

Provider Partnership Program (PPP) E-mail Notification Archives

October 25, 2004

Hello everyone ~ 3 drug-related pieces of information for you.

HHS Enhances Medicare Drug Card Program to Help Seniors Choose Lower-Cost, Similar Drugs

HHS Secretary Tommy G. Thompson recently announced new measures to help seniors get the lowest price possible for their medicines by allowing them -- for the first time -- to compare prices for similar drugs used to treat common diseases such as high cholesterol or blood pressure.

Secretary Thompson said the enhancements to the Medicare-endorsed drug discount program give seniors another tool to save even more money on their prescription drugs and will create more incentives for drug companies to lower their prices as they compete for consumers.

"We are creating greater competition among drug companies and making the price of prescription drugs more transparent - giving seniors more power to compare prices and choose the lowest-cost medicine that's right for them," Secretary Thompson said. "It's another example of President Bush taking decisive action to drive down health care costs for Americans."

The "Lower Cost Rx Comparison Tool" -- accessible at www.Medicare.gov or by calling 1-800-MEDICARE -- will help consumers compare lower-cost prescription drugs by category (cholesterol lowering drugs, blood pressure medicines, allergy medications, etc.) that are similar to the drugs they currently take and are used to treat the same conditions. Secretary Thompson called for the new transparency to be added to the Medicare discount drug Web site so that seniors would have an even clearer picture of drug costs so they can make more informed choices about their medicines in consultation with their doctors.

"Many widely-used drugs for common health problems often have similar effects, but rarely do consumers have good information on how their prices compare," said Centers for Medicare & Medicaid Administrator Mark B. McClellan, M.D., Ph.D. "Only physicians can decide what drug is best for their patient. We want to help patients and their physicians find the least costly way to get the health benefits that prescription drugs can provide -- including an informed discussion about whether a less expensive, similar drug is right for them."

Dr. McClellan noted that this new assistance is part of a set of further enhancements in the opportunities to get drug savings through the Medicare drug card program. "Recent independent studies have confirmed that drug cards provide real savings, often over 20 percent on brand-name drugs alone, and now there are even more ways to save. It's all accessible just by calling 1-800-MEDICARE anytime or going to medicare.gov on the Internet," he said.

Medicare beneficiaries interested in using the new comparison tool can simply go to the "prescription drug and other assistance program" section of www.medicare.gov and enter the medications they are currently taking. A customized report will be generated for each of their medications, including less expensive versions of the same drug and brand name and/or generic versions of similar but less expensive drugs that are available to treat the same condition.

For example, Zocor, a top-selling medication used for treating high cholesterol costs an average of \$89.38 per month for the 20 mg. tablets. Using the new comparison tools, a beneficiary will find several lower cost options, including another brand name drug, Altoprev, that costs \$57.19 per month for the 40 mg. tablets, an annual savings of \$386.32. (It is important to note that different drugs may have different dosing requirements -- which is one reason why this new tool is intended to help doctors and patients make decisions that are informed by cost savings as well as benefits, not to replace those decisions.)

Medicare beneficiaries can take the information they get from the Lower Cost Rx Comparison Tool and discuss it with their doctors. Beneficiaries using the comparison tool will also learn that drugs in a class or category (such as statins, ACE inhibitors, proton pump inhibitors, etc.) to treat similar conditions but may have different side effects. This information should also be discussed with the doctor.

"The new Medicare benefits are saving seniors money on their drugs," Secretary Thompson said. "We are going to remain aggressive in using the new law and new technology to further drive down costs for seniors. We're helping seniors become more informed consumers so they can get the best price and service to meet their needs."

A rigorous medical review process was used to develop the new lower-cost comparison tool. Physicians and pharmacists review all medical content on a monthly basis to ensure the information is up to date. Prices quoted on the site are updated weekly. The comparison tool includes drugs in classes for which substitutions between different drugs should present the lowest number of clinical challenges to patients and providers.

The classes include:

For lowering blood pressure: ACE Inhibitors, Angiotensin Receptor blockers (ARBs), and Angiotensin Receptor Blockers (ARBs)/Diuretic Combinations,

For treating the symptoms of allergies: Low and Non Sedating Antihistamines/Decongestant Combinations, and Low and Non Sedating Antihistamines, for treating the symptoms of allergies;
For lowering cholesterol: HMG-CoA Reductase Inhibitors or "statins"
For treatment of pain and inflammation: NSAID Cox II inhibitors
For treatment of stomach irritation and ulcers: Proton Pump Inhibitors.

The tool includes a total 52 drugs, representing about a quarter of all Medicare drug spending.

The Price Compare services available at 1-800-MEDICARE and www.medicare.gov now also include specific information about the breadth of drugs covered by each drug card, to provide more help to beneficiaries who are interested in whether a card would provide discounts on other drugs that they might need in the future. All cards provide discounts on all of the top 100 drugs used by seniors that can be included in the drug card program (benzodiazepines are excluded). All cards also provide discounts on more than 60 percent of all drug products marketed in the United States that can be included in the drug card program, and 73 percent (48 out of 66) of the national cards provide discounts on more than 80 percent of drug products. This coverage compares favorably to "open formulary" commercial prescription drug plans.

Other enhancements to the Price Compare features of the drug card program include:

Letting beneficiaries know that they may be able to qualify for the Medicare replacement drug demonstration program, which can provide substantial help with potentially lifesaving self-administered medicines for beneficiaries with diseases that can also be treated by physician-administered drugs covered under Medicare Part B; Providing a beneficiary's annual savings by drug card after a beneficiary provides their current drug costs;

Providing new features that allow beneficiaries to focus their choices only on a particular pharmacy, as well as on only certain drug card sponsors that are available at the beneficiary's preferred pharmacy.

To take advantage of all of these new opportunities to save, beneficiaries can call 1-800-MEDICARE at any time, day or night. They can also visit www.medicare.gov, clicking on the Prescription Drug and Other Assistance Program section.

**NEARLY TWO MILLION LOW-INCOME AMERICANS ON MEDICARE
TO GET DRUG DISCOUNT CARDS**
Move Makes \$1,200 Assistance Nearly Automatic

HHS Secretary Tommy G. Thompson recently announced that nearly two million low-income Americans on Medicare will soon be automatically eligible for prescription

discounts through the Medicare Drug Discount card and qualify for an additional \$1,200 in savings over the next 14 months.

The Medicare beneficiaries will receive a drug discount card in the mail next month, which they can begin to use immediately to get savings at pharmacies, Secretary Thompson said. In addition to receiving the card, beneficiaries will also receive instructions on how to activate the \$1,200 benefit. To do so recipients will have to verify by phone that they meet income guidelines and do not have other drug coverage.

"Seniors with limited means who are struggling to pay for their medicines can save right away " Secretary Thompson said. "We're making it automatic, so those who qualify for the \$1,200 credit get it as soon as possible."

The 1.8 million Medicare beneficiaries getting cards can activate the \$1,200 additional benefit by calling the randomly selected sponsor or by calling 1-800-MEDICARE. They also will have the option of choosing a different sponsor's card. If they do choose another card, they will be automatically dis-enrolled from the randomly assigned card.

The letters will go to people who receive state help to pay Medicare premiums in what are known as Medicare Savings Programs (Qualified Medicare Beneficiary, Specified Low-income Medicare Beneficiary, and Qualifying Individual). Those in the Medicare Savings Programs meet the income tests to make them eligible for the credit.

"We are taking aggressive steps to provide literally thousands of dollars in help now through the drug card program," said Centers for Medicare & Medicaid Services (CMS) Administrator Mark B. McClellan, M.D., Ph.D. "There's no reason that anyone who pays for medicines out of their own pocket should choose between paying for drugs and paying for other basic necessities."

The potential credit is \$600 per year between now and the end of 2005. Any portion of the credit that is unused at the end of 2004 can be carried over into 2005. Beneficiaries need to sign up by Dec. 31, 2004 to be eligible for the credit.

Beneficiaries who receive letters can call 1-800-MEDICARE or visit www.medicare.gov to see if their favorite pharmacy takes the card they received and what discounts are available on the drugs they take.

CMS is also working with more than 100 community-based organizations across the country to reach seniors and people with disabilities who are struggling with the costs of their medicines and help them enroll in the discount drug cards and the \$600 credit if they qualify. These partners include 92 groups that formed the Access to Benefits Coalition for the purpose of helping people with Medicare take advantage of the savings that come with the discount drug cards.

Medicare beneficiaries who do not receive prescription drug coverage through Medicaid are eligible for a Medicare-approved drug discount card. In addition, Medicare

beneficiaries whose annual incomes are below \$12,569 for singles and \$16,862 for married couples are eligible for the \$600 credit.

MEDICARE REPLACEMENT DRUG DEMONSTRATION

Nearly 13,000 Medicare beneficiaries with serious illnesses are now enrolled in a new large-scale demonstration program that helps them pay for the cost of expensive medication. The demonstration covers most of the cost of drugs that patients can administer themselves instead of drugs available only in a doctor's office.

Nearly 4,000 beneficiaries who enrolled in the early sign-up period that ended Aug. 16, have been receiving benefits since September. Another 8,000 who signed up by the end of September began receiving benefits on Oct. 18. Those who submitted completed applications since then will begin receiving benefits in the next few weeks.

"This is good news for the thousands of Medicare beneficiaries who are now getting life-saving and life-enhancing drugs that are affordable and that they can take at home," said Mark B. McClellan, M.D., Ph.D., administrator of the Centers for Medicare & Medicaid Services (CMS). "But there are many more who need help with their medication needs, and we urge them to sign up now. Help is just a phone call or computer click away."

There are plenty of available slots in this demonstration, and eligible beneficiaries are urged to enroll right away. The Medicare Replacement Drug Demonstration is authorized by the Medicare Modernization Act of 2003 (MMA) to enroll up to 50,000 Medicare beneficiaries and spend up to \$500 million for the project. Medicare will continue enrolling applicants on a rolling basis until one of the ceilings is reached.

People whose completed applications are received between the 1st and 15th will begin receiving benefits at the start of the following month. Those whose completed applications are received between the 16th and the end of the month will have coverage effective on the 15th of the following month. As of mid October, 12,779 completed applications had been received, with a projected cost of \$173 million.

This demonstration is a vital bridge for seriously ill beneficiaries until the full Medicare prescription drug benefit begins. The demonstration will continue until Dec. 31, 2005, after which time beneficiaries will have the option of joining a Medicare prescription drug plan to continue to receive coverage of these drugs.

Currently Medicare has no prescription drug benefit. The drugs it does cover are those administered in physician offices. This demonstration covers drugs that "replace" those the patient would receive for the same condition in a doctor's office that would be covered by Medicare Part B.

Valerie A. Hart, Director
Division of Provider Information
Planning & Development, CMS
7500 Security Boulevard
Baltimore, MD 21244
(410) 786-6690
vhart@cms.hhs.gov

October 26, 2004

Under the Medicare-Approved Drug Discount Card Program & Transitional Assistance (TA) Program, Medicare beneficiaries who are enrolled in Medicare Savings Programs (MSPs) as Qualified Medicare Beneficiaries (QMBs), Specified Low-income Medicare Beneficiaries (SLMBs), or Qualifying Individuals (QI-1s) are deemed to meet the income requirement to receive TA (\$600/year both in 2004 and in 2005 toward the purchase of prescription drugs).

CMS is undertaking an initiative to increase TA enrollment for this low-income population by facilitating enrollment and providing a streamlined process for making the required attestations for TA. National drug card sponsors that are willing to participate will agree to follow simple procedures to facilitate TA enrollment for MSP beneficiaries.

Starting in mid-October, over one million people with Medicare will receive an "Important Message from Medicare" and a Medicare-approved discount drug card in the mail. People receiving this important message are likely to qualify for up to \$1,200 in credits from Medicare to help pay for their prescription drug costs.

CMS has developed a "tool kit" of materials for health care professionals, and other partners to assist people with Medicare who can benefit from this opportunity to save money on their prescription drugs. Visit www.cms.hhs.gov/partnerships and click on "Automatic Enrollment Information" on the right-hand side box, next to the "Medicare Rx" symbol. The tool kit includes downloadable, printable materials:

- MSP Facilitated Enrollment Flyer - A flier suitable for distribution in pharmacies, physician offices, and other public places. (PDF 17KB) (Last Updated 10/20/2004)
- Letter to Beneficiaries - This letter has been sent to people with Medicare from all approved drug card sponsors involved in the automatic enrollment effort. (PDF 29KB) (Last Updated 10/14/2004)
- ABC Coalition Partners - Listing of the Access to Benefits Coalition (ABC) members who are partnering with CMS to help beneficiaries understand the new choices coming their way. (PDF 37KB) (Last Updated 10/14/2004)
- Article from the Secretary - A question and answer with Secretary Tommy Thompson. This article is suitable for placement in community and local papers. (PDF 16KB) (Last Updated 10/14/2004)
- Public Service Announcements (PSAs) - The public service announcements are suitable for reading on the radio, and are 10, 30 and 60-second spots. (English - PDF 17KB) (Spanish - PDF 17MB) (Last Updated 10/14/2004)

- Call! Enroll! Save! - This pamphlet provides basic information about the simple steps to get a Medicare-approved drug discount card and encourages people to enroll. It was mailed to low-income beneficiaries in early October. (Last Updated 10/14/2004)
- Letter to Pharmacists - This letter has been electronically distributed through national pharmacy organizations and other interested parties to individual pharmacists, providing them with the letter to beneficiaries, and asking them to distribute a fact sheet. (PDF 10KB) (Last Updated 10/15/2004)
- MedLearn Matters Articles for Physicians & Other Health Care Professionals, and Pharmacists and Other Pharmacy Professionals - Articles from MedLearn (www.cms.hhs.gov/medlearn) targeted to physicians and other health care professionals (SEO457.pdf) and at pharmacists (SEO458.pdf) with information about the discount card and \$600 credit.

Please consider sending this message via your listserv and including it in your next newsletter. Thank you for your help.

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
(410) 786-6690
vhart@cms.hhs.gov

October 27, 2004

Hi everyone ~ I apologize if you're receiving this information for a second time. Apparently my initial attempt at sending it wasn't entirely successful so here's take two....

You may have noticed that the Medlearn Web Page has a new look. If you recall, we asked for your opinion in redesigning the Medlearn Web Page and you gave us a tremendous response--and based on that response, we have gone from the "scrolled look" to the more streamlined "tab look." We have also rearranged some of the Medlearn content into what we believe are more logical groupings. These changes are intended to make it easier for Medlearn users to locate the information they are seeking. We have also modified the "Medlearn Matters" page to use tabs for easier navigation.

I also wanted to let you know that CMS has a new "Clinical Laboratory Information Resource for Medicare" Web page available at <http://www.cms.hhs.gov/suppliers/clinlab/default.asp> on the CMS Website. This Web page includes links to specific Clinical Laboratory information on Billing/Payment, Regulations, Educational Publications, Demonstrations, Coding, National Coverage Determinations, and CMS Manual References.

I hope you find these changes and additions helpful in your quest for Medicare Provider Education and Information. As always, we appreciate hearing from you with your comments and suggestions for improvements, so keep those cards and letters coming! ~ Valerie ~

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
(410) 786-6690

October 28, 2004

Hello everyone ~ today I'm passing along a Medlearn Matters article that was just posted regarding important news about flu shots for Medicare Beneficiaries, as well as some additional information from the Centers for Disease Control and Prevention. I hope you find this information helpful.

Medlearn Matters Article ~ Important News about Flu Shots for Medicare Beneficiaries

CMS has recently posted Medlearn Matters Article SE0464 regarding flu shots for Medicare beneficiaries (I have attached a copy of the article to this e-mail for your convenience, or you can go to <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0464.pdf> to obtain the article). The article highlights the difference in the Medicare billing procedure used if a beneficiary receives a flu vaccine from a Medicare-enrolled physician or provider versus a physician or provider who is not currently enrolled in Medicare, as well as how a physician or provider who wishes to enroll in Medicare can do so on an expedited basis. It also provides information on prioritizing who should get the flu vaccine and other flu-related materials from the Centers for Disease Control and Prevention (CDC)--some of which are presented below:

Influenza Antiviral Medications

The Centers for Medicare & Medicaid Services is very interested in making sure that providers of services for Medicare and Medicaid beneficiaries remain up to date regarding the most recent influenza-related information.

The following email is information that the CMS Open Door Forum program is distributing via our listserv system to the physician, nursing, allied health, skilled nursing facility, and acute care hospital forums. The information is relevant to patients, as well as to health care workers providing hands-on care.

While the attached information is timely, these interim recommendations may be updated as more information on the supply of influenza vaccine and antiviral medications becomes available. Please refer to the web addresses within the announcement for future updates.

GUIDELINES & RECOMMENDATIONS

Influenza Antiviral Medications:
2004-05 Interim Chemoprophylaxis and Treatment Guidelines

October 18, 2004

Influenza antiviral medications are an important adjunct to influenza vaccine in the prevention and treatment of influenza. In the setting of the current vaccine shortage, CDC has developed interim recommendations on the use of antiviral medications for the 2004-05 influenza season. These interim recommendations are provided, in conjunction with previously issued recommendations on use of vaccine, to reduce the impact of influenza on persons at high risk for developing severe complications secondary to infection. The recommendations are not intended to guide the use of these medications in other situations, such as outbreaks of avian influenza. These interim recommendations may be updated as more information on the supply of influenza vaccine and antiviral medications becomes available.

Background

Influenza antiviral medications have long been used to limit the spread and impact of institutional influenza outbreaks. They also are used for treatment and chemoprophylaxis of persons in other settings. In the United States, four antiviral medications (amantadine, rimantadine, oseltamivir, and zanamivir) are approved for treatment of influenza, though limited supplies of zanamivir are currently available. When used for treatment within the first two days of illness, all four antiviral medications are similarly effective in reducing the duration of illness by one or two days. Only three antiviral medications (amantadine, rimantadine, and oseltamivir) are approved for chemoprophylaxis of influenza. More detailed information about each medication, including dosage and approved persons for use, may be found at <http://www.cdc.gov/flu/professionals/treatment>.

2004-05 Antiviral Medications Usage Guidelines

CDC is issuing interim recommendations for the use of antiviral medications during the 2004-05 season. Local availability of these medications may vary from community to community, which could impact how these medications should be used.

1) CDC encourages the use of amantadine or rimantadine for chemoprophylaxis and use of oseltamivir or zanamivir for treatment as supplies allow, in part to minimize the development of adamantane resistance among circulating influenza viruses.

2) People who are at high risk of serious complications from influenza may benefit most from antiviral medications. Therefore, in general, people who fall into these high risk groups should be given priority for use of influenza antiviral medications:

Treatment

- Any person experiencing a potentially life-threatening influenza-related illness should be treated with antiviral medications.

- Any person at high risk for serious complications of influenza and who is within the first 2 days of illness onset should be treated with antiviral medications. (Pregnant women should consult their primary provider regarding use of influenza antiviral medications.)

Rimantadine is not approved for treatment of children aged < 13 years. For treatment, these persons should receive amantadine (children aged 1-12), oseltamivir (children aged 1-12), or zanamivir (children aged 7-12).

Chemoprophylaxis

- All persons who live or work in institutions caring for people at high risk of serious complications of influenza infection should be given antiviral medications in the event of an institutional outbreak. This includes nursing homes, hospitals, and other facilities caring for persons with immunosuppressive conditions, such as HIV/AIDS. When vaccine is available, vaccinated staff require chemoprophylaxis only for the 2-week period following vaccination. Vaccinated and unvaccinated residents should receive chemoprophylaxis for the duration of institutional outbreak activity. Rapid tests or other influenza tests should be used to confirm influenza as the cause of outbreaks as soon as possible. However, treatment and chemoprophylaxis should be initiated if influenza is strongly suspected and test results are not yet available. Other outbreak control efforts such as cohorting of infected persons, and the practice of respiratory hygiene and other measures also should be implemented. For further information on detection and control of influenza outbreaks in acute care facilities, see

http://www.cdc.gov/ncidod/hip/INFECT/flu_acute.htm

- All persons at high risk of serious influenza complications should be given antiviral medications if they are likely to be exposed to others infected with influenza. For example, when a high-risk person is part of a family or household in which someone else has been diagnosed with influenza, the exposed high-risk person should be given chemoprophylaxis for 7 days.

3) Antiviral medications can be considered in other situations when the available supply of such medications is locally adequate.

- Chemoprophylaxis of persons in communities where influenza viruses are circulating, which typically lasts for 6-8 weeks:

- Persons at high risk of serious complications who are not able to get vaccinated.
- Persons at high risk of serious complications who have been vaccinated but have not had time to mount an immune response to the vaccine. In adults, chemoprophylaxis should occur for a period of 2 weeks after vaccination. In children aged <9 years, chemoprophylaxis should occur for 6 weeks after the first dose, or 2 weeks after the second dose, depending on whether the child is scheduled to receive one or two doses of vaccine.
- Persons with immunosuppressive conditions who are not expected to mount an adequate antibody response to influenza vaccine.
- Health-care workers with direct patient care responsibilities that are not able to obtain vaccine.

Treatment of infected adults and children aged >1 year who do not have conditions placing them at high risk for serious complications secondary to influenza infection.

4) Where the supplies of both influenza vaccine and influenza antiviral medications may not be sufficient to meet demand, CDC does not recommend the use of influenza antiviral medications for chemoprophylaxis of non-high risk persons in the community.

Private Sector Sources of Influenza Antiviral Medications

Pharmaceutical distributors should be contacted directly for availability and procurement of antiviral medications.

Strategic National Stockpile

The United States has a limited supply of influenza antiviral medications stored in the Strategic National Stockpile for emergency situations. Efforts are underway by Health and Human Services to procure additional supplies of antiviral medications. Some of the supply will be held in reserve in the event of an influenza pandemic. However, some of the supply will be made available to States and Territories for use in outbreak settings, as might occur in a hospital or long term care facility.

Requesting Influenza Antiviral Medications from the SNS

Influenza antiviral medications in the SNS can be requested only by State or Territory Health Departments. Institutions (hospitals or long-term care facilities) experiencing an urgent need for such medications should convey their request to the State or Territory Health Department.

1. The State or Territory Health Department should call (770) 488-7100, the CDC 24/7 emergency number, to make a request for antiviral medications. A logistics plan is being drafted and will be available to all state and territorial health departments in the near future.

2. The State or Territory Health Department should indicate that there is an urgent priority use situation (as defined previously) that can be addressed by use of antiviral medications, and should indicate that all reasonable efforts have been made to procure influenza antiviral medications from private distributors.

For more information, visit www.cdc.gov/flu or call the National Immunization Hotline at (800) 232-2522 (English), (800) 232-0233 (Español), or (800) 243-7889 (TTY).

Best regards,

Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
(410) 786-6690
vhart@cms.hhs.gov

October 29, 2004

Hello everyone ~ this should be the last message that you receive from me this week, but there's just so much going on!

Comprehensive Overhaul of Medicare Appeals System

Centers for Medicare & Medicaid Services Administrator Mark B. McClellan, M.D., Ph.D., recently announced a key step in helping Medicare beneficiaries resolve their appeals more quickly and efficiently, as part of a comprehensive overhaul of the Medicare claims appeals system. CMS awarded contracts to eight Qualified Independent Contractors (QICs) to perform reconsiderations, or second level claims appeals, of denied Medicare fee-for-service claims.

"Seniors and people with disabilities deserve a prompt and consistent and responsive process for their claims appeals in Medicare," said Dr. McClellan. "We are working toward completing our overhaul of the Medicare claims appeals system by October 1, 2005 to better serve Medicare beneficiaries, providers, physicians, and other health care providers."

The reconsiderations that will be conducted by the new QICs will replace the current "fair hearing" process for Medicare Part B claims and establish a new second level of appeal for Medicare Part A claims. Statute requires that reconsiderations must be completed within 60 days from the day the request is filed.

The eight entities selected were:

- + Integriguard, LLC;
- + Q² Administrators (Q²A);
- + Island Peer Review Organization (IPRO);
- + Rivertrust Solutions, Inc.;
- + Computer Sciences Corporation (CSC);
- + Maximus, LLC;
- + First Coast Service Options, Inc.; and,
- + Permedion.

As part of the new process, these contractors will be able to bid on specific types of appeals workloads such as Part A, Part B or durable medical equipment, and in the specific areas of the country for which they will process claims. Other steps that CMS is taking as part of its comprehensive overhaul of Medicare claims appeals include:

- Finalizing the transfer of responsibility for the third level appeals conducted by Administrative Law Judges from the Social Security Administration to the Department of Health and Human Services by October 1, 2005.
- Developing a new appeal-specific data system that will allow authorized users to track individual appeals in real time.
- Establishing an Administrative QIC that will oversee the distribution of case-files, develop appeals processing protocols, conduct training of the QICs, and the dissemination of information on QIC appeals decisions to the public.
- Implementing a 60-day decision deadline and improved notices for claims redeterminations, or first-level appeals performed by fiscal intermediaries and carriers. The improved notices will include the specific reasons for the decision and a summary of relevant clinical or scientific evidence used in making the decision.
- Issuing the final regulations needed to implement the new uniform appeals procedures, including the rules QICs and other appeals entities by the end of the year.

Town Hall Meeting: Medicare Provider Feedback- November 16, 2004

CMS will be hosting a Town Hall meeting on November 16, 2004, from 2:00 p.m to 3:00 p.m. (Eastern Time). The meeting will be held in the auditorium at the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244.

Our goal is to solicit the experience of individual Medicare Fee For Service (FFS) providers to help educate CMS on how to better serve them.

The purpose of the meeting is to provide the Agency with a venue that would allow access to individual Medicare providers for CMS managers, who need provider opinion on various topics. At the meeting, CMS Staff will explain the CMS design for getting individual provider feedback on CMS provider communications and other topics.

On-line registration is available for individuals to participate in the meeting, whether in person or by teleconference. The on-line registration will capture contact information and practice characteristics; such as, name, email address, and provider/supplier type. Providers and other interested parties may speak or ask questions during the meeting, either as a participant in the auditorium, or via teleconference as noted below.

Participation Instructions:

Registration for the meeting will open on Monday, October 25, 2004.

Participants should register at <http://registration.intercall.com/go/cms>. The on-line registration system will generate a confirmation page to indicate the completion of your registration. Please print the page as a confirmation receipt of your registration. Registration after 12 noon, November 15, 2004 will delay confirmation and individuals may not be permitted entrance to the building. Persons participating by teleconference should dial: 1-877-357-7851 and Reference Conference ID:1040512

This meeting will be held in a Federal Government building therefore, persons attending the meeting will be required to show a photographic identification, preferably a valid driver's license and be listed on an approved security list before.

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here <http://www.consumer.att.com/relay/which/index.html>. A Relay Communications Assistant will help.

Encore is a digital recording of this call, which will be available hours after the meeting and can be accessed by dialing 1-800-642-1687 and entering the Conf. ID number 1040512.

Please contact Keri Boston at Kboston@cms.hhs.gov for further information about registration for the meeting.

Clarification on Application Process for Hospitals Applying for Additional GME Cap Slots Under Section 422 of the MMA

Section 422 of Public Law 108-173 (the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003) provides for a reduction in the statutory resident caps under Medicare for certain hospitals and authorizes a "redistribution" of those FTE resident slots to other hospitals. Qualifying hospitals that submit a timely application may receive up to 25 additional FTE resident cap slots for direct GME and IME purposes.

Additional information regarding the reallocation of GME cap slots under section 422 and the application process can be found at http://www.cms.hhs.gov/providers/hipps/app_res_caps.pdf

In light of several questions we have received from hospitals wishing to apply for these cap slots, we are making the following clarifications:

Deadline for Applications: The deadline for applications for additional FTE cap slots is December 1, 2004. We note that some hospitals' FTE counts will be subject to audit for the purposes of section 1886(h)(7)(A) and those audits may not be completed by December 1, 2004. Because the results of such an audit may be a factor in a hospital's decision whether to request an increase in its FTE resident cap, we will allow a later date for those hospitals to apply for increases in their FTE resident caps. Therefore, if a hospital's resident level is audited for the purposes of section 1886(h)(7)(A) of the Act, and that hospital also wishes to apply for an increase in its FTE resident cap(s), that hospital must submit a completed application to CMS that is received on or before March 1, 2005. We note that some hospitals may not be notified of an upcoming audit prior to the December 1, 2004 deadline. Therefore, a hospital that has not been notified of an upcoming audit for the purposes of section 1886(h)(7)(A) must submit an application by the December 1, 2004 deadline in order to be considered for additional FTE cap slots under section 422. If, after submitting an application, a hospital's FTE resident caps or counts is changed pursuant to an audit that was carried out for the purposes of section 1886(h)(7)(A), we will allow that hospital to resubmit an application by March 1, 2005, as that hospital's decisions regarding this request may have changed.

Demonstrated Likelihood Criterion 3: Section 422 of the MMA requires CMS to take into account the "demonstrated likelihood" that a hospital will be able to fill the additional FTE cap slots within the first three cost reporting periods beginning on or after July 1, 2005. CMS designed an application that provides three ways that a hospital may meet this "demonstrated likelihood" criteria. Demonstrated Likelihood Criterion #3 allows a hospital to meet this requirement if it provides certain documentation that indicates that the hospital is already training residents in excess of its FTE resident cap(s). One of the required pieces of documentation under this criterion is the most recent as-submitted Medicare cost report Worksheet E, Part A and Worksheet E3, Part IV that show that the hospital is training residents in excess of its cap(s). We note that there may be instances where a hospital is training a number of residents in excess of its cap at the time of application, but this is not reflected on the most recent as-submitted Medicare cost report. In such instances, we will allow a hospital to submit alternate documentation

to verify that it is training residents in excess of its FTE resident cap(s). Note that there are other documents required in order for a hospital to meet Demonstrated Likelihood #3 and that these documentary requirements remain in effect regardless of whether a hospital submits worksheets E, Part A and E3, Part IV or some other alternate documentation.

Additional information on section 422 of the MMA and on the application process can be found in the August 11, 2004 Federal Register starting on page 49132.

Draft Medicare Plan to Cover Implantable Defibrillators

Centers for Medicare and Medicaid Services (CMS) proposed to expand coverage of implantable cardioverter defibrillators (ICDs), a move expected to save thousands of lives a year.

The expansion, when made final, will increase the number of Medicare beneficiaries eligible for an ICD by one-third, to nearly 500,000. CMS expects to provide this therapy to at least 25,000 patients in the first year of coverage, potentially saving up to 2,500 lives.

For more information please refer to our press release:

<http://www.cms.hhs.gov/media/press/release.asp?Counter=1211>

The coverage decision is available on the CMS web site at

<https://www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=1>

Updated Average Sales Price (ASP) submission of data FAQs Available

An update to the ASP FAQs list has just been posted. To view this, along with the full list of Frequently Asked Questions on Average Sales Price data submission, please go to:

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=8c4IQImh&p_lva=&p_li=&p_page=1&p_cat_lv11=%7Eany%7E&p_cat_lv12=%7Eany%7E&p_prod_lv11=28&p_prod_lv12=39&p_search_text=&p_new_search=1

CCI Edits for Hospital Outpatient Departments (Version 10.2)Updated on CMS

CMS has posted the next version (10.2) of the CCI Edit files for Hospital Outpatient PPS, effective October 1, 2004, on the CMS Website.

You can find the edits at
<http://www.cms.hhs.gov/providers/hopps/cciedits/default.asp> .

Medicare Appoints Advisory Panel for New Durable Medical Equipment Competitive Bidding Process

The Centers for Medicare & Medicaid Services announced on Friday the appointment of a committee to advise the agency about the implementation of competitive bidding for certain supplies and equipment provided to Medicare beneficiaries, and about establishing standards for suppliers who want to participate in the Medicare program.

Medicare anticipates that beneficiaries will have access to higher quality at lower prices when it adopts a competitive bidding model for certain durable medical equipment, prosthetics, orthotics, and supplies (also referred to as DMEPOS). Because the beneficiary pays 20 percent of the costs of these products and Medicare pays 80 percent, lower prices will help both beneficiary and taxpayer.

"We all want seniors and disabled individuals to have access to quality health care at the best possible price," says CMS Administrator Mark B. McClellan. "This committee will help us get the process right."

The Medicare Modernization Act (MMA) requires CMS to make competitive bidding a permanent part of Medicare. CMS demonstration projects in Florida and Texas, involving such items as oxygen, hospital beds, manual wheelchairs and simple orthotics, showed price reductions on average of 20 percent. The MMA requires the new competitive bidding process to be phased in over a period of years, beginning in 2007 in ten of the largest Metropolitan Statistical Areas.

The advisory committee membership represents a broad range of stakeholders in the outcome of the competitive bidding process: beneficiary/consumer, physician/provider, manufacturer, supplier, certification/standards, and federal and state programs. This committee will ensure that CMS maintains an open communication process during the implementation of this new program. Specifically, the committee will be advising CMS on implementation of competitive bidding, beneficiary access issues, appropriate educational strategies, and financial and quality standards for suppliers under the program.

The committee was scheduled to hold its first meeting on Oct. 6 at CMS headquarters in Baltimore. It will meet periodically until the end of 2009. A list of the committee members is below.

COMPETITIVE BIDDING PROGRAM ADVISORY AND OVERSIGHT COMMITTEE MEMBERSHIP ROSTER

- 1.Cara Bachenheimer - Vice President of Government Relations, Invacare Corporation.
- 2.Robert Baum - Program Manager for the Prosthetic and Sensory Aids Service, Strategic Healthcare Group, Veterans Health Administration (VA) Central office, Washington, DC.
- 3.Mary Benhardus - Founder and controlling owner, Handi Medical Supply Inc.
- 4.Henry Claypool - Expert adviser to Social Security Administration's Deputy Commissioner to advise on Interim Medical Benefits
- 5.Asela Cuervo - Senior Vice President, American Association for Homecare.
- 6.David Gray - Associate Professor of Neurology and Associate Professor of Occupational Therapy, Washington University School of Medicine.
- 7.Don Hawley, D.D.S. - Program Director, Utah Department of Health, Division of Utah Health Care Financing.
- 8.Lawrence Higby - President and CFO, Apria Healthcare.
- 9.Rita Hostak - Vice President, Home Healthcare Group of Sunrise Medical Inc.
- 10.Dave Kazynski - President, Van G. Miller & Associates's HOMELINK division.
- 11.Anthony Filippis - President and CEO, Wright & Filippis. Practicing certified prosthetist/orthotist.
- 12.Alan McMullen - Cost Reimbursement Analyst, Medical Assistance Administration, Department of Social & Health Services, State of Washington.
- 13.Jean Minkel - Founder and President, Minkel Consulting. Specializes in Assistive technology.
- 14.William Popomaronis - Vice President, Long-Term/Home Health Care Pharmacy Services, The National Community Pharmacists Association (NCPA).
- 15.Maryanne Popovich - Executive Director, Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- 16.John Prassas - Director, Corporate Provider Development & Contracting, PacifiCare Health Plans.
- 17.Chris Reisdorf - Manager, Benefit Policy Unit - Minnesota Health Care Programs - Medical Assistance, General Assistance Medical Care, and Minnesota Care programs.

18.David Van Sleet - VISN 1 Prosthetics Manager, Department of Veterans Affairs, New England Healthcare System.

19.Ken Viste, M.D. - Medical Director, Physical Rehabilitation Unit Mercy Medical Center and Staff Physician, St. Agnes Hospital.

20.Don Vliegenthart. M.D. - Medical Director, Hoveround Corporation.

21.Daniel Waldmann- Director of Federal Affairs, Johnson & Johnson, Inc.

2004 Fee Schedule for Wheelchair Seat and Back Cushions

CMS has released 2004 fee schedule amounts for wheelchair seat and back cushions. To view the fee schedule amounts, and related questions and answers regarding coding and payment for wheelchair cushions, go to the web page at

<http://www.cms.hhs.gov/suppliers/dmepos/2004WCFeesched.asp#qa>

For additional Medicare information related to durable medical equipment, prosthetics, orthotics, and supplies, visit the CMS website at

<http://www.cms.hhs.gov/suppliers/dmepos/>

Increase in Medicare Payment Rates to HHAs

The Centers for Medicare & Medicaid Services (CMS) announced a 2.3 percent increase in Medicare payment rates to home health agencies for calendar year 2005. The increase would bring an extra \$250 million in payments to home health agencies next year.

"The additional money will mean that beneficiaries will continue to receive quality care from home health agencies," said Mark B. McClellan, M.D., Ph.D., Administrator of the Centers for Medicare & Medicaid Services, which oversees the payment system.

Medicare pays home health agencies under a prospective payment system. Under the payment system, Medicare pays higher rates to home health agencies to care for those beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments conducted by clinicians that all Medicare-participating home health agencies are required to submit.

Home health payment rates are updated annually by either the full home health market basket percentage, or by the home health market basket, adjusted by Congress. CMS establishes the home health market basket index, which measures inflation in the prices of an appropriate mix of goods and services included in home health services.

This year, CMS is rebasing and revising the home health market basket to ensure it continues to adequately reflect the changes in the costs of efficiently providing home health services. This means that CMS is revising the home health market basket to reflect changing data sources, cost categories, and/or price proxies to allow the home health market basket to better track price changes experienced by home health agencies, and rebasing the home health market basket using Fiscal Year 2000 Medicare cost report data so the cost category weights reflect changes in the mix of goods and services that home health agencies purchase in furnishing home health care.

CMS is also updating the fixed dollar loss ratio, which affects the percentage of payments made for outlier episodes under the home health payment system. By reducing the fixed dollar loss ratio, more home health episodes will qualify for outlier payments under the home health prospective payment system.

To qualify for Medicare home health visits, people with Medicare must be under the care of a physician, have an intermittent need for skilled nursing care, or physical therapy, or speech therapy, or continue to need occupational therapy. The beneficiary must be homebound and receive home health services from a Medicare approved home health agency.

Information regarding CMS's Calendar Year 2005 update to the home health prospective payment system rates is available at Medicare's consumer web site, <http://www.medicare.gov> and through Medicare's help line, 1-800-MEDICARE (1-800-633-4227).

Calendar Year 2005 Home Health PPS Final Rule

CMS recently sent out a press release announcing the calendar year 2005 Home Health PPS final rule that includes the payment rate updates. In our email announcement to the Open Door Forum Listserv, we had included some website information where additional information could be found regarding the update. Although the CMS consumer information website at www.medicare.gov does include a substantial amount of information regarding Home Health services, it is primarily intended to serve the beneficiary audience that is interested in learning about CMS programs and how to best utilize them, including comparative information for helping Medicare beneficiaries to choose services and facilities in their area. While there is a link on the Medicare.gov website that takes professionals, such as Home Health Agency representatives to the CMS professional website, we felt it would be useful to send this short reminder email explaining that www.cms.gov is the website where health care providers can find the latest information supporting their needs in serving Medicare beneficiaries.

For the latest information supporting the Home Health industry, the web site is:
<http://www.cms.hhs.gov/providers/hha>

All of the various professions that serve our beneficiaries are provided with up-to-date information tailored to their needs at www.cms.gov. Information for Medicare, Medicaid, SCHIP, HIPAA and CLIA is organized and presented in corresponding web pages. The web site has distinct areas that coordinate information by service setting (such as for skilled nursing facilities, home health agencies, hospitals, etc.), by CMS component (such as Medicare coverage, CMS demonstration projects, Open Door Forums, state Medicaid programs, etc.), and other important current subject areas too (such as the New Freedom Initiative, the Medicare Modernization Act, etc.)

We hope that you will find the CMS websites useful for your needs, and that you continue to share your experience with us on the Open Door Forums.

Correction notice to Hospital Inpatient PPS for FY 2005

A correction notice to the Hospital Inpatient PPS FY 2005 final rule entitled "Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates; Correction" (CMS-1428-CN2) went on display at the Federal Register on September 30, 2004. (We note that the revised wage index, geographic reclassification and rate tables posted

on the CMS website, effective for discharges occurring on or after October 1, 2004, are not included in this correction notice. The corrected tables, addendum language and revised impact analysis will be included in a forthcoming correction notice to be published in the Federal Register.) To view the Correction Notice, click on <http://www.cms.hhs.gov/providers/hipps/cms-1428-cn2.pdf>

Whew--have a great weekend!

Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
(410) 786-6690
vhart@cms.hhs.gov