

Provider Partnership Program (PPP) E-mail Notification Archives

April 4, 2006

When CMS designed the registration website for the Physicians Voluntary Reporting Program, it was set up to require a UPIN to begin the process. Unfortunately, this prevented groups from enrolling en masse because group numbers are 5 digit alphanumerics and UPINs are 6 digit. We have modified the website so that now groups can enroll. Your feedback brought this glitch to our attention. Please let us know if there are other ways we can simplify the process.

Thank you for your patience and cooperation.

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

Hello everyone. While this message is specifically targeted to physicians and non-physician practitioners, I'm sending it to all partners to ensure that anyone who is interested receives the information.

CMS recently launched the Physician Voluntary Reporting Program (PVRP) by issuing an invitation to the physician community to participate in the program. The PVRP is being launched to better analyze the quality of care provided to Medicare beneficiaries. The program has been designed to be voluntary for the physician community. If you wish to participate, click here to download the necessary documents:

<http://www.cms.hhs.gov/pvrp/>

The PVRP will be discussed at the next CMS Physicians, Nurses & Allied Health Professionals Open Door Forum, **which is being held today, April 4, 2006.**

There are several documents available to help you understand and participate in the PVRP. These documents can be downloaded at: <http://www.cms.hhs.gov/pvrp/>. The **Dear Doctor letter** outlines the reasons physicians should enroll in the Physicians Voluntary Reporting Program. There are **4 worksheets** for (1) primary care, (2) surgery, (3) nephrology and (4) emergency medicine. Attach the appropriate work sheet to your patient's chart, check the appropriate boxes during the patient encounter and your billing staff can place the corresponding G codes on the Medicare bill. You get to test your billing system's ability to process G codes and you will get a confidential report from CMS that will help you understand how your practice compares to similar practices across the country.

Open Door Forum Participation Instructions can be found at the end of this message.

Please note that several PVRP performance measure CPT codes in CR4183 have been modified as a result of additional input received by CMS from medical specialty societies. In addition, CPT Category II codes are now available for certain measures. The changes are reflected in Change Request 5036. For additional information, view the MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5036.pdf>

Additional information about the program is available at <http://www.cms.hhs.gov/PVRP> on the CMS website. You may want to visit this web page periodically for updates.

Open Door Forum Participation Instructions

Date: April 4, 2006

Start Time: 2:00 PM Eastern Daylight Time (EDT)

Open Door Participation Instructions:

CMS Staff & Authorized Speakers Only

Dial: 1-877-792-5692

General Public

Dial: 1-800-837-1935

Reference Conference ID 5245810

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.

ADDRESS:

Hubert H. Humphrey Bldg.

Conference Room 305A

200 Independence Avenue S.W.

Washington, D.C. 20201

Map & Directions: <http://www.hhs.gov/about/hhhmap.html>

ENCORE: 1-800-642-1687; Conf. ID# 5245810

"Encore" is a recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conf. ID., beginning 2 hours after the call has ended. The recording will be available for 3 business days.

For Forum Schedule updates, Listserv registration and Frequently Asked Questions please visit our website at

www.cms.hhs.gov/opendoor/

Best regards to everyone ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

April 6, 2006

Six rural health fact sheets are now available in downloadable format from the Centers for Medicare & Medicare Services' Medicare Learning Network web page located at www.cms.hhs.gov/MLNProducts on the CMS website. The fact sheets, which will also be available free of charge in print format in approximately six weeks, are titled:

- Rural Referral Center Fact Sheet (new this year)
- Medicare Disproportionate Share Hospital Fact Sheet (new this year)
- Rural Health Clinic Fact Sheet (revised)
- Critical Access Hospital Program Fact Sheet (revised)
- Federally Qualified Health Center Fact Sheet (revised)
- Sole Community Hospital Fact Sheet (revised)

Sorry about that ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

Hello everyone. I just sent you an e-mail with several Medicare Prescription Drug updates and attached documents. One of those documents was a Provider Toolkit to help you ensure that your patients get the medicines they need. Attached below is an updated version of that attachment that should replace what I previously sent you. In addition, I have also included information on:

*** Increased payment rates for Medicare Advantage plans in 2007**

- * **Site selection for demonstration projects to improve the early detection & treatment of cancer**
- * **Non-availability of Standard Paper Remittance Advice for some providers**
- * **Newly Updated! "Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers"**
- * **Availability of the Medicare Part B Drugs Average Sales Price pricing files**

Hope you are all doing well!



transitional toolkit.pdf (1 MB...

MEDICARE ADVANTAGE PLANS PROVIDE LOWER COSTS AND SUBSTANTIAL SAVINGS

CMS announces increased payment rates for Medicare Advantage plans in 2007

Primarily because of better health care coordination, Medicare Advantage plans across the country are lowering overall costs and providing substantial savings for beneficiaries. The benefits from the plans include the use of proven approaches to keep beneficiaries healthy and avoid complications from chronic diseases.

The CMS Press Release can be found at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1825>

Also attached, is the fact sheet 2007 payment rates for Medicare Advantage Plans.



MA Rate payment fact sheet fin...

CMS SELECTS SITES FOR DEMONSTRATION SEEKING WAYS TO REDUCE DISPARITIES IN CANCER HEALTH CARE

The Centers for Medicare & Medicaid Services (CMS) recently announced the selection of sites for six demonstration projects to improve the early detection and treatment of cancer and reduce health disparities among minority Medicare beneficiaries.

This press release is located at the following CMS website: <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1816>

Medicare to Stop Mailing Standard Paper Remittance (SPR) for Those Providers/Suppliers Also Receiving the Electronic Remittance Advice (ERA)

Beginning June 1, 2006, the Standard Paper Remittance Advice (SPR) received through the mail will no longer be available to providers/suppliers who also receive an Electronic Remittance Advice (ERA), whether the ERA is received directly or through a billing agent, clearinghouse, or other entity representing a provider/supplier. In response to the provider/supplier communities continued need for SPRs, CMS has developed free software call Medicare Remit Easy Print (MREP) that gives providers/suppliers a tool to read and print a remittance advice (RA) from the HIPAA compliant Health Care Claim Payment/Advice (835) file. The MREP software was designed to incorporate new functionality to save providers/suppliers time and money. The paper output generated by MREP is similar to the SPR format. The CMS has worked with other payers to insure their acceptance of the SPR generated by the MREP software for Coordination of Benefit claim submission. Additionally, CMS has worked with clearinghouses to assure similar software is available to read and print an ERA for those providers/suppliers that utilize clearinghouse services.

CMS encourages providers/suppliers currently receiving the ERA, who don't use software to read and print RAs from these files, to begin using MREP or other similar software before the June 1st cutoff. Please go to your Medicare carrier or DMERC's website for further information regarding MREP software. We appreciate your continued cooperation as the Medicare program moves toward a more electronic environment.

For more information, click on the Medicare Learning Network (MLN) Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4376.pdf>.

"Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers" has been updated and is now available online through the Medicare Learning Network's publication page located at, www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf, on the CMS website. This comprehensive publication provides practical information on the types, uses, components of and standardized codes sets used on the RA as well as how to read the Standard Paper Remittance Advice and the Electronic Remittance Advice using PC-Print software (for institutional providers who receive RAs from Fiscal Intermediaries or Regional Home Health Intermediaries) and Medicare Remit Easy Print software (for professional providers who receive RAs from Carriers or DMERCs). It also includes a number of helpful resources including field indexes (for institutional RAs and professional RAs), an acronym list, and a glossary. In addition to the online version of "The RA Guide", it will also be available in print and on CD ROM later this Spring. CMS will announce the availability of these products as they become available.

The **Medicare Part B Drugs Average Sales Price pricing files** for April 1, 2006 to June 30, 2006 have been posted to the CMS website at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp. Revisions to prior pricing files for 2005 and January 2006 have also been posted. Use the links in the left hand margin to select the specific year. The files are located in the "Downloads" section of the web pages.

Best regards ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

April 7, 2006

The CMS Electronic Mailing Lists (listservs) can help you with your business! I know that many of you already subscribe to at least one CMS mailing list; however, did you know that there are a multitude of other listservs that can give you up-to-the-minute, accurate news regarding other CMS activities? We have prepared a Fact Sheet that describes the many listserv choices available, the advantages of receiving updates electronically, and how to subscribe. The Fact Sheet is attached or you can download it at www.cms.hhs.gov/MLNProducts/downloads/maillinglists_factsheet.pdf.

I encourage you to share this information with your membership, post it on your website, and place it in any of your publications.

Thanks again for all of your help and I hope you all have a great weekend!

Best regards ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330



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April 13, 2006

While the attached four messages are primarily of interest to our hospital partners, I thought I'd send them to everyone just in case...

CMS PROPOSES PAYMENT AND POLICY CHANGES FOR ACUTE CARE HOSPITAL SERVICES TO INPATIENTS

The Centers for Medicare & Medicaid Services (CMS) issued a notice of proposed rulemaking on April 12, 2006 that would begin the transition to the first significant revision of the Inpatient Prospective Payment System (IPPS) since its implementation in 1983. When fully implemented, which is planned to occur by fiscal year (FY) 2008 and potentially earlier, the revised IPPS would improve the accuracy of payment rates for inpatient stays by basing the weights assigned to Diagnosis Related Groups (DRGs) on hospital costs rather than charges, and adjusting the DRGs for patient severity.

The estimated market basket increase of 3.4 percent in FY 2007 would increase payments to acute care hospitals by \$3.3 billion. Over 1000 hospitals in rural areas would see an average increase of 6.7 percent.

“The hospital payment reforms we are proposing today will mean payments for hospital inpatient services will more accurately reflect the costs of providing the services,” said CMS Administrator Mark B. McClellan, M.D., Ph.D. “We are taking important steps to make payments fairer to hospitals and to assure beneficiary access to services in the most appropriate setting.”

“This proposed rule will be shaped by the public comment process,” Dr. McClellan added. “We look forward to comprehensive feedback from hospitals, suppliers, and other stakeholders that will help to refine and improve the final version of the rule.”

The proposed changes reflect recommendations from the Medicare Payment Advisory Commission (MedPAC), and respond to some Congressional concerns that the existing system may create incentives for certain hospitals to “cherry-pick” more profitable cases. The reforms will significantly affect payments to specialty hospitals – hospitals that typically are owned, in whole or in significant part, by physicians who serve as referral sources. The growth in specialty hospitals has been slowed temporarily by statute or regulation since the Medicare Modernization Act was signed in December 2003.

CMS is considering a two-step process of transformation. The first step, set out in the proposed rule, would assign weights to DRGs based on hospital costs, rather than hospital charges. This would eliminate biases in the current DRG system arising from the differential markup hospitals assign for ancillary services among the DRGs. The new DRG weights would go into effect October 1, 2006.

A second step, currently scheduled for FY 2008, would replace the current 526 DRGs with either the proposed 861 consolidated severity-adjusted DRGs or an alternative severity adjusted DRG system developed in response to the public comments CMS is soliciting on this issue. CMS is also considering ways of improving recognition of severity in the current DRG system by FY 2007. When the two steps are fully implemented, hospitals can expect more accurate payment for their services.

CMS is proposing to increase the outlier threshold for FY 2007 to \$25,530, up from \$23,600 in 2006. This proposed increase is based on data suggesting a consistent pattern of inflation in hospital charges which affect hospital cost-to-charge ratios used in determining eligibility for outlier payment. The proposed FY 2007 threshold is expected to keep aggregate hospital outlier payments within the target of 5.1 percent of total payments under the IPPS.

In addition to accurate payment for existing technologies, CMS is committed to ensuring that Medicare beneficiaries have rapid access to new technologies by providing for temporary add-on payments for appropriate technologies. In order to be eligible for additional reimbursement, a product must be:

1. New – that is, less than two to three years old;
2. Expensive – that is, it must meet a defined cost threshold in relation to the underlying DRG; and
3. A substantial clinical improvement for the Medicare patient population.

CMS has received three applications for new technology add-on payments in FY 2007. CMS is soliciting comments on whether these technologies meet the criteria for the temporary add-on payments. CMS is also proposing to continue new technology payments for two of the three technologies that were approved for payment in FY 2006.

The proposed rule was published in the April 25, 2006 *Federal Register*. Comments will be accepted until June 12, 2006, and a final rule will be published later this year.

The display copy can be viewed at

<http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/cms1488p.pdf>.

For general Hospital information, go to the Hospital Center page at

<http://www.cms.hhs.gov/center/hospital.asp>.

Additional information on the proposed regulations can be obtained from the attached Fact Sheet.



General Fact Sheet-FY2007 IPPS..

Availability of Expanded Modified MedPAR Data

CMS makes available for purchase the Expanded Modified MedPAR data that were used in simulating the policies in the Inpatient Prospective Payment System (IPPS) proposed rule. If readers have already ordered the proposed rule data, we are in the process of filling the orders and will be providing the FY 2005 MedPAR data that were used to model the proposed changes to the DRGs and relative weights for FY 2007 as well as the FY 2004 MedPAR data that we used to model the consolidated severity adjusted DRGs that we are proposing to implement in FY 2008 (if not earlier). If readers have not ordered the proposed rule MedPAR data but are interested in receiving them, we encourage them to order the data as soon as possible by following the directions provided below. We will process orders in the order they are received.

For information on how to order the Expanded Modified MedPAR, go to the following Web site:

<http://www.cms.hhs.gov/LimitedDataSets/> and click on "MedPAR Limited Data Set (LDS) - Hospital (National)." This Web page will describe the file and provide directions to further detailed instructions for how to order. Persons placing orders must send the following: Letter of Request, LDS Data Use Agreement and Research Protocol (see Web site for further instructions), LDS Form, and a check for \$3,655 to:

Centers for Medicare & Medicaid Services,
Public Use Files,
Accounting Division,
P.O. Box 7520,
Baltimore, MD 21207-0520.

CMS IMPROVES PAYMENT FOR TRAINING MEDICAL RESIDENTS IN PROGRAMS AFFECTED BY NATURAL DISASTERS

The Centers for Medicare & Medicaid Services (CMS) recently issued an interim final rule with comment period that provides for continued Medicare financing of medical residents in training programs affected by natural disasters or public health emergencies, promoting the continuity of training in affected hospitals and programs. The interim final rule will apply retroactively to arrangements between home hospitals in the areas affected by Hurricanes Katrina and Rita that temporarily closed parts of their residency programs and the host hospitals that accepted the displaced residents as well as to future disasters.

To view the entire press release, go to:

<http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1829>

To view the display version of the interim final rule with comment, go to:

<http://www.cms.hhs.gov/AcuteInpatientPPS/Downloads/CMS-1531-IFC.pdf>.

For additional information, go to: <http://www.cms.hhs.gov/AcuteInpatientPPS/>

Proposed Rule: Notification Procedures for Hospital Discharges

On April 5, 2006 the Centers for Medicare & Medicaid Services (CMS) published a notice of proposed rulemaking (NPRM), CMS-4105-P, Notification Procedures for Hospital Discharges. This rule proposes to revise the discharge notice requirements in the inpatient hospital setting by establishing a simple, standardized notice for all hospital discharges, both for Original Medicare and Medicare Advantage (MA) patients. A more detailed notice would be required only in situations where a patient wishes to dispute the hospital's discharge decision and contacts the Quality Improvement Organization (QIO) to initiate an appeal.

This proposed process largely parallels the process applicable to other Medicare providers, such as home health agencies (HHAs) and skilled nursing facilities (SNFs) in both Original Medicare and Medicare Advantage. These proposed regulations stem from the settlement agreement associated with the Weichardt vs. Leavitt lawsuit. CMS welcomes comments and suggestions related to the proposed process and all aspects of the hospital discharge notice process.

The proposed regulation, CMS-4105-P can be viewed at <http://www.gpoaccess.gov/fr/index.html>, search on “page 17052”. There is a 60-day comment period. Comments should be submitted according to the instructions in the regulation.

The announcement regarding the proposed notices (CMS10066) associated with this regulation was also published on April 5 and can be found at <http://www.gpoaccess.gov/fr/index.html>, search on “page 17104”, under the heading “Agency information collection activities; proposals, submissions and approvals.”

The notices and associated Paperwork Reduction Act documents can be found on CMS' Web site at <http://www.cms.hhs.gov/PaperworkReductionActof1995/>, click on “PRA listing” on the left side of the page and search for “10066”. Comments on these notices should be submitted according to the instructions in the Federal Register Notice.

To be assured consideration, comments and recommendations for the proposed regulation and notices must be received no later than 5 p.m. on June 5, 2006.

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

April 14, 2006

NPI Tip

When applying for your NPI, CMS urges you to include your legacy identifiers, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State name. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

Revised EFI Materials

The EFI Summary, User Manual and Technical Companion Guide have all been revised. Please visit http://www.cms.hhs.gov/NationalProvIdentStand/07_efi.asp to view and download these revised materials.

Encore Presentation of WEDI's NPI 101 Audiocast

This presentation is scheduled for Thursday, April 27th. Please visit http://www.wedi.org/npioi/public/articles/dis_viewArticle.cfm?ID=476 for more information including scheduled times.

Hope everyone has a wonderful weekend!

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

April 19, 2006

Developed by America's Health Insurance Plans (AHIP) and the American Medical Association (AMA), the Exceptions Request Form is a standardized form that can be used by physicians to request an exception, and coverage, for non-formulary drugs. Many health insurance plans are expected to begin incorporating this new form immediately.

The Exceptions Request Form is available at http://www.cms.hhs.gov/MLNProducts/Downloads/Form_Exceptions_final.pdf on the CMS website.

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

April 20, 2006

This is a reminder that the Medicare Learning Network has changed the name of its very popular Medicare fee-for-service provider education articles. See <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0620.pdf> for all of the details!

The Medicare Learning Network is pleased to announce the availability of two new provider education products--

The electronic version of the *Evaluation & Management Services Guide*, which provides evaluation and management services information regarding medical record documentation; International Classification of Diseases, 9th Revision, Clinical Modification and American Medical Association Current Procedural Terminology Codes; and key elements of service is now available from the Medicare Learning Network at http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf on the CMS website.

New for vascular access surgeons, interventional radiologists/nephrologists, nephrologists, physicians, and hospital health care professionals! The training module titled "Creating AV Fistulas in All Eligible Hemodialysis Patients" is now available, **free of charge**, from the Medicare Learning Network located at www.cms.hhs.gov/MLNGenInfo on the CMS website. Scroll down and select "MLN Product Ordering Page" to request the training module.

Best regards ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

April 24, 2006

Medicare's New Competitive Acquisition Program (CAP) for Outpatient Drugs and Biologicals

The Centers for Medicare & Medicaid Services (CMS) has made a vendor selection announcement for the initial phase of the new Competitive Acquisition Program (CAP) for certain Part B drugs and biologicals that begins on July 1, 2006. The CAP is a voluntary program that offers physicians an option to acquire many drugs they use in their practice from an approved CAP vendor, who will then bill Medicare for the cost of the drug and collect the coinsurance from the beneficiary. Physicians who choose to participate in the program will continue to be paid for the costs of administering the drugs. Please visit http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp to learn more about the approved CAP vendor, physician election to the CAP, and other information on the CAP program. I have also attached the related Press Release.



PR09.CAPVendors.
04.21.06.pdf (...)

Valerie A. Hart, Director
Division of Provider Information

Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

April 25, 2006

Happy Tuesday everyone! Four items are included in this message--

- 1. Exciting information on the new Medicare Remit Easy Print software;*
- 2. Availability of the hospital-specific cost relative weights for the consolidated severity adjusted DRGs discussed in the FY 2007 Hospital IPPS proposed rule;*
- 3. Acute Inpatient Hospital PPS Occupational Mix Survey; and*
- 4. Notice of Proposed Rulemaking for the Durable Medical Equipment Competitive Acquisition Program*

Enjoy!

Are you receiving an Electronic Remittance Advice (ERA)? Have you tried Medicare Remit Easy Print (MREP) software?

As of June 1, 2006, if you have been receiving **both** an Electronic Remittance Advice (ERA), either directly from your Medicare carrier/DMERC or indirectly from a clearinghouse, billing agent, or other entity representing you, **and** a Standard Paper Remittance (SPR) from your carrier/DMERC for 45 days or more, **you will no longer be mailed an SPR** by your carrier/DMERC, in accordance with Change Request (CR) 4376. Check out Special Edition MLN Matters article SE0627 which outlines some of the options available to providers who will no longer receive the SPR directly from their carrier/DMERC. The article is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0627.pdf> on the CMS website.

In the **FY 2007 Hospital Inpatient Prospective Payment System (IPPS)** proposed rule, CMS proposed to adopt hospital-specific cost weights for FY 2007 and consolidated severity DRGs for FY 2008 (or earlier). The proposed rule provides the hospital-specific cost weights being proposed for FY 2007 for the current DRG system. CMS recently posted the hospital-specific cost relative weights for the consolidated severity adjusted

DRGs discussed in the FY 2007 IPPS NPRM. The file can be accessed from the list on the following web page: <http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp> .

On April 3, 2006, in Bellevue Hosp. Ctr v. Leavitt, the Court of Appeals for the Second Circuit ("the Court") ordered the Centers for Medicare & Medicaid Services (CMS) to apply the **occupational mix adjustment** to 100 percent of the wage index effective for Federal fiscal year (FY) 2007. The Court required CMS to "immediately ... collect data that are sufficiently robust to permit full application of the occupational mix adjustment." The Court also required that all "data collection and measurement and any other preparations necessary for full application should be complete by September 30, 2006, at which time we instruct the agency to immediately apply the adjustment in full." 2006 WL 851934 at *13.

For more details regarding the Occupational Mix Survey, visit the website at <http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=ascending&itemID=CMS062033>

The **Durable Medical Equipment Competitive Acquisition Program** Notice of Proposed Rulemaking (CMS-1270-P) is now on display at the Office of the Federal Register. The NPRM is expected to be published on May 1, 2006. The rule is available on the CMS website at http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/cms1270p_dme.pdf

The Press Release is posted at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1841>

We expect the next Program Advisory and Oversight Committee (PAOC) meeting to be scheduled sometime in mid to late May. Additional information regarding the next PAOC meeting will be posted on the DME Competitive Bidding website in the near future: http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/03_paoc.asp#TopOfPage

Best regards ~ Valerie

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

April 26, 2006

Reminder

The Centers for Medicare & Medicaid Services is sponsoring an audio training conference call **this afternoon, April 26, 2006, from 2:30 to 3:30 pm EDT.**

Today's topic is **“Countdown to May 15...Enrolling in Medicare Prescription Drug Coverage”**

This presentation will cover operational issues and questions related to the rapidly approaching May 15 enrollment deadline and will include:

- Information on how the Centers for Medicare & Medicaid Services is preparing for the final few weeks of enrollment in Medicare Prescription Drug Plans
- Description of enrollment periods and how each type works and the process for disenrolling from a plan
- Opportunity to ask questions of subject matter experts

Call-In Procedures

Dial: 1-800-374-1332 (please call in 15 minutes before session begins)

Enter pass code: # 251065

The PowerPoint Presentation is available for download at:

http://www.cms.hhs.gov/NationalMedicareYouTrain/09_MedicareRxConferenceCalls.asp

Download [4a]

*Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330*

April 28, 2006

The Centers for Medicare & Medicaid Services (CMS) issued guidance to the Medicare prescription drug plans on mid-year formulary change requests. The attached formulary policy applies to formulary changes that affect beneficiary access to drugs.

All proposed formulary changes, excluding formulary expansion changes, must be submitted to CMS for review and approval. The formulary change policy addresses changes in specific drugs covered on the formulary, changes in prior authorization or tiering. Beneficiaries will not lose coverage for their drugs because of a mid-year formulary change except for clear scientific evidence, cost reasons related to a new generic drug coming on the market, or new FDA or clinical information becomes available.

CMS recognizes the importance of formulary stability for the Medicare population. However, prescription drug use is constantly evolving, and new drug availability, new medical knowledge,

and new opportunities for improving safety and quality at low cost will inevitably occur over the course of a year requiring changes to the formulary. CMS will continue to ensure that each formulary provides a broad range of medically appropriate drugs and does not discriminate or substantially discourage enrollment of certain groups of beneficiaries.



formulary guidance
hpms.pdf (7...

Today, the Centers for Medicare & Medicaid Services (CMS) is posting additional plan level enrollment information to the Medicare Drug Coverage Enrollment Data web page. The web page includes the following information:

- **National Enrollment Data:** There are two separate tables for Medicare Prescription Drug Plans (PDPs) and Medicare Advantage Plans that includes Medicare prescription drug coverage (MA-PDs), listed in order of the number of people enrolled in each plan's parent organization. These tables also indicate "national" plans that are available in every state, and the name(s) used to market the plan.
- **Local Enrollment Data (by state and county):** There are also two separate tables for PDPs and MA-PDs that lists specific drug plans offered in each area and the number of people enrolled in each. The PDPs are listed by state under the name used to market the plan in that state, and the MA Plans that include MA-PDs are listed by county under the name used to market the plan in that county.

The following files will be posted at the following website:

http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp



PDPs by Total
Enrollment in Pa...



MA-PDs by Total
Enrollment in ...



PDPs by Total
Enrollment by St...



MA-PDs by Total
Enrollment by ...

Please note: All enrollment counts have been rounded to the nearest hundred, and data for any organization that represents less than one percent of the total is not shown. Additionally, Employer-sponsored PDPs were excluded from all PDP tables. Review the "Notes" section of each data set carefully to fully understand the limitations of each data set. Also, some of these tables above are fairly long when you print them.

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

NPI Tip

When applying for your NPI, CMS urges you to include your legacy identifiers, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State name. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI

CMS has released three new educational products on the National Provider Identifier (NPI):

- **"Guidance for Organization Health Care Providers Who Apply for National Provider Identifiers (NPIs) for Their Health Care Provider Employees" Tip Sheet** - contains helpful information for organization health care providers who wish to apply for NPIs, or submit updates using the NPPES web-based process, on behalf of their employed health care providers. This is NOT the EFI process.
- **"Tips for Health Care Professionals - Preparing Your Office Staff for NPI" Tip Sheet** - provides basic steps to prepare your office staff, and your business, for NPI implementation.
- **"NPI Overview" PowerPoint Presentation** - this presentation was presented by a CMS staff member at a recent WEDI meeting and contains basic information on the NPI that is suitable for self education, as well as training purposes.

Visit the Educational Resources page on CMS' NPI website at http://www.cms.hhs.gov/NationalProvIdentStand/04_education.asp to view these new products.

Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330

CMS is embarking on the next major step in acquisition activities for the Part A/Part B Medicare Administrative Contractors (MACs), the future contractors that will replace the current fiscal intermediaries and carriers and handle administration of both the Part A and Part B programs in specified geographic regions.

Section 911 of the Medicare Modernization Act of 2003 mandates that the Secretary for Health & Human Services replace the current contractors administering the Medicare Part A or Part B fee-for-service programs (fiscal intermediaries and carriers) with new MACs. CMS will compete and award contracts for 15 A/B MACs servicing the majority of all types of providers.

We are drawing near to the planned announcement of the award of the first A/B MAC contract, i.e., the contract for Jurisdiction 3, encompassing Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming. CMS is planning to make the announcement in late June and complete cutover of work to the new MAC in July 2007.

CMS staff also are working on the Scope of Work and other information that will be part of the Requests for Proposal to be used in the acquisitions for our next group of MAC contractors. We refer to this next group of the MAC acquisitions as Cycle One.

Cycle One will involve separate competitions for 7 MAC jurisdictions, accounting for approximately 45 percent of the Part A/Part B fee-for-service claims workload. CMS will conduct these 7 competitions in two rounds, using slightly different Statements of Work (SOWs) in each of the 2 rounds of competitions.

The first round of competitions under Cycle One will cover 3 jurisdictions:

- J4 (Colorado, Oklahoma, New Mexico, and Texas)
- J5 (Iowa, Kansas, Missouri, and Nebraska) and
- J12 (Delaware, Maryland, New Jersey, and Pennsylvania)

On May 3, 2006, a Request for Information (RFI) that includes the draft SOW planned for use in the first round of Cycle One will be published on the Federal Business Opportunities website (www.FedBizOpps.gov). CMS would like to get reactions and concerns about this draft SOW from our providers, contractors, and other partners and therefore encourages everyone to review the RFI and provide comments or questions. You will find guidance on how/where to submit comments and questions about the RFI on that same FedBizOpps site.

To learn more about the Medicare Contracting Reform authority mandated by section 911 of the MMA and the transition to the A/B MAC contracting environment, please visit the Medicare Contracting Reform website at:
<http://www.cms.hhs.gov/MedicareContractingReform/>.

*Valerie A. Hart, Director
Division of Provider Information
Planning & Development
Provider Communications Group, CMS
7500 Security Boulevard
Mailstop C4-11-27
Baltimore, MD 21244
E-mail: Valerie.Hart@cms.hhs.gov
Phone: (410) 786-6690
FAX: (410) 786-0330*