt action to address the current budget uncertainty and the economic hardships imposed by sequestration.

This listserv message is directed at the Medicare FFS program (i.e., Part A and Part B). In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.The claims payment adjustment shall be applied to all claims **after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments**.

Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. The Centers for Medicare & Medicaid Services encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to discuss with beneficiaries the impact of sequestration on Medicare's reimbursement. Questions about reimbursement should be directed to your Medicare claims administration contractor. As indicated above, we are hopeful that Congress will take action to eliminate the mandatory payment reductions.

Competitive Bidding Contract Suppliers Selected

The CMS recently announced that 799* suppliers have been awarded contracts as part of Round 2 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program to provide certain medical equipment and supplies (such as scooters, wheelchairs and oxygen) to beneficiaries in 91 communities across the country. Additionally, CMS announced 18 suppliers that accepted contracts to provide mail-order diabetic testing supplies at competitively bid prices nationwide. The competitive bidding program, which has already resulted in $202 million in savings in its first year of implementation in nine areas, is expected to save the Medicare Part B Trust Fund an estimated $25.7 billion between 2013 and 2022. Beneficiaries are expected to save an estimated $17.1 billion as a result of lower coinsurance and premium payments.

CMS awarded 13,126 Round 2 DMEPOS competitive bidding program contracts to 799 suppliers. The Round 2 contract suppliers have 2,988 locations to serve Medicare beneficiaries in these competitive bidding areas. The National Mail-order Program contract suppliers have 52 locations to serve the entire country through mail or other home delivery. All contract suppliers must comply with Medicare enrollment rules, be accredited, meet applicable licensing requirements, and meet financial standards. 90 percent of contract suppliers are already established in the competitive bidding area, the product category, or both. Small suppliers, those with gross revenues of $3.5 million or less as defined for the DMEPOS competitive bidding program, make up about 63 percent of the Round 2 contract suppliers. CMS received 48,424 Round 2 bids from 2,641 suppliers during a 60-day bidding period last year. 245 bids for the national mail-order competition were received.
Round 2 of the competitive bidding program and the national mail-order program will go into effect July 1, 2013. Based on bids submitted by these suppliers, beneficiaries and Medicare will see prices, on average, 45 percent lower than Medicare currently pays for the same items included in the Round 2 areas and 72 percent lower on mail-order diabetic testing supplies nationwide.

Consumers, physicians and other providers can find a list of Medicare contract suppliers in their areas by visiting www.medicare.gov/supplier/home.asp or by calling 1-800-MEDICARE (TTY users should call 1-877-486-2048). People can also visit the local offices of the various partner groups for help in finding a Medicare contract supplier, such as their State Health Insurance and Assistance Program, Administration for Community Living and a number of community organizations that can provide information on the program.
Please visit CMS' DMEPOS Competitive Bidding website for more information regarding the program.

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Prepare to Help Patients Navigate the New Health Insurance Market Place

Starting in October, 2013, individuals, families, and small-business owners in every state will be able to shop in the new Health Insurance Marketplace (also known as the Exchanges) for private insurance coverage that begins January 1, 2014.

A recent article posted in the JAMA (The Journal of the American Medical Association), " Connecting to Health Insurance Coverage " by HHS Assistant Secretary for Health Dr. Howard Koh and CMS Acting Administrator Marilyn Tavenner provides key information about the new healthcare landscape.

For many patients to fully benefit in this new environment, they will need the guidance of their most trusted health sources. Prepare now to connect people to coverage and make a lasting difference in the health of our nation.

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HHS Announces 2013 HIT Costs and Improved Quality Care

Centers for Medicare & Medicaid Services (CMS) Acting Administrator Marilyn Tavenner and the National Coordinator for Health Information Technology Farzad Mostashari, M.D., recently announced HHS's plan to accelerate health information exchange (HIE) and build a seamless and secure flow of information essential to transforming the health care system.

This year, HHS will:

-Set aggressive goals for 2013: HHS is setting the goal of 50 percent of physician offices using electronic health records (EHR) and 80 percent of eligible hospitals receiving meaningful use incentive payments by the end of 2013.

-Increase the emphasis on interoperability: HHS will increase its emphasis on ensuring electronic exchange across providers. It will start that effort by issuing a request for information (RFI) seeking public input about a variety of policies that will strengthen the business case for electronic exchange across providers to ensure patients' health information will follow them seamlessly and securely wherever they access care.

-**Enhance the effective use of electronic health records through initiatives like the Blue Button initiative**. Medicare beneficiaries can access their full Medicare records online today. HHS is working with the Veterans Administration and more than 450 different organizations to make health care information available to patients and health plan members. HHS is also encouraging Medicare Advantage plans to expand the use of Blue Button to provide beneficiaries with one-click secure access to their health information.

-**Implement Meaningful Use Stage 2**: HHS is implementing rules that define what data must be able to be exchanged between Health IT systems, including how data will be structured and coded so that providers will have one uniform way to format and securely send data.

-Underscore program integrity: HHS is taking new steps to ensure the integrity of the program is sound and technology is not being used to game the system. For example, it is conducting extensive medical reviews and issuing Comparative Billing reports that identify providers.

The goals build on the significant progress HHS and its partners have already made on expanding health information technology use. EHR adoption has tripled since 2010, increasing to 44 percent in 2012 and computerized physician order entry has more than doubled (increased 168 percent) since 2008.

In addition to seeking public input, the RFI also discusses several potential new policies and ideas to accelerate interoperability and exchange of a patient's health information across care settings so that they can deliver better and more affordable care to their patients.

The RFI can be found at http://www.ofr.gov/OFRUpload/OFRData/2013-05266_PI.pdf. Deadline for comments is April 21, 2013.

eRX: Avoiding the Payment Adjustment

Medicare eligible professionals (EPs) are reminded that the 6-month reporting period to avoid the 2014 eRx payment adjustment ends on June 30, 2013. The final eRx payment adjustment will be applied during the 2014 calendar year and is a 2.0% adjustment (EP will receive 98% of his/her Medicare Part B Physician Fee Schedule amount for professional covered services). CMS has developed a fact sheet that details the exclusion criteria for individual EPs and for those opting for the group reporting option (GPRO). EPs can visit the Quality Net Communication Support Page to request a hardship exemption by June 30, 2013.

See **eRx: Avoiding the Payment Adjustment** Page 4

DMEPOS CB YouTube Training Video Available

Round two of the DMEPOS Competitive Bidding Program is targeted to go into effect in 91 Metropolitan Statistical Areas on July 1, 2013. Medicare will also implement a national mail-order program for diabetic testing supplies on July 1, 2013. When the program becomes effective in a competitive bidding area, beneficiaries with Original Medicare who obtain competitively bid items in the area must obtain these items from a contract supplier in order for Medicare to pay, unless an exception applies.

CMS Regional Offices held a number of very successful webinars in January and February of this year. In response to demand, CMS has developed a video slideshow of one of those presentations that helps educate providers and suppliers about the program. This video slideshow is now posted to the CMS You Tube channel.

For further information about the DMEPOS Competitive Bidding Program, see the revised fact sheets and visit the CMS website.

Information Disclaimer:

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

Links to Other Resources:

Our newsletter may link to other federal agencies. You are subject to those sites' privacy policies. Reference in this newsletter to any specific commercial products, process, service, manufacturer, or company does not constitute its endorsement or recommendation by the U.S. government, HHS, or CMS. HHS or CMS are not responsible for the contents of any "off-site" resource identified.

Getting Ready for ICD10

ICD-10 Tips for Small Provider Practices

All health care providers covered by HIPAA must make the transition from ICD-9 to ICD-10 codes by the **October 1, 2014**, compliance deadline. ICD-10 will affect every aspect of how your organization provides care, from software upgrades and patient registration and referrals, to clinical documentation and billing.

Key Steps to Prepare for ICD-10

With adequate planning and preparation, you can ensure a smooth transition for your practice. Whether you are just starting the planning process, or ahead of schedule, the checklist below can help make sure you keep your efforts on track.

1. Inform and educate staff about the transition to ICD-10. Appoint an ICD-10 coordination manager

- Tell your staff about upcoming changes and your transition plan

- Educate staff on changes in documentation requirements from health plans

- Seek resources from CMS and professional and membership organizations to help with the transition

2. Perform an impact assessment. Identify potential changes to existing work flow and business processes by looking at your current use of ICD-9.

-Make a list of staff members who need ICD-10 resources and training, such as billing and coding staff, clinicians, management, and IT staff

-Evaluate the effect of ICD-10 on other planned or ongoing projects (e.g., electronic health records)

3.Plan a comprehensive and realistic budget. Estimate and secure a budget, including costs such as software, hardware, staff training, and production costs.

4.Contact system vendors, clearinghouses, and/or billing services to assess their readiness and evaluate current contracts.

-Ask your vendors how they will support you in the transition to ICD-10

-Request a timeline and cost estimate

Getting Ready for Testing

Once you have completed the planning steps, prepare to test ICD-10. It is important to conduct internal testing of ICD-10 within a clinical practice as well as external testing with payers and other external business partners

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Resources

The CMS ICD-10 website at ICD10 offers resources and guidance to help plan for the ICD-10 transition. Tailored guidance and tips for planning are available on the provider resources page. To keep up to date on the latest news, sign up for weekly ICD-10 email update messages and follow @CMSGov on Twitter.

eRX: Avoiding the Payment Adjustment

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Please note: CMS established two additional hardship categories for the 2014 eRx payment adjustment that will be granted automatically to EPs or members with a group practice participating in eRx GPRO who either achieved meaningful use or who show intent to participate in the Medicare or Medicaid EHR incentive program. However, there are specific timeframes for both of these exemption categories. EPs and GPRO participants who achieved meaningful use during the period from January 1, 2012 through June 30, 2013 will be granted an automatic exemption (based on a review of attestation data in the EHR Incentive Program Attestation and Registration system). EPs and GPRO participants who demonstrate intent to participate in the Medicare or Medicaid EHR Incentive Program must have registered and provided the EHR certification ID between January 1 and June 30, 2013. Registrations that were entered into the EHR Incentive Program Attestation and Registration system before January 1, 2013 will not qualify for this automatic exemption.

EPs are encouraged to carefully review the fact sheet to determine the action needed to be taken to meet the June 30, 2013 deadline.