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CMS Implements New Incentives to Encourage E-Prescribing

CMS has announced a new initiative for physicians to trade in their prescription pads and improve efficiency and safety when ordering drugs for patients with Medicare. The initiative is included in the Medicare Physician Fee Schedule final rule for calendar year 2009.

Widespread adoption of electronic prescribing can eliminate medication errors that result from the misreading of handwritten prescriptions. Medicare beneficiaries may also have reduced out-of-pocket costs as e-prescribing facilitates communication between prescribers and pharmacies on lower-cost generic alternatives.

Physicians and other eligible professionals who adopt and use qualified electronic prescribing (e-prescribing) systems to transmit prescriptions to pharmacies may earn an incentive payment of 2 percent of their total Medicare allowed charges during 2009. This incentive is in addition to a 2 percent incentive payment for 2009 for physicians who successfully report measures under the Physician Quality Reporting Initiative (PQRI), and both incentive payments are in addition to the 1.1 percent fee schedule update required by the Medicare Improvements for Patients and Providers Act of 2008. Thus, a physician who successfully reports under both the e-prescribing and PQRI initiatives could receive up to a 5.1 percent pay boost for 2009.

In the final rule, CMS also adopts improvements to the PQRI, which allows eligible professionals to report quality measures relating to their clinical practice. Physicians who successfully report on their cases during 2009 will be able to earn an incentive payment, in addition to the e-prescribing incentive payment of 2 percent of their total Medicare allowed charges.

The revised policies and payment rates will become effective January 1, 2009.

The final rule with comment will appear in the November 19 *Federal Register.* Comments on designated provisions are due by 5:00 P.M. EST on December 29, 2008, and a final rule responding to the comments will be published at a later date.

For more details on the general provisions of the rule, CMS' implementation of the PQRI and e-prescribing initiative, and MIPPA changes, see the Medicare Fact Sheets posted on the CMS website.

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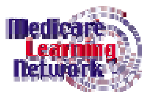

New Product

The revised ***Guidelines for Teaching Physicians, Interns, and Residents*** (July 2008), which provides information about payment for physician services in teaching settings, general documentation guidelines, and evaluation and management documentation guidelines, is now available in downloadable format from the CMS Medicare Learning Network.

2009 PQRI Set to Begin with Changes

The Physician Quality Reporting Initiative (PQRI) for 2008 will end on December 31, 2008. If you have participated in 2008, all applicable measures must be received by February 28, 2009. The final list of qualified registries is posted on the PQRI website.

To submit measures via a qualified registry, contact any registry on the list via their website to ensure that they will be submitting quality data to CMS using the reporting period, the option, and the specific measures or measures groups that you would like to report.

The Medicare Improvements for Patients and Providers Act (MIPPA) contains several new authorities and requirements for quality reporting for 2009 and beyond. These changes include the addition of "qualified audiologist" in the definition of eligible provider. For 2009 and 2010, eligible professionals shall be paid a 2 percent incentive of total allowable charges submitted no later than two months after the end of the reporting period. The rule allows nine reporting options with some changes in the reporting options from 2008. There are two reporting periods for 2009 which include the entire year and the alternate reporting period beginning July 1, 2009 through December 31, 2009.

The final rule includes 153 quality measures for 2009. Some measures are to be reported via registry only. Several measures groups were added including coronary artery bypass graft (CABG) surgery, rheumatoid arthritis, perioperative care, and back pain.

For more information about the measure specifications, go to the PQRI website.

CMS Clarifies MIPPA Changes for Oxygen

The Medicare Improvements for Patients and Providers Act of 2008 implements new payment rules for oxygen suppliers effective January 1, 2009. These changes were made under the physician fee schedule for 2009 which went on display in the *Federal Register* on October 30, 2008.

It is important to note that Medicare has not changed coverage of oxygen for beneficiaries. There is a change of supplier responsibilities and ownership of equipment after 36 months of use mandated by recent changes in the Medicare law. Medicare is changing how it pays oxygen suppliers as follows:

- For the first 36 months, the supplier will receive rental payments for oxygen and equipment.
- After 36 months, the supplier is required to continue to furnish and maintain the equipment without additional charge, but Medicare will continue to pay for oxygen contents furnished for use with liquid or gaseous oxygen systems.
- Also, after 36 months, the supplier is required to continue to furnish replacement accessories and supplies (e.g., masks, regulators, tubing) without additional charge.
- When the equipment is no longer needed, it goes back to the supplier; title is not transferred to the beneficiary after 36 months as was done previously.

This new payment method ensures continuity of provision of oxygen, prevents suppliers from continuing to receive payment for equipment long after Medicare payments have fully covered the cost of the equipment, and does not leave beneficiaries owning equipment to dispose of when it is no longer needed. Medicare continues to pay for needed oxygen and maintenance of the equipment for Medicare beneficiaries both during and after the 36-month rental period.

An MLN article has been published that goes into more detail on the new rules. You can also visit the DME/Oxygen page of the CMS website.

Ready for MAC Transition?

If you have not yet transitioned from the fiscal intermediary/carrier contractors to the new Medicare Administrative Contractors (MACs), click on the special MLN article to help you get ready.

CMS Physician Fee Schedule Includes Changes Required by MIPPA

CMS issued a final rule for the Medicare Physician Fee Schedule for 2009 on October 30, 2008. The final rule implements a number of provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which became law on July 15, 2008. Most of these changes are self-implementing and require only conforming changes, if any, to CMS regulations. Some provisions require administrative interpretation for implementation. For those provisions, CMS will accept comments on the rule and respond to them in a subsequent final rule.

Initial Preventive Physical Examination:
In an effort to increase beneficiary access to care, section 101 of MIPPA waives the deductible for the initial preventive physical examination (IPPE), expands the types of services included in the IPPE to include discussion of end-of-life planning and body mass index assessments, and extends the timeframe for IPPE coverage to 12 months from Part B enrollment. The changes are effective for services on or after January 1, 2009.

Authority to Cover Additional Preventive Services:
MIPPA, for the first time, authorizes the Secretary of Health and Human Services to extend coverage to additional preventive services through the national coverage determination process if:

- The Secretary determines them to be reasonable and necessary for the prevention or early detection of an illness or disability;
- They are recommended with a grade of A or B by the United States Preventive Services Task Force, a task force of the Agency for Healthcare Research and Quality); and
- They are appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B.

Changes to Physician Fee Schedule Payment Rates:
Section 131 of MIPPA substitutes a positive update to payment rates under the MPFS of 1.1 percent for the negative update that would have resulted from the application of the statutory formula that includes the sustainable growth rate.

Ambulance Payment Changes:
Section 146 of MIPPA increases payments for ground ambulance services furnished during the period July 1, 2008, through December 31, 2009, by 3 percent for services originating in a rural area and by 2 percent for services originating in a non-rural area. It also establishes a 1½ year "hold harmless" period from July 1, 2008, through December 31, 2009, for air ambulance services originating in an area that was switched from rural to urban under new geographic classifications that took effect January 1, 2007.

Miscellaneous Changes Required By MIPPA:
Technical Component of Pathology Services for Hospital Patients - Section 136 of MIPPA allows independent laboratories to bill Medicare directly for the technical component of physician pathology services furnished to hospital inpatient and outpatients until December 31, 2009, rather than requiring that it be bundled into the payment to the hospital.

Exceptions to Therapy Caps - Section 141 of MIPPA extends the exceptions process for therapy caps through December 31, 2009.

Telehealth Services - Section 149 of the MIPPA adds the following new telehealth originating sites: a hospital-based or critical access hospital-based renal dialysis center (including satellites), a skilled nursing facility, and a community mental health center, effective for services furnished on or after January 1, 2009.

The MPFS CY 2009 Final Rule with Comment will appear in the November 19 *Federal Register* and will be effective for services on or after January 1, 2009. Comments on designated provisions must be received by December 29, and CMS will respond in a final rule at a later date.

For more information, see: www.cms.hhs.gov/center/physician.asp.

Medicare Providers Continue to Be Satisfied with Contractors

Medicare healthcare providers continue to be satisfied with services provided by Medicare fee-for-service contractors, showing a relatively smooth transition to the new Medicare Administrative Contractors. The average score on this year's satisfaction survey across all contractors was 4.51 on a scale of 1 to 6. This year's average score was comparable to last year's average score of 4.56.

The Medicare Contractor Provider Satisfaction Survey (MCPSS), conducted by CMS for the third year, is designed to gather and report objective, quantifiable data on provider satisfaction with the fee-for-service contractors which process and pay Medicare claims. In 2007, more than one billion claims were processed and paid to approximately one million health care providers who provided medically necessary items and services to 44 million beneficiaries.

As in 2007, the top indicator of satisfaction among providers in 2008 was how Medicare contractors handled provider inquiries. This is the third consecutive year this function was cited as one of the key indicators of provider satisfaction. Across all contractor types, claims processing also remained a strong indicator in 2008 of provider satisfaction, as in the past two years. The parts of the claims function particularly associated with provider satisfaction included claims editing and ease of submitting electronic claims.

The 2008 survey queried about 35,000 randomly-selected providers, including physicians, health care practitioners and facilities, which serve Medicare beneficiaries across the country.

The summary report of the survey findings is available on the CMS Web site in the MCPSS section at www.cms.hhs.gov/MCPSS.

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http://list.nih.gov

New Marketing Guidelines for Medicare Advantage Plans Released

CMS has released final regulations that will protect Medicare beneficiaries from deceptive or high-pressure marketing tactics by private insurance companies and their agents during the upcoming 2009 Medicare Advantage and prescription drug open enrollment period. The regulations also include other non-marketing related Medicare Advantage and prescription drug plan (PDP) provisions.

The two regulations include prohibitions on telemarketing and other unsolicited sales contacts. The new rules also prohibit financial incentives that could encourage agents and brokers to maximize commissions by inappropriately moving, or churning, beneficiaries from one plan to another each year. Plans were to be in compliance with these provisions when they begin their marketing activities on October 1.

CMS will emphasize efforts that will build upon the success of past marketplace surveillance program activities to ensure that drug plans' and health plans' marketing practices reflect the new requirements. Surveillance will include:

- Tripling the number of "secret shopper" activities in which a Medicare official poses as a prospective enrollee and monitors sales agents' presentations for inaccurate information and prohibited sales tactics;
- Reviewing plans' local print and broadcast advertisements;
- Reviewing recordings of enrollment calls to ensure compliance with the new regulations; and
- Ensuring that health and drug plans detect, report, and respond to agent/broker marketing misrepresentation and other issues.

Another key provision specifies restrictions on how agents and brokers are paid for enrolling a beneficiary in a plan to eliminate incentives for agents or brokers to move beneficiaries from plan to plan. These guidelines, designed to protect beneficiaries from agents and brokers who may have been acting in their own financial interest rather than meeting the needs of the beneficiary, are based on existing industry standards for agent and broker compensation structure.

The final rule implementing MIPPA marketing requirements and guidance for MA plans under Part C and PDPs under Part D plans may be viewed on the health plans page of the CMS website.

CMS Focuses Hospital Quality on Outpatient Services in 2009

CMS has announced plans to strengthen the tie between the quality of care furnished to people with Medicare in hospital outpatient departments (HOPDs) and the payments hospitals receive for those services. In a final rule establishing Medicare payment and policy changes for services in HOPDs and ambulatory surgical centers (ASCs) for calendar year 2009, CMS reiterates its commitment to implementing Value Based Purchasing and transforming Medicare from a passive payer to a prudent purchaser of health care.

The final Outpatient Prospective Payment System/Ambulatory Surgical Center Payment System (OPPS/ASC) rule also includes a 3.6 percent annual inflation update for HOPDs, and adopts changes to payment policies for HOPDs and ASCs beginning on January 1, 2009.

The final rule emphasizes that a compelling rationale exists for CMS to develop and implement a policy that would not pay hospitals for care related to illness or injuries acquired by the patient during a hospital outpatient encounter. Such a policy would make adjustments to OPPS payments to ensure equitable and appropriate payment for care, similar to the quality adjustments applied to payment for hospital-acquired conditions in the inpatient setting.

The rule also establishes new conditions of coverage for ASCs that focus on the care provided to patients and the impact of that care on patient outcomes. These will help ensure ASCs are safely equipped and qualified to perform a much broader range of services.

Story continued on next page

IRS Federal Tax Levy Program

In July 2000, the Treasury Department's Financial Management Service and the IRS started the Federal Payment Levy Program (FPLP), which is authorized by Internal Revenue Code Section 6331 (h), as prescribed by Section 1024 of the Taxpayer Relief Act of 1997. Through this program, collection of overdue taxes through a continuous levy on certain federal payments is authorized. This includes federal payments made to contractors and vendors, including Medicare providers, doing business with the government.

Beginning in October 2008, Medicare provider payments will be levied to pay delinquent tax debts owed by Medicare providers. Payments will be subject to a maximum 15 percent levy. The levy is continuous until overdue taxes are paid in full or other arrangements are made to satisfy the debt. Each time a federal payment is levied, CMS will send out a remittance advice to include the amount that is withheld and a Department of the Treasury telephone number to be used by the payee to discuss the reduction in payment. If the amount of the withholding through FPLP exceeds the total debt owed by the payee, the IRS/Treasury is responsible for refunding the overpayment to the payee.

If you are a Medicare provider affected by this program, note that under current privacy rules, only IRS or Treasury may discuss the tax issue with you. Medicare contractors will not have any information to share with you. You must contact the IRS directly by calling 1-800-829-3903.

A Medicare Learning Network article has been published that discusses this issue in more detail.

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New Resources Now Available for Medicare Caregivers

Chances are, you know a Linda.

Linda takes care of her mother, a widow, who lives 1,200 miles away, and takes care of her recently disabled husband at home. Linda also commutes 45 minutes to and from a full-time office job.

Family caregivers like Linda actually hold down more than one full-time job. They respond to the demands of the workplace and then come home to meet the needs of elderly or disabled loved ones. In fact, family caregivers provide almost 80 percent of long term-care in the U.S. They're providing this service, which some estimates place at a staggering $350 billion a year, for free.

Now Medicare offers some help.

CMS has launched a new service called *Ask Medicare,* to support Linda and the more than 44 million Americans—one in five adults—who provide care to a loved one.

Ask Medicare provides information on a wide range of issues and help navigating social services network around the country. Linda and others can go to the Caregivers page on the CMS website and browse such topics as: Medicare basics, planning for a healthy future, help with hospitalization, home health care and community services, nursing homes and housing options, and many others.

Ask Medicare is a one-stop shop with online tools to compare health plan choices across the country, find a prescription drug plan or find a doctor. It can point searchers to helpful telephone numbers, links to partner websites, and help them connect with financial assistance.

Caregivers can use *Ask Medicare* to find information on how to take better care of the people close to them, as well as themselves. According to a recent study, about one in six caregivers report they are in fair or poor health.

Chances are, you recognize Linda. If that's the case we hope we hope you'll go online to the CMS website.

Hospital Outpatient Quality (cont'd)

Story continued from previous page

The changes in the final rule will apply to outpatient services furnished by more than 4,000 HOPDs in general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, community mental health centers, children's hospitals, and cancer hospitals. CMS projects that hospitals will receive $30.1 billion in CY 2009 for outpatient services furnished to Medicare beneficiaries. Furthermore, CMS expects to make payments of almost $3.9 billion in CY 2009 to more than 5,100 ASCs that participate in Medicare.

Under the final rule, the amount beneficiaries will pay for outpatient services will continue to decline based on a formula in the Medicare law that is designed to provide a gradual transition to 20 percent coinsurance for all ASCs. CMS estimates that nearly 25 percent of all types of services furnished in HOPDs, reflecting 85 percent of all billed services, will be subject to the 20 percent coinsurance rate in CY 2009.

The final rule with comment will appear in the November 18 *Federal Register.* Comments on designated provisions are due by 5:00 P.M. EST on December 29, 2008, and a final rule responding to the comments will be published at a later date.

Please see the CMS website for more information on the 2009 final rule with comment period for the OPPS and the ASC payment system.

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