Provider Partnership Program (PPP) E-mail Notification Archives

January 2, 2008

Special ODF on Minimum Data Set, Version 3.0 (MDS 3.0)

This message contains updated information--please disregard all previous versions including the one contained in the e-mail I sent you on Friday, December 28, 2007.

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Special Open Door Forum:
Minimum Data Set, Version 3.0 (MDS 3.0)
Thursday, January 24, 2008
1:00 pm to 3:00 pm EST
CMS Auditorium

This Minimum Data Set, Version 3.0 (MDS 3.0) Special Open Door Forum (ODF) is scheduled to report on the findings of a 5-year CMS Nursing Home MDS 3.0 Validation Study. CMS will post the MDS 3.0 timeline for implementation on the "MDS 3.0 for Nursing Homes" page of its Nursing Home Quality Initiative website on December 31, 2007 at:
http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage
http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage on the CMS website.

The updated Draft version of the MDS 3.0 form and written introduction is delayed and will be posted before the ODF. The MDS has not had extensive clinical updating since 1995. The changes in MDS 3.0 have been designed to improve data assessment, care planning, and quality measurement. Changes were based on extensive written and oral provider feedback, a Town Hall meeting, CMS/Veterans Administration Research Collaborative, technical expert review and data collection in 8-States. CMS now plans to evaluate the impact of the MDS 3.0 changes on the resident classification system, Resource Utilization Group (RUG-III), used in the Medicare payment structure. This analysis will be conducted as part of the Staff Time and Resource Intensity Verification (STRIVE) study and the results will be available in late 2008/early 2009. Then, the MDS 3.0 changes can be finalized and implemented nationally on October 1, 2009.

We look forward to your participation.

To participate (onsite or by telephone) in this Special ODF, please register on the CMS website at http://registration.intercall.com/go/cms2 on the internet. Upon registering, you will receive a confirmation email containing further participation information. The

deadline for registration is **2:00 PM EST, January 22, 2008**. Capacity is limited so register early. Registering via the web will ensure we can accommodate as many participants as possible.

An audio recording of this Special Forum will be posted to the Special ODF website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp on the CMS website and will be accessible for downloading beginning January 30, 2008 and available for 30 days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at: http://www.cms.hhs.gov/OpenDoorForums/ on the CMS website

Thank you for your interest in CMS Open Door Forums.

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Visit the Medicare Learning Network ~ it's free!

Special ODF on the Competitive Acquisition Program

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum (ODF) on the Competitive Acquisition Program (CAP). The CAP is an alternative to the Average Sales Price (ASP) "buy and bill" method for acquiring certain Medicare Part B drugs and biologicals. CMS anticipates releasing a solicitation for contracts to be awarded to vendors to supply drugs for the CAP. These vendor contracts would be effective January 1, 2009 to December 31, 2011. CMS anticipates that the vendor bidding period will begin on January 14, 2008 and end on February 15, 2008.

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Visit the [Medicare Learning Network](#) ~ it's free!

January 4, 2008

Your Friday Reading Materials

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

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Happy Friday and Happy New Year everyone! I have several items for you this afternoon, including information on:

- **Physician Quality Reporting Initiative (PQRI) Updates**
- **Medicare Competitive Acquisition Program (CAP) for Physicians Updates**
- **Glaucoma Awareness Month**
- **Notice for Competitive 9th SOW QIO Contracts**
- **Medicare Health & Prescription Drug Plan Update**
- **The Latest Edition of *News from ORDI***
- **January Flu Shot Reminder**

* *

Physician Quality Reporting Initiative (PQRI) Updates

Eligible professionals should begin submitting appropriate 2008 Quality Data Codes on qualifying Part B claims with a date of service of January 1, 2008. Information on the 119 2008 Physician Quality Reporting Initiative (PQRI) measures, release notes, and detailed specifications are available on http://www.cms.hhs.gov/pqri/ on the CMS website. Eligible professionals are encouraged to contact their professional associations for additional information and tools that will facilitate participation.

The American Medical Association (AMA) has posted PQRI worksheets for the 2008 PQRI program on the AMA website at http://www.ama-assn.org/ on the Internet. These worksheets will also be available in the CMS 2008 PQRI Toolkit which will be announced and posted soon on http://www.cms.hhs.gov/pqri/ on the CMS website.

PQRI Question of the Week:

Q: What is the bonus available for eligible professionals who successfully participate in 2008 PQRI?

A: Incentive payments for successful participation in 2008 PQRI will be paid from the Medicare Part B Trust Fund- same as for 2007. Eligible professionals may earn a bonus payment of 1.5% of total allowed charges for covered services payable under the Medicare Physician Fee Schedule.

* *

Medicare Competitive Acquisition Program (CAP) for Physicians Updates

An additional election period for the 2008 Medicare Part B Drug Competitive Acquisition Program (CAP) will begin on **January 15, 2008** and will conclude on **February 15, 2008**. The CAP is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practice from an Approved CAP Vendor, thus reducing the time they spend buying and billing for drugs.

This additional election period is for physicians who have not already elected to participate in the CAP for 2008. Effective dates of participation for physicians who elect to join the CAP during this additional election period will be April 1, 2008 to December 31, 2008.

Once a physician has elected to participate in CAP, they must obtain all drugs on the CAP drug list from the CAP drug vendor. Physicians can still continue to purchase and bill Medicare under the Average Sale Price (ASP) system for those drugs that are not provided by the physician's CAP vendor.

Additional information about the CAP is available at the following website:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp

The physician election form can be found at the following webpage in the Downloads section. Additional information for physicians can also be found at this site:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp

The list of drugs supplied by the CAP vendor, including NDCs, is in the Downloads section at:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp

Please note that completed and signed physician election forms should be returned by mail to your local carrier. Forms must be postmarked on or before February 15, 2008. DO NOT return forms to CMS offices.

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Special Open Door Forum:
Medicare Part B Competitive Acquisition Program (CAP) for the Approved CAP Vendor Bidding Period

January 10, 2008
2 pm - 3:30 pm Eastern Standard Time

Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum (ODF) for the Competitive Acquisition Program (CAP). The CAP is an alternative to the Average Sales Price (ASP) "buy and bill" method for acquiring certain Medicare Part B drugs and biologicals. CMS anticipates releasing a solicitation for contracts to be awarded to vendors to supply drugs for the CAP. These vendor contracts would be effective January 1, 2009 to December 31, 2011. CMS anticipates that the vendor bidding period will begin on January 14, 2008 and end on February 15, 2008.

The participating audience for this Special ODF is limited to entities that are interested in bidding to be an approved CAP vendor. Representatives from CMS and the CAP designated carrier will present information and be available to answer questions about the CAP and the bidding process. We look forward to your participation.

Special Open Door participation instructions:

If you are interested in registering for this Special Open Door Forum, please register on the CMS website at http://registration.intercall.com/go/cms2 . Upon registering, you will receive a confirmation email containing further participation information. The deadline for registration is 5:00 PM EST, January 9, 2008. Capacity is limited so register early. Registering via the web will ensure we can accommodate as many participants as possible.

An audio recording of this special forum will be posted to the Special Open Door Forum website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning January 16, 2008.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at: http://www.cms.hhs.gov/OpenDoorForums/

Thank you for your interest in CMS Open Door Forums.

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January is National Glaucoma Awareness Month!

Approximately 3 million Americans have glaucoma. Because the disease often progresses silently in the initial stages, with no symptoms, it is estimated that up to half of the approximately 3 million Americans with the disease don't know they have it. Vision loss from glaucoma is permanent and irreversible. While anyone can get glaucoma, certain groups of people are at higher risk for the disease. Glaucoma is more likely to occur in African Americans than in Caucasians and is a leading cause of blindness among African American and Hispanic populations in the United States. People

with diabetes are nearly twice as likely to develop glaucoma as adults without diabetes. And people with a family history of glaucoma are more likely to get glaucoma too. Although glaucoma cannot be cured, early detection and treatment usually can stop further damage and prevent blindness. The benefit provided by Medicare offers a comprehensive glaucoma screening for seniors and others with Medicare at high risk for the disease.

Medicare Coverage
Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high risk groups:

- Individuals with diabetes mellitus;
- Individuals with a family history of glaucoma;
- African-Americans age 50 and older; and
- Hispanic-Americans age 65 and older.

A covered glaucoma screening includes:

- A dilated eye examination with an intraocular pressure (IOP) measurement; and
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

What Can You Do?
CMS needs your help to ensure that all *eligible* people with Medicare take full advantage of the annual glaucoma screening benefit. Your high risk Medicare patients may not remember to schedule their annual glaucoma screening exam. You can help remind them by talking with them about glaucoma and their risk for the disease, what can happen when glaucoma goes undetected/untreated, and how they can help protect themselves from severe consequences with early detection by getting an annual glaucoma screening exam. Your reminder and referral for a glaucoma screening exam can help provide high risk Medicare beneficiaries with peace of mind and safeguard their vision.

For More Information
- CMS has developed a variety of educational products and resources to help health care professionals and their staff learn more about coverage, coding, billing, and reimbursement for preventive services and screenings 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.
    - Glaucoma Screening Brochure ~ This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of glaucoma screening services. To view online go to *http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma.pdf* on the CMS website. To order copies of the brochure, go to the Medicare Learning Network

Product Ordering System located at:
http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5

  - The CMS website provides information for preventive service covered by Medicare. Go to *http://www.cms.hhs.gov*, select "Medicare", and scroll down to the "Prevention" section.

- For information to share with your Medicare patients, visit *http://www.medicare.gov*

- For more information about glaucoma, visit The National Eye Institute *http://www.nei.nih.gov/index.asp*
- For more information about National Glaucoma Awareness Month, please visit *http://www.preventblindness.org/*

Thank you for helping CMS protect the vision of Medicare beneficiaries who are at higher risk for glaucoma by spreading the word about glaucoma, early detection, and the glaucoma screening benefit covered by Medicare.

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Notice for Competitive 9th SOW QIO Contracts
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Date: January 4, 2008

The Centers for Medicare & Medicaid Services (CMS) plans to issue a Request for Proposal (RFP) for competitions resulting in awards of separate contracts for Quality Improvement Organizations (QIOs) for the states of Alaska, California, Minnesota, Mississippi, North Carolina, Nevada, New York, Oklahoma, and South Carolina. In order to be eligible to receive a QIO contract, an Offeror must be deemed a responsible entity in accordance with Federal Acquisition Regulation (FAR) Part 9.1 and must meet the definition of a utilization and quality control peer review organization as set forth in Section 1152 of the Social Security Act. Please refer to the following link for additional information:

> **Special Open Door Forum** ***"How to Participate in the Quality Improvement Organization Program's 9th Statement of Work."***
> ***http://www.cms.hhs.gov/OpenDoorForums/Downloads/112907SpecialOpen%20DoorForum.pdf***

The RFP for the 9th Statement of Work is anticipated to be released on the Federal Business Opportunities website on **January 18, 2008**. As a follow-up to the preceding Open Door Forum, CMS will host a "*Pre-Proposal Conference*" on **January 28, 2008** from **9:00 AM – 5:00 PM** in Baltimore, MD. Interested offerors must register for the conference at:

http://www.fbo.gov/spg/HHS/HCFA/AGG/CMS%2D2007%2DQIO9thSOW%2DNAHC/listing.html.

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MEDICARE HEALTH AND PRESCRIPTION DRUG PLAN ENROLLEES EXPECTED TO EXPERIENCE SMOOTH TRANSITION TO 2008

Medicare beneficiaries who have chosen to change their health and drug coverage for 2008 should experience very few difficulties when getting their covered prescription drugs through Medicare Part D, the Centers for Medicare & Medicaid Services (CMS) announced today.

"A top priority throughout the fall open enrollment season has been to help beneficiaries prepare and compare their plan choices so that they could make informed decisions about switching plans. In addition, we've been working hard to ensure a smooth enrollment process," said CMS Acting Administrator Kerry Weems.

The CMS has taken multiple steps to ensure that pharmacies can obtain accurate enrollment information in 2008, particularly for low-income beneficiaries. CMS has improved procedures for getting accurate plan information into the E1 eligibility system, which is the computer system that pharmacists use to identify current plan enrollment, often for beneficiaries who were reassigned to new plans, or who may not have received their new drug card. The CMS has also implemented better processing requirements for all enrollees, and CMS continues support a point-of-sale facilitated enrollment process that provides immediate coverage for people with Medicare who have Medicaid or have qualified for extra help, but aren't enrolled in a Medicare drug plan.

The CMS also has worked aggressively to ensure a smooth transition for low-income subsidy (LIS) eligible beneficiaries who would be responsible for paying a portion of their plan premium in 2008. Earlier this fall, these beneficiaries received letters explaining steps they could take to remain in their plan by paying a small premium and a list of all the zero premium plans available in their community. Blue reassignment letters were mailed to people who qualify for the full extra help and who will be reassigned to a new plan in 2008. Tan letters were sent to beneficiaries receiving the LIS who selected a plan, but who will be responsible for paying a portion of their plan premium beginning in January 2008 unless they join a new plan. Beneficiaries who received one of these letters can receive personalized assistance at their local State Health Insurance Assistance Program (SHIP) office or their local Social Security office.

While CMS does not expect beneficiaries to encounter difficulties at the pharmacy counter due to the collaborative work among beneficiaries, partners and advocates, pharmacies, and plans, nevertheless, those beneficiaries who have newly enrolled or changed plans should keep these four tips in mind when visiting the pharmacy:

1. Bring your red, white, and blue Medicare card, a photo ID, and your new drug plan membership card – these items will help the pharmacist in verifying your coverage;
2. Bring an enrollment acknowledgement, confirmation letter, or the name of your new drug plan if you have not received a plan membership card – your enrollment search might take longer, but these items will assist the pharmacist in verifying your coverage;
3. Keep copies of your receipts – in the rare instance where the pharmacist cannot confirm enrollment, you can work with your new plan prospectively to obtain reimbursement; and
4. Don't leave the pharmacy counter without your medicine – if you cannot pay out of pocket, call 1-800 MEDICARE for assistance or ask the pharmacist to dial the special hotline for these cases.

In addition, CMS and others have taken the following measures to smooth beneficiaries' transition into 2008:

Online Enrollment and Toll-Free Assistance: Since November 15, 2007, Medicare's online enrollment center has processed more than 347,000 enrollments. In the same period, its Web site has recorded over 36 million page views on www.medicare.gov and over 19 million page views of the Medicare Prescription Drug Plan Finder.

Since November 15, 2007, 1-800-MEDICARE has received more than three million calls and more than 3,000 customer service representatives are ready to answer questions about enrollment status. The Medicare ombudsman's office has senior casework analysts available to resolve problems for beneficiaries who need individualized assistance because of a critical health need or financial circumstance.

At the Pharmacy: National and local chains and independent pharmacies have worked closely with beneficiaries to provide information and assistance during the open enrollment period. Thousands of pharmacies have helped beneficiaries through in-store informational days, medication reviews, and community presentations. For example, Rotz Pharmacy, an independent pharmacy in Winchester, Va., provides a navigation guide to the www.medicare.gov Medicare Drug Plan Finder, other comparison tools as well as personalized consultation to beneficiaries who need help in finding a plan that best suits their needs. In-person counseling and other enrollment assistance has been provided nationwide and regionally by many chains, including: CVS; Kroger; Longs Pharmacy; Medicine Shoppe International; Rite-Aid; Target; Stop & Shop, Giant Foods and Giant Food Stores; Walgreens; and Wal-Mart.

In-person: At more than 10,000 events held nationwide, Medicare has worked closely with its partner organizations, including the National Aging Services network of state, local and community service providers, to provide enrollment

counseling and sign-up opportunities where people with Medicare live, work, play and pray.

The 2007 CMS Mobile Office Tour visited 128 communities across the nation sharing information about Part D with beneficiaries. That tour highlights the personalized assistance provided by the many thousands of partners across the country who are helping beneficiaries compare their drug plan options and change enrollment if necessary.

Through the Secret Shopper initiative, CMS officials have attended over 220 events to ensure that health plans are adhering to marketing and enrollment guidelines.

Recent surveys show that a large majority of seniors enrolled in the Medicare drug benefit are satisfied with their plan and few intend to change their plan in 2008. A *Wall St. Journal* /Harris Interactive survey of U.S. adults age 65 or older shows that 87 percent of Medicare drug benefit enrollees are satisfied with their plan. "Our educational efforts are paying off and we will continue to provide information and assistance throughout 2008," said Weems.

The annual open enrollment period for prescription drug coverage began on November 15 and runs through December 31, 2007. For Medicare Advantage plans only, beneficiaries can make one change in enrollment -- enrolling in a new plan, changing plans or canceling a plan -- between January 1 and March 31, 2008. However, beneficiaries cannot join or drop Medicare drug coverage during this time.

Beneficiaries eligible for the LIS have the ability to change plans at any time. They can continue to visit www.medicare.gov and view all the health and prescription plans available in their area. Users can compare plans based on costs, coverage, customer service and quality of each plan. They can also receive the same online information by calling 1-800-MEDICARE.

For more information on where to find a SHIP counselor available to provide free one-on-one help with your Medicare questions or problems, visit www.medicare.gov/contacts/static/allStateContacts.asp

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The Latest Edition of *News from ORDI (CMS' Office of Research, Development and Information)*

Below please find the Fall 2007 edition of *News from ORDI*, a quarterly publication summarizing recent work undertaken in ORDI and the results we've produced. Highlights from this quarter's *News* include:

- Release of the Fall 2007 edition of the *Health Care Financing Review*, CMS' journal of information, analysis, and research on a broad range of issues affecting the Medicare, Medicaid, and State Children's Health Insurance (SCHIP) programs.

- Recently awarded demonstration contracts and health services research grant awards.

- Newly available research reports on such timely topics as the care needs of people with multiple chronic conditions and a national evaluation of SCHIP.

1. *Health Care Financing Review*

Since our last newsletter, ORDI released the Fall 2007 edition of the *Health Care Financing Review*, the agency's journal of information, analysis and research on a broad range of health care financing and delivery issues. The theme of this edition is Pay for Performance. There are articles addressing pay-for-performance issues from financial gains and risks in pay for performance to results of CMS demonstrations examining different aspects of pay for performance. Click **here** to view the Fall edition. (There are also links on that page to previous issues.)

To request copies of the printed edition, please contact Patty Manger at 410-786-3253.

2. Current Demonstrations and Research Projects

Study to Assess the Impact of Transitioning Medicare Part B Drugs to Part D:

In September, ORDI let a contract to Acumen, LLC, to study further the issues involved with the relationship between Part B and Part D drug coverage as indicated in the Secretary's 2005 Report to Congress on Transitioning Medicare Part B Covered Drugs to Part D. (Available **here**) That report, which was mandated under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), suggested that there were a limited number of categories of drugs where it might be beneficial to consolidate coverage under one program. This study aims to better understand the financial and programmatic impacts of consolidating certain categories of similar drugs under one program. Under the base contract, this study will focus on three categories of drugs that may have the greatest potential for program consolidation: 1) certain oral drugs used in cancer treatment, 2) durable medical equipment supply drugs, and 3) vaccines.

For additional information, please contact Steve Blackwell at 410-786-6852.

Evaluation of Care and Disease Management under Medicare Advantage:

In August, CMS awarded a contract to L&M Policy Research to qualitatively assess care and disease management programs utilized by plans participating under Medicare Advantage. This study seeks to understand the type of programs and models of care and disease management utilized by the plans, the population receiving the care and disease management services, the role of the health plans, and what has been learned on the effectiveness of these programs for the Medicare population.

For more information, please contact Noemi Rudolph at 410-786-6662.

Evaluation of Payment Demonstrations for Medicare Part D:

In August, CMS awarded a contract to Acumen, LLC, to evaluate four Medicare Part D payment demonstrations. Specifically, we seek to assess: 1) the effect of late enrollment penalty (LEP) waivers on Part D enrollment and Medicare costs. This demonstration waives LEP for beneficiaries receiving the low-income subsidy (LIS; both full and partial subsidies) and individuals affected by Hurricane Katrina during 2006 and 2007, with an extension to 2008; 2) the impact of phasing in the weighted average, by plan's prior enrollment, calculation of the regional low-income benchmark premium over a multi-year period on low-income beneficiaries' need to change plans or pay higher premiums, and on Medicare administrative costs; 3) the impact of phasing in the weighted average calculation of the Part D plans' national average bid on beneficiaries' need to change plans or pay higher premiums, and whether maintaining stable beneficiary premiums result in more accurate bidding by Part D sponsors; and, 4) the efficiency and economy between the two systems (state-to-plan (S2P) and contractor-based point-of-sale (POS)) currently in operation to eliminate lapses in Part D coverage for full dual eligible and LIS beneficiaries due to delays in receipt of eligibility information.

For more information, please contact Iris Wei at 410-786-6539.

Evaluation of Medical Savings Account (MSA) Plans Offered under the Medicare Program:

ORDI recently awarded a contract to L&M Policy Research, Inc to design and implement a qualitative evaluation of the types of MSA plans offered under the Medicare program. Through this study, we seek to understand the additional choices available beyond the standard fee-for-service Medicare and the other Medicare Advantage (MA) plans. This evaluation will entail a comparison of the Medicare enrollees in the MA and demonstration MSA plans with the Medicare beneficiaries in fee-for-service and the other MA plan types.

For more information, please contact Melissa Montgomery at 410-786-7596.

Medicare Home Health Pay For Performance (HHP4P) Demonstration:

Under the demonstration, home health agencies (HHAs) will be eligible to receive incentive payments if their quality improvement efforts result in the highest performance levels or if they realize significant improvements in patient outcomes. The availability of incentive payments will depend on whether or not the demonstration results in improvements in the quality of care and the actual savings to the Medicare program overall - not just for home health services, but for all Part A and Part B services in the demonstration. It is expected that system-wide savings can be achieved when a home health agency prevents a re-hospitalization of the Medicare beneficiary or a further complication stemming from an illness. Since the payments will be funded out of Medicare savings, none of the participating organizations will face payment reductions as a result of their participation in the demonstration.

CMS is now soliciting home health agency sites to voluntarily participate in the demonstration, with the actual demonstration performance period to begin January 1, 2008, and operate through December 31, 2009. The states selected for the HHP4P demonstration include Connecticut, Massachusetts, Alabama, Georgia, Tennessee, Illinois, and California.

For additional information, please contact Jim Coan at 410-786-9168 or visit the demonstration website **here** .

3. New Research Reports Published

"The Impact of a Change in Medicare Reimbursement Policy and HEDIS Measures on Stage at Diagnosis among Medicare HMO and Fee-for-Service Female Breast Cancer Patients" by Elizabeth B. Habermann, M.P.H., Beth A. Virnig, Ph.D., M.P.H., Gerald F. Riley, M.S.P.H., Nancy N. Baxter, M.D., Ph.D., in *Medical Care* Vol. 45, no. 8, August 2007, pp. 761-766.

Description: *This study was conducted to examine the effects of health plan enrollment (health maintenance organization (HMO) or fee-for service (FFS)), a change in Medicare reimbursement policy which allowed for annual rather than biennial mammograms, and HEDIS measures on stage at diagnosis among older women with breast cancer.*

Researchers identified 20,106 women enrolled in FFS Medicare, and 10,751 women enrolled in an HMO. Women ages 65 through 74 and enrolled in a Medicare HMO were more likely to be diagnosed at an early stage both prior to and following the policy change, but the disparity decreased from 4.7 percent to 2.3 percent, a relative change of 51.1 percent. The disparity was not specific to the ages included in the HEDIS measure. The findings were that a decrease of 51.1 percent in the HMO-FFS disparity in breast cancer stage at diagnosis coincided with the 1998 change in Medicare mammography reimbursement policy. The existence of HEDIS measures for HMOs does not create a

disparity in stage at diagnosis between those whose mammograms are measured by HEDIS (younger women) and those whose mammograms are not (older women).

For more information contact: Gerald Riley at 410-786-6699.

"The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions" Rick Kronick, Ph.D., Melanie Bella, Todd P. Gilmer, Ph.D., and Stephen A. Somers, Ph.D.

Description: This paper, published by the Center for Health Care Strategies (CHCS), with data support from ORDI, examines the patterns of multiple chronic conditions among Medicaid beneficiaries using CMS Medicaid Analytic eXtract (MAX) data files.

The CHCS analysis sought to answer two key questions:

- *What is the prevalence of chronic conditions within the Medicaid population; and*
- *Are there patterns of these conditions that can inform the development of more appropriate guidelines, care models, performance measurement systems, and reimbursement methodologies?*

The authors found that beneficiaries with three or more chronic conditions are responsible for a significant portion of Medicaid spending. The findings shed light on how Medicaid stakeholders can rethink care management approaches for high-need, high-cost beneficiaries with multimorbidity. Traditional disease management programs focused on single diseases that "silo" beneficiaries into disease specific interventions do not address the complex needs of those with multiple conditions. By clearly identifying the complex needs of these beneficiaries, states, plans and providers can develop integrated and coordinated delivery systems that incorporate clinical care with behavioral and non-medical supportive services.

The report is available **here.**

For more information, contact Bill Clark at 410-786-1484.

"National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access" by Margo Rosenbach, Carol Irvin, Angela Merrill, Shanna Shulman, John Czajka, Christopher Trenholm, Susan Williams, So Sasigant Limpa-Amara, Anna Katz, Mathematica Policy Research, Inc.

Description: *CMS contracted with Mathematica Policy Research, Inc., (MPR) to conduct a national evaluation of SCHIP. In addition to providing CMS with input to its SCHIP report to Congress, the national evaluation of SCHIP also contained seven other components: (1) analysis of SCHIP enrollment, disenrollment, and reenrollment patterns based on the SCHIP Enrollment Data System (SEDS) and the Medicaid Statistical Information System (MSIS); (2) analysis of trends in the number and rate of uninsured children based on the Current Population Survey (CPS); (3) synthesis of published and*

unpublished literature about retention, substitution (also referred to as "crowd out"), and access to care in SCHIP; (4) special studies on outreach and access to car ebased on the state SCHIP annual reports; (5) analysis of outreach and enrollment effectiveness using quantitative and qualitative methods; (6) case study of program implementation in eight states; and (7) analysis of SCHIP performance measures.

The report is available **here.**

For more information, contact Susan Radke at 410-786-4450.

4. ORDI Presentations

Throughout the year, ORDI seeks to work closely with other members of the research community and to share key findings in research and policy with health service researchers and policy analysts. Below is a description of recent collaborative efforts and presentations.

- *Potentially Preventable Hospitalizations Among Medicare Home Health Patients* by Ann Meadow, Sc.D., ORDI, Centers for Medicare & Medicaid Services, and Judith Sangl, Sc.D., Agency for Healthcare Research and Quality, Poster Presentation at "2007 AHRQ Annual Conference: Improving Healthcare, Improving Lives"

Currently, a risk-adjusted hospitalization measure is included in Medicare's outcomes measurement system for home health services and reported on Medicare's Home Health Compare Website. This preliminary study applied the AHRQ adult Prevention Quality Indicators (PQIs) to explore potentially preventable hospitalizations of beneficiaries that occur within 30 days of admission into Medicare home health services. Approximately 17 percent of all home health admissions incur a hospitalization within the 30-day period. PQIs are used to identify ambulatory care sensitive conditions—conditions for which good outpatient care can potentially prevent the need for hospitalization or medical complications. Potential applications of preventable hospitalization algorithms include pay-for-performance programs and extensions of current outcomes measurement methodologies. Results from a 2003 sample and a 2005 sample suggested that up to 30 percent of all hospitalizations among Medicare home health patients within 30 days of admission were PQI-related. Congestive heart failure was the leading PQI category in 2005, followed by bacterial pneumonia, dehydration, chronic obstructive pulmonary disease, urinary tract infection, and diabetes. Preliminary data on patient demographic characteristics suggested that males and rural residents were at higher risk of a PQI-related stay than females and urban residents. Future work in developing PQI's for application to home health patients should include methods of distinguishing likely unavoidable hospitalizations from avoidable ones, in view of the poor health status of many home health users.

Slides from the presentation are available **here**.

For more information, contact Ann Meadow at 410-786-6602.

- *Understanding the Potential for Medicare Health Support* presented by Mary Kapp, ORDI, Centers for Medicare & Medicaid Services, Poster Presentation at "Disease Management Leadership Forum" in Las Vegas on September 17, 2007.

Presented were findings on *The Evaluation of Phase I of Medicare Health Support (Formerly Voluntary Chronic Care Improvement) Pilot Program Under Traditional Fee-for-Service Medicare* Report to Congress by Nancy McCall, Jerry Cromwell, and Shulamit Bernard of RTI International, June 2007. (Report available **here**.) Section 721(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established the Voluntary Chronic Care Improvement Programs under Traditional Fee-for-service Medicare. These programs have been implemented by CMS under the name Medicare Health Support. This interim report serves as the first of four Reports to Congress on this program and presents an overview of the scope of the programs, their design and early implementation experience, as well as preliminary cost and quality findings through the first six months of operations. Eight organizations implemented care management programs in different geographic regions beginning between August 1, 2005, and January 16, 2006. In each region, approximately 30,000 Medicare beneficiaries with heart failure or diabetes were identified as eligible; 20,000 were offered the intervention and the remaining 10,000 serve as a comparison population. The population selected is frail, with multiple comorbidities and high utilization of health care services. The organizations vary in how they engage beneficiaries and approach meeting their needs. Participation rates in the first 6 month period range from 65 percent to 92 percent. Participating beneficiaries tend to be a healthier subset of the intervention group. Within the first 6 months of operations, the programs have made only modest progress toward achieving targets for savings to the Medicare program, far less than their management fees. At this point, it is too early to assess the programs' impact on clinical quality or beneficiary satisfaction.

Slides from the presentation are available **here**.

For more information, contact Mary Kapp at 410-786-0360.

5. HBCU and Hispanic Health Services Research Grants Awards

ORDI recently made two awards under its Historically Black Colleges and Universities (HBCU) Grants Program and two awards under its Hispanic Health Services Research Grants Program.

Under the HBCU Grants Program, Meharry Medical College was awarded $250,000 to develop and test an intervention for prostate cancer screening in low-income African American males. Tennessee State University was also awarded $250,000 under this program to conduct a community-based intervention project to assess whether a

telephone patient navigator model is effective for improving diabetes self-management, metabolic control, and quality of life among older African Americans with type 2 diabetes mellitus.

Under the Hispanic Health Services Research Grants Program, Arizona State University was awarded $250,000 for a project aimed at increasing Latino mothers' access to inter-conception care as a means of enhancing the overall well-being of the mothers and their children. Under the same program, California State University at Long Beach was awarded $250,000 for an AIDS prevention program project designed to educate and empower Latino communities.

For more information on any of these grants, contact Richard Bragg at 410-786-7250.

6. Medicare Advantage Quality Measurement and Performance Assessment Training Conference – April 2008

The Medicare Health Outcomes Survey (HOS) is hosting a 2-day training conference, addressing salient topics in Medicare Advantage (MA) Quality Measurement (QM) and Performance Assessment (PA).

The training conference is open to CMS staff, MA health plan professionals, Quality Improvement Organization professionals, health services researchers, and health care policy professionals. Participants will gain insight into CMS quality reporting requirements and how to apply quality and outcomes metrics to improve performance. Experts will discuss the timely issues of pay-for-performance, Part C and Part D report cards, and risk-based approach to auditing.

When: Tuesday, April 8, 2008, from 8:30 a.m. to 4:30 p.m. and Wednesday, April 9, 2008, from 8:30 a.m. to 12:00 p.m.

Where: Sheraton Inner Harbor Hotel, Baltimore, Maryland

What:

- CMS vision for quality improvement and performance assessment
- MA Report Cards and Best Practices
- The Role of Health Information Technology in QM and PA
- The Impact of Pay-for-Performance on QM and PA

Also featuring CMS MA policy requirements for:

- HEDIS, CAHPS, and HOS
- Medicare Part D
- Special Needs Plans

REGISTRATION: Complimentary for federal employees; for all other participants there is a $100 fee.

Please visit the **[National Committee for Quality Assurance's web site]** for more information and to register online. You may also contact Chris Haffer at 410-786-8764.

Previous Listserv newsletters are available under the heading "ORDI Research News Listserv Archive" **here**.

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JANUARY FLU SHOT REMINDER

"It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because flu viruses change each year. Please encourage your Medicare patients who haven't already done so to get their annual flu shot. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu!

Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0748 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf* on the CMS website."

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I hope everyone enjoyed a happy new year and that you have a terrific 2008!

With best regards ~ Valerie

Valerie A. Haugen, Director

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Medicare Learning Network **Visit the Medicare Learning Network ~ it's free!**

January 7, 2008

UPDATE: New 2008 Payment Rates for Services Paid Under the Medicare Physician Fee Schedule and the Extension of the Participation Decision Period

The following is an update to the original message that was sent to you on Monday, December 31, 2007. This update includes additional information regarding the posting of new fee schedule amounts on Medicare Contractor websites. (Updated information is in red.) CMS asks that you share this important information with all of your association members and State and local chapters. Thanks!

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The Medicare, Medicaid and SCHIP Extension Act of 2007 made several changes affecting payments to physicians. One such change provides for a 0.5 percent increase to the Medicare Physician Fee Schedule (MPFS) conversion factor for dates of service beginning **January 1 through June 30, 2008**, instead of the (negative) -10.1 percent that was scheduled to take place. Effective for dates of service on and after **July 1**, **2008,** the (negative) -10.1 percent update to the physician fee schedule will go into effect. **Your Medicare contractors have been instructed to be ready to process claims with January 2008 dates of service with the new fees beginning January 7, 2008.**

The new fees are expected to be posted on your local contractor's website no later than January 11, 2008. The "Medicare Physician Fee Schedule Look-Up" link on the Centers for Medicare & Medicaid Services (CMS) Website, which allows you to customize your search, will be updated with the new 2008 fees during the week of January 21, 2008. However, the carrier specific public use files are available now on the CMS Website for the new 2008 MPFS rates at the following link: http://www.cms.hhs.gov/PhysicianFeeSched/PFSCSF/list.asp#TopOfPage .

Since there is a change to the 2008 Medicare Physician Fee Schedule rates, CMS is extending the Participation Decision Period an additional 45 days. The participation decision period now runs through **February 15, 2008**, instead of ending on December 31, 2007. All participating status changes will be effective January 1, 2008.

To become a participating physician, complete the CMS-460 form which can be found on the CD that was mailed to physicians in November. You can also request the form from your local contractor. The form must be completed, signed, and mailed to your local contractor and post-marked by February 15, 2008. If you are changing your participation status to non-participating, please send your request in a letter to your local contractor, post-marked by February 15, 2008.

An official CMS change request and an *MLNMatters* article will be forthcoming.

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January 8, 2008

Medicare Part B Drug CAP: Additional Physician Election Period & "Ask the Contractor" Conference Call

Medicare Part B Drug Competitive Acquisition Program (CAP): Additional Physician Election Period
January 15 – February 15, 2008; Ask the Contractor Teleconference January 23, 2008 at 2:00PM CST

The CAP is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practice from an Approved CAP Vendor, thus reducing the time and cost of buying and billing for drugs.

An additional election period for the 2008 Medicare Part B Drug Competitive Acquisition Program (CAP) will begin on **January 15, 2008 and will conclude on February 15, 2008**. This additional election period will be conducted because recent changes in the CAP make it more flexible for physicians. Changes to the program include:

- CAP drug administration claims may now be filed up to 30 days after administering CAP drugs;
- Participating CAP Physicians may now request to leave the CAP within the first 60 days of election if program participation results in a burden to a practice (ex: difficulty meeting CAP drug ordering or billing requirements);
- After 60 days, a Participating CAP Physician may request to leave the CAP if an unexpected change in circumstance causes CAP participation to become a burden to a practice (ex: a change in patient population or practice personnel).

Effective dates of participation for physicians who elect to join the CAP during this additional election period will be **April 1, 2008 to December 31, 2008.** This additional election period is for physicians who have not already elected to participate in the CAP for 2008.

The designated carrier for the Competitive Acquisition Program (CAP), Noridian Administrative Services (NAS), will hold a **2008 Additional Election Ask the Contractor Teleconference on January 23, 2008 at 2:00PM CST.** Prospective CAP physicians will have an opportunity to learn more about the CAP and how to elect into the program during the upcoming 2008 additional physician election. Additionally, NAS staff will be available to answer questions.

Call Number: (888) 830-6260
Passcode: 463742

A PowerPoint slide presentation to accompany the 2008 Additional Election teleconference will be posted on the NAS website at: https://www.noridianmedicare.com/cap_drug/train/act.html. The slides will be available at least one day prior to the teleconference (Tuesday, January 22). CAP staff will be available to respond to inquiries during a question and answer session after the presentation

NOTE: Once a physician has elected to participate in CAP, he or she must obtain all drugs on the CAP drug list from the Approved CAP Vendor. Approved CAP Physicians can still continue to purchase and bill Medicare under the Average Sale Price (ASP) system for those drugs that are not provided by the physician's Approved CAP Vendor.

Additional information about the CAP is available at the following website:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp

The physician election form can be found at the following webpage in the Downloads section. Additional information for physicians can also be found at this site:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp

The list of drugs supplied by the CAP vendor, including NDCs, is in the Downloads section at:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp

- **Please note that completed and signed physician election forms must be returned by mail to your local carrier or A/B MAC.**
- **Forms must be postmarked on or before February 15, 2008.**
- **DO NOT return forms to CMS offices.**

For questions on the CAP election process or general program inquiries, please call NAS's CAP Vendor Contact Center at
(888) 671-0536.

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CMS Announces Round 2 of the Medicare DMEPOS Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) has announced the metropolitan statistical areas and product categories for **Round 2** of the Medicare Durable Medical

Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

Visit the CMS web site at http://www.cms.hhs.gov/competitiveacqfordmepos/01_overview.asp to view additional information.

To view the Press Release, please click:
http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2811&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date .

Additional details will be provided in a forthcoming *MLN Matters* article; a Physician Tip Sheet will also be available soon.

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January 9, 2008

Medicare Part B Drug CAP: Upcoming Training for CAP Vendors and Elected Physicians

Upcoming Training for the Medicare Part B Drugs Competitive Acquisition Program (CAP)

Noridian Administrative Services, the designated carrier for the CAP, offers interactive, online workshops about the CAP for Part B Drugs and Biologicals. These workshops train CAP vendors and elected physicians on a number of CAP topics and requirements such as billing for CAP claims, and NAS personnel are available to answer questions. Physicians and/or their staff are strongly encouraged to attend.

Interested parties may view additional information about and register for these workshops at: https://www.noridianmedicare.com/cap_drug/train/workshops/index.html

Upcoming workshops will be held on the following dates:

- 1/15/08 at 2:00 pm CST
- 2/21/08 at 2:00 pm CST
- 3/12/08 at 10:00 am CST
- 4/22/08 at 2:00 pm CST
- 5/28/08 at 10:00 am CST

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January 10, 2008

CMS to Host Audio Conference/Q&A Session on DMEPOS Supplier Accreditation

The Centers for Medicare & Medicaid Services (CMS) will host an audio conference/Q&A session regarding Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier accreditation.

This audio conference is the first in a series of four designed to provide guidance to DMEPOS suppliers regarding accreditation. We will be discussing compliance with the DMEPOS Quality Standards and the accreditation process, and will provide ample time to answer questions from the supplier audience. To download the call presentation that will be posted in the days just prior to the call, please visit http://www.cms.hhs.gov/MedicareProviderSupEnroll/ on the CMS website.

Conference call details:

Date: January 22, 2008
Conference Title: DMEPOS Accreditation 101
Time: 1:00-2:30 p.m. EST

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to receive the call-in data. This registration is solely to reserve a phone line, NOT to allow participation. If you cannot attend the call, replay information is available below.

Registration will close at **1:00 p.m. EST on January 21, 2008**, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

To register for the call, participants must:

1. **Go to** http://www2.eventsvc.com/palmettogba/012208 .
2. Fill in all required data.
3. Verify your time zone is displayed correctly the drop down box.
4. Click "Register".

You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. Note: Please print and save this page in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been blocked by that mechanism.

For those of you who will be unable to attend the call, a replay option will be available shortly following the end of the call. This replay will be accessible from 3:30 p.m. EST 1/22/2008 until 11:59 p.m. EST 1/29/2008. The call-in data for the replay is (800) 642-1687 and the passcode is 25607950.

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January 11, 2008

Another Update Regarding the New 2008 Medicare Physician Fee Schedule Amounts

The following is another update to previous messages regarding the new 2008 Medicare Physician Fee Schedule Amounts. (Updated information is in red.) CMS asks that you share this important update with all of your association members and State and local chapters. Thanks!

In two previous messages distributed to you, the Centers for Medicare & Medicaid Services (CMS) indicated that the Medicare, Medicaid and SCHIP Extension Act of 2007 replaced the scheduled 10.1 percent reduction in the Medicare Physician Fee Schedule (MPFS) conversion factor with a 0.5 percent increase for dates of service beginning January 1 through June 30, 2008. CMS has received a number of inquiries asking whether physicians need to take any special action to get paid at the rates required by the statute. ***Physicians do not need to take any additional action in order for their MPFS claims to be paid at the new rate that reflects the 0.5 percent increase in the conversion factor.*** Medicare contractors are able to process claims for services paid under the MPFS that contain dates of service January 1 and after with the new 2008 rates. No adjustments should be necessary. Your Medicare contractors have been instructed to process, beginning January 7, all claims with dates of service January 1, 2008, and after, that contain MPFS services.

We are also taking this opportunity to reiterate two points made in earlier messages:

1. The new fees are expected to be posted on your local contractor's website no later than January 11, 2008. The "Medicare Physician Fee Schedule Look-Up" link on the CMS Website, which allows you to customize your search, will be updated with the new 2008 fees during the week of January 21, 2008. However, the carrier specific public use files are available now on the CMS Website for the new 2008 MPFS rates at the following link: http://www.cms.hhs.gov/PhysicianFeeSched/PFSCSF/list.asp#TopOfPage.

2. CMS extended the participation decision period an additional 45 days. The participation decision period now runs through **February 15, 2008**, instead of ending on December 31, 2007. All participating status changes will be **effective January 1, 2008.** Contractors will accept and process any participation elections or withdrawals, made during the extended enrollment period that are received or post-marked on or before February 15, 2008.

   To become a participating physician, complete the CMS-460 form which can be found on the CD that was mailed to physicians in November. You can also request

the form from your local contractor. The form must be completed, signed, and mailed to your local contractor and post-marked by February 15, 2008. If you are changing your participation status to non-participating, please send your request in a letter to your local contractor, post-marked by February 15, 2008.

Contractors will not automatically make adjustments for providers who change their participation status after January 1, 2008 (you should begin billing claims according to the participation decision that you have made). However, they will adjust claims based on participation status changes that you bring to their attention.

An official CMS change request and an *MLNMatters* article will be forthcoming.

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January 14, 2008

Medicare Part B Drug CAP: Additional Physician Election Period January 15 – February 15, 2008; Ask the Contractor Teleconference January 23 at 2:00PM CST

Medicare Part B Drug Competitive Acquisition Program (CAP): Additional Physician Election Period January 15 – February 15, 2008; Ask the Contractor Teleconference January 23 at 2:00PM CST

The Medicare Part B Drug Competitive Acquisition Program (CAP) is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practice from an Approved CAP Vendor, thus reducing the time and cost of buying and billing for drugs.

An additional election period for the 2008 Medicare Part B Drug CAP will **begin on January 15, 2008 and will conclude on February 15, 2008.** This additional election period will be conducted because recent changes in the CAP make it more flexible for physicians. Changes to the program include:

- CAP drug administration claims may now be filed up to 30 days after administering CAP drugs;

- ❑ Participating CAP physicians may now request to leave the CAP within the first 60 days of election if program participation results in a burden to a practice (e.g., difficulty meeting CAP drug ordering or billing requirements);

- ❑ After 60 days, a participating CAP physician may request to leave the CAP if an unexpected change in circumstance causes CAP participation to become a burden to a practice (e.g., a change in patient population or practice personnel).

Effective dates of participation for physicians who elect to join the CAP during this additional election period will be **April 1, 2008 to December 31, 2008.** This additional election period is for physicians who have not already elected to participate in the CAP for 2008.

The designated carrier for the CAP, Noridian Administrative Services (NAS), will hold a 2008 Additional Election **Ask the Contractor Teleconference on January 23, 2008 at 2:00PM CST**. Prospective CAP physicians will have an opportunity to learn more about the CAP and how to elect into the program during the upcoming 2008 additional physician election. Also, NAS staff will be available to answer questions.

Call Number: (888) 830-6260
Passcode: 463742

A PowerPoint slide presentation to accompany the 2008 Additional Election teleconference will be posted on the NAS website at: https://www.noridianmedicare.com/cap_drug/train/act.html. The slides will be available at least one day prior to the teleconference (Tuesday, January 22). CAP staff will be available to respond to inquiries during a question and answer session after the presentation

NOTE: Once a physician has elected to participate in CAP, he or she must obtain all drugs on the CAP drug list from the Approved CAP Vendor. Approved CAP physicians can still continue to purchase and bill Medicare under the Average Sale Price (ASP) system for those drugs that are not provided by the physician's Approved CAP Vendor.

Additional information about the CAP is available at the following website: http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp

The physician election form and additional information for physicians can be found at the following web page on the CMS Website: http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp. The form is located in the Downloads section of this web page.

The list of drugs supplied by the CAP vendor, including NDCs, is in the Downloads section at: http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp .

- **Please note that completed and signed physician election forms must be returned by mail to your local carrier or A/B MAC.**
- **Forms must be postmarked on or before February 15, 2008.**
- **DO NOT return forms to CMS offices.**

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Visit the Medicare Learning Network ~ it's free!

January 15, 2008

NPI: Test Your Medicare Claims Now & National NPI Roundtable Scheduled

The NPI is here. The NPI is now. Are you using it?

Important Information for Medicare Providers

Urgent: Test Your Medicare Claims Now!
After Medicare providers have submitted claims containing both NPIs and legacy identifiers and those claims have been paid, Medicare urges these providers to send a small batch of claims now with **only the NPI** in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch.

(Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.)

Save the Date – National NPI Roundtable Scheduled for 2/6/2008
CMS will host a national NPI Roundtable on Wednesday, February 6th from 2:30 – 4PM ET. This call will focus on the status of the Medicare implementation and a related question and answer session. Registration details coming soon!

Need More Information?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.

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

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Visit the Medicare Learning Network ~ it's free!

January 18, 2008

Your Friday Reading Materials

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

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Happy Friday everyone ~ several items this afternoon, including information on:

- **Physician Quality Reporting Initiative (PQRI) Update**
- **Medicare Part B Drug Competitive Acquisition Program (CAP) Additional Physician Election Period and "Ask the Contractor" Teleconference**
- **Vendor Bidding Period for the Medicare Part B Drug Competitive Acquisition Program (CAP)**
- **Update Regarding the MDS 3.0 Special Open Door Forum**
- **New Products from the Medicare Learning Network**
- **Proposed Rule to Empower Medicaid Beneficiaries to Direct Personal Assistance Services**
- **January Flu Shot Reminder**

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Physician Quality Reporting Initiative (PQRI) Update

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the Physician Quality Reporting Initiative (PQRI) website has been reorganized to facilitate access and navigation to 2008 PQRI information and educational resources, including a 2008 PQRI Tool Kit. Key documents related to 2008 measure specifications have been retained and placed as downloadable documents within their corresponding sections. In addition, new documents that further inform eligible providers about 2008 PQRI have been added to the website. Information about the 2007 PQRI program, which ended on December 31, 2007, has also been reorganized with relevant documents pertaining to 2007 measures retained for reference.

We encourage all eligible providers to visit the website and become familiar with the 2008 materials at: http://www.cms.hhs.gov/PQRI/ on the CMS website.

* *

Medicare Part B Drug Competitive Acquisition Program (CAP) Additional Physician Election Period and Ask the Contractor Teleconference

The CAP is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practices from an Approved CAP Vendor, thus reducing the time and cost of buying and billing for drugs.

An additional election period for the 2008 Medicare Part B Drug Competitive Acquisition Program (CAP) will begin on **January 15, 2008 and will conclude on February 15, 2008**. This additional election period will be conducted because recent changes in the CAP make it more flexible for physicians. Changes to the program include:

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Effective dates of participation for physicians who elect to join the CAP during this additional election period will be **April 1, 2008 to December 31, 2008.** This additional election period is for physicians who have not already elected to participate in the CAP for 2008.

The designated carrier for the Competitive Acquisition Program (CAP), **Noridian Administrative Services (NAS),** will hold a 2008 **Additional Election Ask the**

Contractor Teleconference on January 23, 2008 at 2:00PM CST. Prospective CAP physicians will have an opportunity to learn more about the CAP and how to elect into the program during the upcoming 2008 additional physician election. Additionally, NAS staff will be available to answer questions.

Call Number: (888) 830-6260
Passcode: 463742

A PowerPoint slide presentation to accompany the 2008 Additional Election teleconference will be posted on the NAS website at: https://www.noridianmedicare.com/cap_drug/train/act.html. The slides will be available at least one day prior to the teleconference (Tuesday, January 22). CAP staff will be available to respond to inquiries during a question and answer session after the presentation

NOTE: Once a physician has elected to participate in CAP, he or she must obtain all drugs on the CAP drug list from the Approved CAP Vendor. Approved CAP Physicians can still continue to purchase and bill Medicare under the Average Sale Price (ASP) system for those drugs that are not provided by the physician's Approved CAP Vendor.

Additional information about the CAP is available at the following website: http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp

The physician election form can be found at the following webpage in the Downloads section. Additional information for physicians can also be found at this site: http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp

The list of drugs supplied by the CAP vendor, including NDCs, is in the Downloads section at:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp

- **Please note that completed and signed physician election forms must be returned by mail to your local carrier or A/B MAC.**
- **Forms must be postmarked on or before February 15, 2008.**
- **DO NOT return forms to CMS offices.**

For questions on the CAP election process or general program inquiries, please call NAS' CAP Vendor Contact Center at (888) 671-0536.

* *

Vendor Bidding Period for the Competitive Acquisition Program (CAP)

The Competitive Acquisition Program (CAP) is an alternative to the ASP "buy and bill" method for acquiring certain Medicare Part B drugs and biologicals. CMS has released a solicitation for contracts to be awarded to vendors to supply drugs for the CAP.

Approved CAP Vendor contracts would be effective January 1, 2009 to December 31, 2011.

The vendor bidding period began on January 14, 2008 and ends on February 15, 2008.

Additional information about the CAP including bidding documents, background information on the previous bidding period, and the list of CAP drugs currently supplied under the CAP may be found at the following CMS website: http://www.cms.hhs.gov/CompetitiveAcquisforBios .

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<u>Update Regarding the Minimum Data Set 3.0 Special ODF</u>

As a result of high demand for participation in the Special Minimum Data Set 3.0 Special Open Door Forum, CMS has worked diligently to obtain additional lines to accommodate as many telephone participants as possible. If you haven't had the opportunity to register, now is your chance. To register, go to the website at http://registration.intercall.com/go/cms2 . Registration will close at **3PM EST on January 23, 2008**. Thank you for your patience and interest in CMS Open Door Forums.

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<u>New From the Medicare Learning Network</u>

The ***Home Health Prospective Payment System Fact Sheet***, which provides information about coverage of home health services and elements of the Home Health Prospective Payment System, is now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at http://www.cms.hhs.gov/MLNProducts/downloads/HomeHlthProspPymtfctsht08-508.pdf .

The ***Ambulatory Surgical Center Fee Schedule Fact Sheet***, which provides general information about the Ambulatory Surgical Center (ASC) Fee Schedule, ASC payments, and how ASC payment amounts are determined, is now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at http://www.cms.hhs.gov/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508.pdf .

<u>New *MLN Matters* Article</u>

SE0753 – Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE SECOND IN A SERIES OF ARTICLES ON THE IACS
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf

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CMS ISSUES PROPOSED RULE TO EMPOWER MEDICAID BENEFICIARIES TO DIRECT PERSONAL ASSISTANCE SERVICES

A proposed rule that would allow more Medicaid beneficiaries to be in charge of their own personal assistance services, including personal care services, instead of having those services delivered by an agency, was announced today by the Centers for Medicare & Medicaid Services (CMS).

Through the rule on display today at the *Federal Register*, CMS requests public comment on how states could allow Medicaid beneficiaries who need help with the activities of daily living to hire, direct, train or fire their own personal care workers rather than working with personnel employed by an agency. Beneficiaries could even hire qualified family members who may already be familiar with the individual's needs to perform personal assistance (not medical) services.

The NPRM will be published in the *Federal Register* on Friday, January 18, 2008. Comments will be accepted through the close of business on Tuesday, February 19, 2008.

To view the entire Press Release, click on:
http://www.cms.hhs.gov/apps/media/press_releases.asp
Direct Link to Regulation:
http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2229P.PDF

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January Flu Shot Reminder: It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because flu viruses change each year. Please encourage your Medicare patients who haven't already done so to get their annual flu shot. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu!

Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0748 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf*) on the CMS website.

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I hope everyone enjoys a wonderful weekend!

With best regards ~ Valerie

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January 22, 2008

UPDATED INFORMATION RE: Your Friday Reading Materials (January 18, 2008)

Hello everyone ~ I want to provide you with updated information on one of the items I sent you last Friday regarding a Special Edition MLN Matters article on Individuals Authorized Access to CMS Computer Services. Below is a more complete summary of the educational products available on this topic. Thanks and have a great week!

IACS-Related Educational Products:

A new **Fact Sheet/Chart** is available on the Medicare Learning Network website that contains **Steps to Accessing CMS Enterprise Applications for Provider Organizations**. The fact sheet/chart can be accessed at the following url: *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf*

CMS enterprise applications are those hosted and managed by CMS and do not include Fiscal Intermediary (FI)/carrier/Medicare Administrative Contractor (MAC) internet applications. The fact sheet/chart outlines each step of the process; e.g., how to register, selecting application roles for each enterprise application, and entering into the application. To date, there have also been three ***MLN Matters*** articles prepared on this subject:

SE0747 - http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf (first in the series)

SE0753 - http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf (second in the series)

SE0754 - http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf (third in the series)

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January 25, 2008

Your Friday Reading Materials

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

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Happy Friday everyone ~ just two items this Friday:

- **Rate Year 2009 Payment, Policy Changes for Long-Term Care Hospitals**
- **New from the Medicare Learning Network**

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CMS PROPOSES RATE YEAR 2009 PAYMENT, POLICY CHANGES FOR LONG-TERM CARE HOSPITALS

The Centers for Medicare & Medicaid Services (CMS) recently issued a proposed payment rule designed to assure that long-term care hospitals (LTCHs) continue to receive appropriate payment for services provided while giving them incentives to provide more efficient care to Medicare beneficiaries. LTCHs are a type of acute care hospital that treats some of Medicare's most severely ill or medically complex patients. The new policies and payment rates would apply to services provided to individuals who are discharged from these hospitals on or after July 1, 2008.

“The proposals announced today will help make sure Medicare beneficiaries who need longer term inpatient care get high quality services appropriate to their medical conditions,” CMS Acting Administrator Kerry Weems said. “The proposals seek increased incentives for efficient delivery of care, ensuring that beneficiaries and taxpayers get the best value for the Medicare dollar.”

To view the entire press release: http://www.cms.hhs.gov/apps/media/press_releases.asp

The proposed rule is posted on the CMS Web site at:
http://www.cms.hhs.gov/LongTermCareHospitalPPS/LTCHPPSRN/list.asp.

A Tip Sheet for Beneficiaries is posted on the Medicare.gov Web site at:
http://www.medicare.gov/Publications/Pubs/pdf/11347.pdf.

Comments on the proposed rule are due by **March 24, 2008**, and a final rule will be issued later in the spring.

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New from the Medicare Learning Network!

The ***Hospice Payment System Fact Sheet***, which offers providers information about the Medicare hospice benefit, is now available from the Centers for Medicare & Medicaid Services ***Medicare Learning Network*** in downloadable format at http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf.

The Network has also developed a quick reference chart entitled ***The ABCs of Providing the Initial Preventive Physical Examination,*** ICN# 006904. This laminated chart can be used by Medicare fee-for-service physicians and qualified non-physician practitioners (physician assistants, nurse practitioners, or clinical nurse specialists) as a guide when providing the initial preventive physical examination (IPPE) (also know as the "Welcome to Medicare" physical exam). This handy tool identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the IPPE, and lists references for additional information. To download, view and print this useful resource, go to, http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf, on the CMS MLN Publications web page. Copies of the IPPE chart may be ordered, free of charge, through the MLN Product Ordering System located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.

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I hope you have a wonderful weekend ~ Valerie

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January 29, 2008

Medicare Part B Drug Competitive Acquisition Program (CAP): Additional Physician Election Period for 2008 is Underway!

The CAP is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practice from an Approved CAP Vendor, thus reducing the time and cost of buying and billing for drugs.

An additional election period for the 2008 Medicare Part B Drug Competitive Acquisition Program (CAP) **began on January 15, 2008 and will conclude on February 15, 2008.** This additional election period is being conducted to accommodate recent changes in the CAP that make it more flexible for physicians. Changes to the program include:

- CAP drug administration claims may now be filed up to 30 days after administering CAP drugs;
- Participating CAP Physicians may now request to leave the CAP within the first 60 days of election if program participation results in a burden to a practice (e.g., difficulty meeting CAP drug ordering or billing requirements);
- After 60 days, a Participating CAP Physician may request to leave the CAP if an unexpected change in circumstance causes CAP participation to become a burden to a practice (e.g., a change in patient population or practice personnel).

Effective dates of participation for physicians who elect to join the CAP during this additional election period will be **April 1, 2008 to December 31, 2008**. This additional election period is for physicians who have not already elected to participate in the CAP for 2008.

NOTE: Once a physician has elected to participate in CAP, he or she must obtain all drugs on the CAP drug list from the Approved CAP Vendor. Approved CAP Physicians can still continue to purchase and bill Medicare under the Average Sale Price (ASP) system for those drugs that are not provided by the physician's Approved CAP Vendor.

Additional information about the CAP is available at the following website:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp

The physician election form can be found at the following webpage in the Downloads section. Additional information for physicians can also be found at this site:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp

The list of drugs supplied by the CAP vendor, including NDCs, is in the Downloads section at:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp

- **Please note that completed and signed physician election forms must be returned by mail to your local carrier or A/B MAC.**
- **Forms must be postmarked on or before February 15, 2008.**
- **DO NOT return forms to CMS offices.**

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Your Latest NPI News

The NPI is here. The NPI is now. Are you using it?

ATTENTION: FFS Medicare Physicians, Non-Physician Practitioners & Other Suppliers

MARCH 1ST IS A CRITICAL DATE!
Last week, CMS issued the January NPI message to all providers. (You can view the January NPI message online at http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp on the CMS website.) This week begins a weekly messaging campaign for Medicare Fee-For-Service providers in order to raise the level of urgency as the March 1st implementation date approaches.

Prior to March 1, 2008:
Claims with both an NPI and a Medicare legacy number are rejected if the pair is not found on the Medicare NPI Crosswalk.
Claims submitted with just a Medicare legacy number are being paid (unless of course, they have other errors that cause them to be rejected).

As of March 1, 2008:
Claims with both an NPI and a Medicare legacy number will continue to be rejected if the pair is not found on the Medicare NPI Crosswalk.

Claims without an NPI in the primary provider field will be rejected!
Claims with only a Medicare legacy number in the primary provider field will be rejected!

This means that you will not be able to get paid for any Medicare services you provide until you begin using your NPI. Also, if needed, you must correct any data which may be preventing an NPI/legacy match on the NPI crosswalk. The correction might require that you file a CMS-855 Medicare Provider Enrollment form with your Medicare carrier, A/B MAC, or DME MAC a process which can take a number of months to accomplish.

TEST NPI-only NOW: If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number). If the Medicare NPI Crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims reject, call your Medicare carrier or A/B MAC enrollment staff for advice right away. The enrollment number is likely to be quite busy after the March 1 deadline, so don't wait.

Reminder - CMS to Host National NPI Roundtable on 2/6/2008

CMS will host a national NPI Roundtable on Wednesday, February 6th from 2:30 – 4PM ET. This call will focus on the status of the Medicare implementation and a related question and answer session. Registration details are available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/listservwording2-6-08npicall.pdf on the CMS website.

Need More Information?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.

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