

Provider Partnership Program (PPP) E-mail Notification Archives

July 5, 2006

CMS asks that you share this important information with all of your association members and State and local chapters. Thanks!

This message is a reminder for all physicians, providers, and other health care professionals who bill Medicare contractors for their services.

A brief hold will be placed on Medicare payments for all claims during the last 9 days of the Federal fiscal year (September 22 through September 30, 2006). These payment delays are mandated by section 5203 of the Deficit Reduction Act of 2005. No interest will be accrued and no late penalties will be paid to an entity or individual by reason of this one-time hold on payments. All claims held during this time will be paid on October 2, 2006.

This policy only applies to claims subject to payment. It does not apply to full denials, no-pay claims, and other non-claim payments such as periodic interim payments, home health requests for anticipated payments, and cost report settlements.

Please note that payments will not be staggered and no advance payments will be allowed during this 9-day hold.

For more information, please view the MLN Matters Article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf>.

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July 7, 2006

Together We Can Close the Prevention Gap

Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. Although chronic diseases are among the most common and costly health problems, they are also some of the most preventable. Over

the years Medicare has continued to expand the range of preventive services for which it pays and now provides coverage for the following preventive services and screenings (subject to certain eligibility and other limitations):

- Cardiovascular Disease Screening
- Cancer Screenings
 - Breast (Mammography)
 - Cervical & Vaginal (Pap Test & Pelvic Exam)
 - Colorectal
 - Prostate
- Diabetes Screening, and
 - Self-Management Training
 - Medical Nutrition Therapy
 - Supplies
- Initial Preventive Physical Exam (IPPE) (“Welcome to Medicare” Physical Exam)
- Bone Mass Measurements
- Adult Immunizations
 - Influenza (Flu)
 - Pneumococcal Polysaccharide Vaccine (PPV)
 - Hepatitis B Virus (HBV)
- Glaucoma Screening
- Smoking and Tobacco-Use Cessation Counseling Services

While the number of Medicare-covered preventive services is higher than ever, we are finding that many beneficiaries are not taking advantage of the full range of services for which they may be eligible. Some of the reasons for this under-utilization include beneficiaries:

- Not knowing that these services are covered by Medicare;
- Being afraid to talk with their physician or not knowing how or what questions to ask;
- Not understanding the value of prevention, early detection and treatment;
- Fearing the pain that may occur during the preventive service procedure; or
- Fearing the results of the preventive service procedure.

In addition, there may be physical and social barriers that prevent Medicare beneficiaries from obtaining preventive services.

How Can You Help?

Regardless of the reason for your Medicare patient not using a service, you are in a key role to help address this problem. The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that people with Medicare are aware that Medicare provides coverage for preventive services that could save their lives. You can help by doing the following:

- Talk with your patients about their risk for disease and the value of prevention and early detection, and encourage utilization of appropriate Medicare-covered preventive services
- Perform or provide referrals for the appropriate preventive services
- Follow-up with patients on all screening results, even negative ones
- Provide information about appropriate lifestyle modifications that support a healthy lifestyle

For More Information

CMS has developed a variety of educational products and resources to help healthcare professionals and their staff become familiar with coverage, coding, billing, and reimbursement for preventive services covered by Medicare.

- The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The web page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS website.
- The CMS Website provides information for each preventive service covered by Medicare. Click on www.cms.hhs.gov, select “Medicare”, and scroll down to “Prevention”.

For products to share with your Medicare patients, visit www.medicare.gov on the Web.

As a trusted source of patient health care information, your recommendation is one of the most important factors in increasing the utilization of preventive services covered by Medicare. We hope that you will join with CMS as we strive to close the prevention gap and encourage appropriate utilization of preventive services. It could save seniors’ lives.

Thank you so much for your help!

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July 13, 2006

CMS and the Workgroup for Electronic Data Interchange (WEDI) are working together to ensure that all healthcare providers are educated and informed on the new National Provider Identifier (NPI). As such there are a few upcoming outreach events, sponsored by WEDI, that healthcare providers may find helpful:

- **Taxi-ing to the Taxonomy Code Audiocast**
July 26th from 2 - 3:30PM Eastern Time
- **WEDI NPI Industry Forum IV: NPI Is Knocking At Your Door—Will You Let It In?**
August 15th and 16th at the Hyatt Fair Lakes in Fairfax, VA

Please note that there is a cost to participate in these events. To learn more about the events, as well as the latest news on WEDI NPI outreach, visit <http://www.wedi.org/npoi/index.shtml> on the web.

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July 24, 2006

This note was previously sent on July 7, 2006. I am re-sending it to clarify that Medical Nutrition Therapy is available as a Medicare-covered preventive service for Medicare beneficiaries with diabetes OR renal disease (subject to certain eligibility and other limitations).

Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. Although chronic diseases are among the most common and costly health problems, they are also some of the most preventable. Over the years Medicare has continued to expand the range of preventive services for which it pays and now provides coverage for the following preventive services and screenings (subject to certain eligibility and other limitations):

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 - Colorectal
 - Prostate
- Diabetes Screening
- Diabetes Supplies
- Diabetes Self-Management Training
- Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease)
- Initial Preventive Physical Exam (IPPE) (“Welcome to Medicare” Physical Exam)
- Bone Mass Measurements
- Adult Immunizations
 - Influenza (Flu)
 - Pneumococcal Polysaccharide Vaccine (PPV)
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July 27, 2006

CMS asks that you share this information with all of your association members and State and local chapters. Thanks!

Hello Everyone! Plenty of information to share with you this fine July day including information on the following:

- *Revised Guidance for National Coverage Determinations With Evidence Development*

- *Overview of New Requirements on Citizenship Documentation for Medicaid Benefits*
- *New Steps to Provide Beneficiaries with Access to Coverage Through Consumer-Directed Health Plans in the Medicare Advantage Programs in 2007*
- *A Comprehensive Medicaid Integrity Plan*
- *New Educational Products from the Medicare Learning Network*
- *NPI Panel Discussions*

MEDICARE RELEASES REVISED GUIDANCE FOR NATIONAL COVERAGE DETERMINATIONS WITH EVIDENCE DEVELOPMENT

Mark B. McClellan, M.D., Ph.D, CMS Administrator, recently announced the release of revised guidance on Medicare National Coverage Determinations (NCDs) that include, as a condition of payment, the development and submission of additional patient data to supplement standard claims data. This process, termed Coverage with Evidence Development (CED), is intended to generate data to document the appropriateness of an item or service for Medicare beneficiaries, inform future changes in coverage, and improve the evidence base on which providers base their treatment recommendations.

The revised guidance follows a draft document, which was posted for public comment on April 7, 2005. CMS received a large number of comments on the draft guidance and considered them in developing this revision. The revision clarifies particular applications of CED as well as the legal bases for incorporating CED into the larger NCD process. In particular, the revision identifies two sub-types of CED including (1) coverage conditioned on specific data collection to ensure patients are receiving care consistent with the parameters of the NCD (referred to as Coverage with Appropriateness Determination), and (2) coverage conditioned on patient participation in a clinical study (referred to as Coverage with Study Participation).

The revised guidance also follows CMS' decision to reconsider its National Coverage Determination on coverage of clinical research, to better clarify how and when CMS can pay for both routine costs and investigational costs incurred in clinical trials, as well as the relationship of the clinical trials policy to CED.

CMS invites public comment on this revision. The revision is available on CMS' Coverage website at www.cms.hhs.gov/coverage.

A Press Release describing the revised guidance document is attached FYI. Please contact Don McLeod (202-690-7183) in the CMS Office of External Affairs with any questions.

HHS ISSUES FINAL REGULATIONS WITH COMMENT ON CITIZENSHIP GUIDELINES FOR MEDICAID ELIGIBILITY

Overview of New Requirements on Citizenship Documentation for Medicaid Benefits

HHS published interim final regulations with comment on July 12, 2006 for States to implement a new requirement, effective July 1, that persons applying for Medicaid must document their citizenship. This interim final rule with comment will amend Medicaid regulations to implement the provision of the Deficit Reduction Act that requires States to obtain satisfactory documentary evidence of an applicant's or recipient's citizenship and identity in order to receive Federal financial participation. This interim final with comment regulation will provide States with guidance on the types of documentary evidence that may be accepted, including alternative forms

of documentary evidence in addition to those described in the statute and the conditions under which this documentary evidence can be accepted to establish the applicant's declaration of citizenship. It will also give States guidance on the processes that may be used to help minimize the administrative burden on States, applicants and recipients.

Recognizing the diversity of beneficiaries served by Medicaid, the regulations provide for a range of ways that citizenship status and personal identity may be documented. Because seniors and people with a disability who receive Medicare or Supplemental Security Income already have met certain documentation requirements, the regulation does not include new documentation requirements for these groups. This exemption reflects the special treatment of these groups in the statute, implying that they should be exempt from additional documentation requirements. For all other individuals, in addition to the range of documents outlined in the regulation, states can also document citizenship and identity through data matches with government agencies. Additional types of documentation, such as school records, may also be used for identity of children. If other forms of documentation cannot be obtained, documentation may be provided by a written affidavit, signed under penalty of perjury, from two citizens, one of whom cannot be related to the applicant or recipient, who have specific knowledge of a beneficiary's citizenship status. Applicants or recipients must also submit an affidavit stating why the documents are not available. Affidavits are only expected to be used in rare circumstances. Current beneficiaries should not lose benefits during the period in which they are undertaking a good-faith effort to provide documentation to the state.

The interim final regulations match most of the guidance that was provided to State Medicaid Directors on June 9, 2006. Comments from the public will be accepted through August 11, 2006.

COMPREHENSIVE MEDICAID INTEGRITY PLAN

On Tuesday, July 18, 2006, the Centers for Medicare & Medicaid Services (CMS) released the initial Comprehensive Medicaid Integrity Plan. Under the provisions of the Deficit Reduction Act (DRA) of 2005, Congress provided resources to CMS to establish the Medicaid Integrity Program (MIP). MIP represents the first national strategy to detect and prevent Medicaid fraud and abuse in the program's history. Under the leadership of the Center for Medicaid & State Operations (CMSO), the agency will fulfill the mandates of this new program. The Comprehensive Medicaid Integrity Plan will guide CMSO's efforts to fulfill this new obligation. The Comprehensive Plan can be found on the web at <http://www.cms.hhs.gov/DeficitReductionAct/>. **Please see the attached fact sheet for more information.**

CMS ANNOUNCES STEPS TO IMPROVE ACCESS TO CONSUMER-DIRECTED HEALTH PLANS IN MEDICARE

The Centers for Medicare & Medicaid Services (CMS) recently announced new steps to provide beneficiaries across the country with access to coverage through consumer-directed health plans in the Medicare Advantage programs in 2007. In addition to new Medical Savings Account (MSA) coverage, beneficiaries will have access to coverage with additional features similar to health savings accounts (HSAs) through a demonstration program that permits Medicare Advantage organizations to offer more flexible accounts. Until now, the increasingly popular HSA-type plans have not been available to people with Medicare. The increased interest in HSAs among both individuals and employers has generated market interest for vendors.

In an MSA, Medicare pays for a high-deductible health insurance plan, for beneficiaries who enroll, and puts money in an account established for the beneficiary generally at the beginning of the year. This money and any earnings on this money are tax free for the beneficiary as long as he or she uses it to purchase allowable health care. Please see that attached MSA Press Release for more information.

NEW PRODUCTS FROM THE MEDICARE LEARNING NETWORK

The *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other HealthCare Professionals* is now available in CD-Rom and hard copy formats, free of charge, from the Medicare Learning Network (MLN) at <http://www.cms.hhs.gov/mlngeninfo/> on the Centers for Medicare & Medicaid Services, website. Select MLN Product Ordering Page under Related Links Inside CMS to place your order. You may also download this publication by going to <http://www.cms.hhs.gov/mlnproducts/> and selecting MLN Publications on the left side menu.

The *Facilitator's Guide*, which provides facilitators with everything needed to prepare for and conduct a Medicare Program training course and is a companion to the *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*, is now available in downloadable format on the MLN Publications Page located at www.cms.hhs.gov/MLNProducts/MPUB/list.asp on the CMS website.

SOUTHERN HEALTHCARE ADMINISTRATIVE REGIONAL PROCESS PRESENTS FREE TELECONFERENCES!

Please join us in a series of free audio conferences sponsored by the Atlanta and Dallas CMS Regional Offices regarding the "NPI Panel Discussion". See below for more information:

"E-Prescribing Pilot"

1:00 - 2:00 PM ET, Wednesday, August 2, 2006

This presentation will provide an overview and status of the CMS sponsored E-Prescribing pilot.

Presenters: Denise Buening and Andrew Morgan, CMS

"Electronic Health Records – Physician Perspective"

1:00 – 2:00 PM ET, Wednesday, August 16, 2006

Presenter: Dr. Jim Morrow with the North Fulton Family Medicine will discuss choosing an EHR system. He will share his experiences and lessons learned.

"Electronic Health Records – RHIO Perspective"

1:00 – 2:00 pm ET, Wednesday, August 23, 2006

Presenter: Liesa Jenkins, Executive Director of CareSpark, will provide an overview of CareSpark and of its experience in improving the health of people in Northeast TN and Southwest VA through collaborative use of health information.

SPECIAL NOTE: Please call 877-203-0044 fifteen minutes prior to call start time and provide the conference ID number.

August 2, 2006 ID # 2512410

August 16, 2006 ID # 2512447

August 23, 2006 ID # 2512465

Call sponsored by CMS Regions IV and VI

Best regards ~ Valerie

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CEDIIFinal.pdf



Citizenship.pdf



MSA Press Release
fnl.pr7.10.06.pdf

July 28, 2006

CMS asks that you share this information with all of your association members and State and local chapters. Thanks!

NPI: Get It. Share It. Use It.

As the industry transitions to NPI compliance, remember that there is no charge to get an NPI. Providers can apply online for their NPI, free of charge, by visiting <https://nppes.cms.hhs.gov> or by calling 1-800-465-3203 to request a paper application. The CMS NPI page, located at www.cms.hhs.gov/NationalProvIdentStand/, is the only source for official CMS education and information on the NPI initiative; all products located on this site are free of charge.

CMS continues to urge providers to include legacy identifiers on their NPI applications, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State name. If providers have already applied for their NPI, CMS asks them to go back into the NPPES and update their information with their legacy identifiers. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

REMINDER: The National Plan and Provider Enumeration System (NPPES) will be down for scheduled maintenance on August 2nd and 3rd, and will return to operation on August 4th **after** 8:00 a.m., Eastern Time. And finally, please remember...

Getting an NPI is free - not having one can be costly.

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I apologize for the short notice...

On Friday, July 28, 2006, from 1:00 to 2:00 pm ET, the Centers for Medicare & Medicaid Services (CMS) will hold a briefing to discuss the initial Comprehensive Medicaid Integrity Plan, released on July 18, 2006 by CMS.

Under the provisions of the Deficit Reduction Act (DRA) of 2005, Congress provided resources to CMS to establish the Medicaid Integrity Program (MIP). MIP represents the first national strategy to detect and prevent Medicaid fraud and abuse in the program's history. Under the leadership of the Center for Medicaid & State Operations (CMSO), the agency will fulfill the mandates of this new program. The Plan will guide CMSO's efforts to fulfill this new obligation.

Please join Nanette Foster Reilly and CMSO staff on a conference call as they describe the broad responsibilities, guiding principles, and operational functions and strategies of the MIP included in the Plan. Call-in information is found below.

DATE: Friday, July 28, 2006

TIME: 1:00 PM ET

DURATION: 1 Hr.

TOLL FREE #: 1-888-606-9537

PASSCODE: MIP

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I'm sending this item as a separate e-mail because it is an especially long (but important) message on the efforts of a newly-formed National Quality Alliance Steering Committee to better coordinate the promotion of quality measurement, transparency and improvement in care. As you will read, this information should be of interest to a wide array of health care professionals.

HEALTH CARE QUALITY LEADERS JOIN FORCES

AQA and HQA Collaborate to Expedite National Quality Strategy

Two key health care quality alliances, the AQA alliance and the Hospital Quality Alliance (HQA), have formed a new national Quality Alliance Steering Committee to better coordinate the promotion of quality measurement, transparency and improvement in care. Through the joint efforts of the AQA – an alliance of 135 physician organizations, consumers, employers and health plan representatives that makes available quality information about physician care – and the HQA – a coalition of hospitals, nurses, physician organizations, accrediting agencies, government, consumers and business that shares quality information about key aspects of hospital care – Americans will have helpful information on health care available through the Internet.

The new steering committee will work closely with the Centers for Medicare & Medicaid Services (CMS) and Agency for Healthcare Research and Quality (AHRQ), which are key members of both the AQA and HQA.

As a first step, this new steering committee will coordinate and expand several ongoing pilot projects that are designed to combine public and private information to measure and report on performance in a way that is fully transparent and meaningful to all stakeholders.

In March 2006, the AQA alliance announced six pilot projects charged with the responsibility of identifying, collecting and reporting data on the quality of physician performance across care settings. The joint steering committee will explore options for expanding these pilots to include hospital and cost-of-care measures. The committee also will develop a strategy to expand the number of pilots.

The HQA has been providing meaningful and useful information on the quality of heart attack, heart failure and pneumonia care to patients in more than 4,000 of the nation's hospitals since April 2005. In September 2005, the HQA expanded its Web site to include information on prevention of surgical wound infections, and has plans to add many additional aspects of care over the next couple of years.

“This collaborative effort is an important step toward the critical goals of enabling consumers to make more informed health care decisions and supporting improvements in the quality and cost of health care in the United States,” said Dr. Mark McClellan, administrator of the Centers for Medicare & Medicaid Services.

A key responsibility of the steering committee will be to consider how best to expand the scope, speed and adoption of the work of AQA and HQA.

“This new steering committee will help coordinate efforts across a broad spectrum of cross-cutting issues as the two organizations continue working toward a more uniform approach to measuring and reporting hospital and physician performance nationwide,” said Dr. Carolyn Clancy, AHRQ director.

The new joint steering committee comprises physicians, hospitals, consumers, and employers and includes Janet Corrigan, National Quality Forum; Robert Dickler, Association of American Medical Colleges; Karen Ignagni, America’s Health Insurance Plans; Chip Kahn, Federation of American Hospitals; Peter Lee, Pacific Business Group on Health; Debra Ness, National Partnership for Women & Families; Nancy Nielsen, American Medical Association; Margaret O’Kane, National Committee for Quality Assurance; Jeff Rich, Society of Thoracic Surgeons; Gerry Shea, AFL- CIO; John Tooker, American College of Physicians; and Rich Umbdenstock, American Hospital Association.

About the AQA Alliance

The AQA alliance is a broad-based national coalition of more than 135 organizations that seeks to improve health care quality through a process in which key stakeholders agree on a strategy for measuring, reporting, and improving performance at the physician level. These 135 organizations represent physicians, consumers, employers, government, health insurance plans, and accrediting and quality organizations. Visit www.aqaalliance.org for further information.

About the Hospital Quality Alliance

The Hospital Quality Alliance (HQA) is a public-private collaboration to improve the quality of care provided by the nation’s hospitals by measuring and publicly reporting on that care. The goal of the voluntary program is to collect and report data on a robust set of standardized and easy-to-understand hospital quality measures. The hospital quality information is available on the Web at <http://www.hospitalcompare.hhs.gov/>.

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Hi everyone. This should be the last communication from me for this week, but you never know. Here's the list of topics for this e-mail:

- * Medicare Announces Disaster Response Plan for Individuals with Kidney Failure**
- * Proposed Payment Changes for Medicare Home Health Services & Certain Medical Equipment**
- * Medicare Nursing Home Payments to Increase in 2007**
- * CMS Takes Steps to Improve Coverage and Sustainability of Care for Dual-Eligible Beneficiaries**
- * 2007 'Money Follows the Person' (MFP) Grant Announcement**

MEDICARE ANNOUNCES DISASTER RESPONSE PLAN FOR INDIVIDUALS WITH KIDNEY FAILURE

The Centers for Medicare & Medicaid Services (CMS) recently announced that CMS and other Federal Agencies have joined with organizations and healthcare providers in the kidney community to form the Kidney Community Emergency Response Coalition and to develop a nationwide disaster response plan.

“The Kidney Community Emergency Response Coalition is an excellent example of effective collaboration,” said CMS Deputy Administrator Leslie Norwalk. “This is a model of how we can work together to ensure that health care needs of individuals with kidney disease are met, even in a time of a disaster.”

The Coalition will ensure that national resources are in place to assist state and local response efforts in meeting the life saving medical needs of individuals with kidney failure in the event of a disaster.

“Other healthcare provider groups, in preparing for disasters, can learn a great deal from the kidney community, Barry Straube, M.D., CMS Chief Medical Officer and a nephrologist. “This effort will help save lives by making sure critical needs such as supplies, medications and services are available.”

For more information and links to CMS disaster planning activities and resources, please visit <http://www.cms.hhs.gov/Emergency/>. The National Kidney Foundation is host of a clearing house of Coalition activities that can be accessed at www.kidney.org/help.

CMS PROPOSES PAYMENT CHANGES FOR MEDICARE HOME HEALTH SERVICES AND CERTAIN MEDICAL EQUIPMENT

CMS recently announced their proposal for a 3.1 percent increase in Medicare payment rates to home health agencies for calendar year 2007. The increase would bring an estimated extra \$460 million in payments to home health agencies next year.

For further information please see the attached Press Release, which includes links to relevant areas of the CMS Website.



FINALHHDMEReleas
e.pdf (72 KB)

The proposed rule is currently on display and will be published in the *Federal Register* on August 3, 2006. Comments will be accepted until September 25, 2006 and a final rule will be published later in the fall. The rule can be located at <http://www.cms.hhs.gov/HomeHealthPPS/downloads/CMS1304Pdisplay.pdf> and a backgrounder on the DME portion of the rule can be found at <http://www.cms.hhs.gov/HomeHealthPPS/downloads/DMEBackground.pdf>.

CMS ANNOUNCES MEDICARE NURSING HOME PAYMENTS TO INCREASE IN 2007

Medicare payments to nursing homes will increase by approximately \$560 million in 2007, the Centers for Medicare & Medicaid Services (CMS) announced today. The annual update notice of the new payment rates is on display at the offices of the Federal Register.

The 3.1 percent increase will be reflected in Medicare payment rates to nursing facilities that furnish certain skilled nursing and rehabilitation care to Medicare beneficiaries recovering from serious health problems.

Please see the attached Press Release for further information, including links to the SNF section of the CMS Website.



snfpps07ltrhd.pdf
(74 KB)

The SNF PPS update notice is available on the CMS website at <http://www.cms.hhs.gov/providers/snfpps>.

CMS TAKES STEPS TO IMPROVE COVERAGE AND SUSTAINABILITY OF CARE FOR DUAL-ELIGIBLE BENEFICIARIES

To encourage people to make better plans for their future long-term care needs, and to protect the stability of the Medicaid program, CMS recently announced a set of important steps to keep coverage secure and improve care and coverage options for people with Medicare and Medicaid.

These policies include new incentives for people to buy private long-term care insurance, improved rules governing the transfer of assets to prevent inappropriate use of taxpayer funded programs, and improved coordination of care for those with both Medicare and Medicaid coverage, the so-called "dual eligibles" who are in managed care plans.

To view the entire press release, please click here:
<http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1911>

2007 'Money Follows the Person' (MFP) Grant Announcement

CMS recently announced the 'Money Follows the Person' (MFP) Rebalancing Demonstration. Enacted by the Deficit Reduction Act (DRA) of 2005, the MFP Rebalancing Demonstration is a part of a comprehensive, coordinated strategy to assist States, in collaboration with stakeholders, to make widespread changes to their long-term care support systems. With the history and strength of the Real Choice Systems Change grants as a foundation, this initiative will assist States in their efforts to reduce their reliance on institutional care while developing community-based long-term care opportunities, enabling the elderly and people with disabilities to fully participate in their communities. An applicants' informational teleconference is scheduled for August 22, 2006, and proposals are due November 1, 2006.

For further information regarding this program, please click the link below to view the Press Release:

<http://www.hhs.gov/news/press/2006pres/20060726.html>

I hope you enjoy a safe and relaxing weekend ~ Valerie

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