Provider Partnership Program (PPP) E-mail Notification Archives

February 2, 2005

Hello everyone. Here's notice of a Medlearn Matters article on the Influenza Treatment Demonstration and a new Fact Sheet on Inpatient Rehabilitation Facility Classification Requirements. I hope you find them helpful. (I have attached the Medlearn Matters article for your convenience.)

INFLUENZA TREATMENT DEMONSTRATION

Medicare will cover four new flu medications including, where applicable, their generic equivalents. These drugs will be paid under a Centers for Medicare & Medicaid Services (CMS) Demonstration for dates of service through May 31, 2005. In addition, physicians, providers and suppliers that enroll in Medicare before May 31, 2005 may also file claims for drugs furnished under this demonstration for dates of service beginning when the provider or supplier completes such enrollment.

For more information, please visit our Medlearn website to view the Medlearn Matters article at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3696.pdf

For additional information about this demonstration, please visit the CMS Website at:
http://www.cms.hhs.gov/researchers/demos/flu/

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INPATIENT REHABILITATION FACILITY CLASSIFICATION REQUIREMENTS

CMS has issued Fact Sheet #1 entitled the "Inpatient Rehabilitation Facility Classification Requirements." The fact sheet is informational only and elaborates on the revised classification requirements for IRFs described in CR 3334 (Transmittal 221) and CR 3503 (Transmittal 347) issued on June 25, 2004 and October 29, 2004, respectively. The purpose of the fact sheet is to update the status of the initiatives that CMS is actively pursuing and to highlight specific aspects of the operational procedures as described regarding the classification requirements for IRFs. We are also addressing the provision of the Consolidated Appropriations Act, 2005 regarding how the application of the revised classification requirements may affect IRFs. The fact sheet can be accessed via the CMS IRF website.

The direct URL is,
http://www.cms.hhs.gov/providers/irfpps/fs1classreq.pdf

or the "Fact Sheet" links can be used from the IRF home page at,
http://www.cms.hhs.gov/providers/irfpps/default.asp .

Best regards,

Valerie

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Good evening everyone--offerings in this note include news items of special interest to ESRD facilities and hospitals, as well as more detailed information (than what I recently sent you) regarding CMS' flu demonstration and updates on some beneficiary-related publications. Enjoy!

News of particular interest to ESRD Facilities:

CMS PUBLISHES PROPOSED CONDITIONS FOR COVERAGE
CMS recently published a proposed rule that would modernize the Medicare End-Stage Renal Disease (ESRD) conditions for coverage for participation in the Medicare program by dialysis facilities and promote higher quality care. The purpose of the ESRD NPRM is to modernize Medicare's requirements by focusing on patient outcomes of care. The comment period for this proposed rule will be 90 days.

CMS also proposed new requirements that organ procurement organizations (OPOs) and organ transplant centers must meet to have their services covered by Medicare and Medicaid. The proposed OPO requirements include process and outcome performance standards that address all OPO functions. The proposed requirements for transplant centers focus on a center's ability to perform successful transplants and deliver quality patient care as evidenced by good outcomes as well as sound policies and procedures. These rules are on display at the Federal Register and will be published in the Federal Register on 2/4/2005. The comment period for these rules will be 60 days.

The following link will take you to the proposed rules: http://www.cms.hhs.gov/cop

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CMS ESRD ADVISORY BOARD MEETING 2/16/05
CMS recently published a Federal Register notice to announce the first public meeting of the Advisory Board on the Demonstration of a Bundled Case Mix Adjusted Payment System for End-Stage Renal Disease (ESRD) Services. Notice of this meeting is required

by the Federal Advisory Committee Act (5 U.S.C. App. 2, section 10(a)(1) and (a)(2)). The Advisory Board will provide advice and recommendations with respect to the establishment and operation of the demonstration mandated by section 623(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This notice also announces the appointment of eleven individuals to serve as members of the Advisory Board, including one individual to serve as co chairperson, and one additional co-chairperson, who is employed by CMS.

DATES: The meeting is on February 16, 2005 from 9 a.m. to 5 p.m., eastern standard time.

The Federal Register weblink is
http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-1743.pdf

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News of particular interest to Hospitals:

UPDATES RELATED TO HOSPITAL OUTPATIENT PPS
CMS announces the following recent updates of the hospital outpatient prospective payment system (OPPS) for calendar year 2005:

(1) CMS-1427-CN: Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates; Wage Index Tables and Corrections;

(2) CMS-1285-N: Meeting of the Advisory Panel on Ambulatory Payment Classification (APC) Groups (Panel) - February 23, 24, and 25, 2005, and Re-chartering of APC Panel on November 8, 2004 published at the Federal Register on December 30, 2004;

(3) Wage Index Addenda to CMS-1427-FC: Addenda H, I, J, L, M, and N;

(4) Revised List of Device Codes Required for Procedure Codes in Selected Device Dependent APCs, which updates Table 19 that was published in CMS-1427-FC on November 15, 2004;

(5) Revenue Code to Cost Center Crosswalks. (This is a preliminary crosswalk for discussion at the February 2005 APC Panel Meeting, in preparation for the 2006 OPPS annual update.);

(6) Proposed Device Code Edits for July/October 2005 (comments requested by February 20, 2005)

(7) Change Request 3586 - Summary of OPPS Outpatient Code Editor (OCE) Data Changes and OPPS PRICER Logic Changes; Changes to Payment for Diagnostic Mammography;

(8) Change Request 3606 - Billing for devices that do not have transitional pass-through status and that are not classified as New Technology ambulatory payment classification (APC) groups;

(9) Change Request 3610 - Changes to coding and payment for drug administration;

(10) Change Request 3632 - Summary of payment policy Changes;

(11) Change Request 3583 - January 2005 Outpatient Prospective Payment System Outpatient Code Editor (OPPS OCE) Specifications.

These updates can be found on the CMS Website at: www.cms.hhs.gov/providers/hopps . Check this Web page often for current Hospital Outpatient PPS information.

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MEDICARE PROPOSES PAYMENT CHANGES FOR LONG-TERM CARE HOSPITALS FOR RATE YEAR 2006

CMS recently issued a proposed rule that would increase the Medicare payment rates for long-term care hospitals (LTCHs) by 3.1 percent for discharges on or after July 1, 2005, through June 30, 2006. Medicare projects that aggregate payments to these hospitals under the LTCH Prospective Payment System (PPS) would increase to $2.96 billion during the 2006 LTCH rate year. "We are continuing a smooth transition to a prospective payment methodology for services provided by long-term care hospitals to pay them most appropriately for treating the most severely ill Medicare beneficiaries," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "As we have seen with the other prospective payment systems, we have been able to ensure that beneficiaries will continue to get the care they need while providing incentives to the hospitals for delivering care efficiently."

Long-term care hospitals, in general, are defined as hospitals that have an average Medicare inpatient length of stay greater than 25 days. These hospitals typically provide extended medical and rehabilitative care for patients who are clinically complex and may suffer from multiple acute or chronic conditions. Services typically include comprehensive rehabilitation, respiratory therapy, head trauma treatment and pain management. The LTCH PPS, which now sets payments for over 330 long-term care hospitals, was designed to assure appropriate payment for services to the medically complex patients treated in these facilities, while providing incentives to hospitals to provide more efficient care to Medicare beneficiaries. Payments under the LTCH PPS are updated annually.

The LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002, to replace the previous cost-based payment methodology. The new system was based on the hospital inpatient prospective payment system (IPPS), but modified to reflect the relatively higher costs experienced by LTCHs in treating the most severely ill beneficiaries. CMS had offered hospitals a five-year transition period, during

which they would be paid based on a blend of the reasonable cost-based payment and the Federal Rate. Because the base standard Federal Rate was determined as if all LTCHs are paid based on 100 percent of the Federal rate, in order to maintain budget neutrality during the 5-year transition period, CMS reduces all LTCH payments to account for the additional costs of the transition period methodology. At this time, 96 percent of LTCHs have elected to be paid at 100 percent of the Federal Rate, which is proposed to be $37,975.53 for the 2006 rate year. Therefore, the proposed budget neutrality adjustment is 0.998.

The proposed rule would revise the labor market area definitions to be based upon the Core-Based Statistical Areas (CBSAs) designated by the Office of Management and Budget using the 2000 Census Data. This is consistent with the realignment of the labor market areas that were adopted in the FY 2005 hospital IPPS, published in August 2004. In unusually costly cases, Medicare will pay a hospital an amount in addition to the payment under the LTCH PPS for the LTC Diagnosis Related Group (DRG). To be eligible for this payment, the hospital's estimated costs in treating the case must exceed the LTC-DRG payment by an outlier fixed-loss amount. The proposed rule would set the outlier fixed-loss amount for rate year 2006 at $11,544, down from $17,864 in rate year 2005. This means that more cases would potentially qualify for outlier payments. The proposed rule would also extend for one year the surgical DRG exception to the three-day or less interrupted stay policy, which allows an acute care hospital providing care to an LTCH patient that is grouped to a surgical DRG under the acute care hospital inpatient prospective payment system (IPPS) to receive a separate payment under the IPPS. The three-day or less interrupted stay policy provides that Medicare will only pay for one LTC-DRG in situations in which a patient is discharged to an acute care hospital, inpatient rehabilitation facility (IRF), skilled nursing facility (SNF) or to the patient's home and is readmitted to the long-term care hospital within three days. Further, payment for any covered inpatient or outpatient services provided by an acute care hospital or IRF, or any covered services provided by a SNF to the LTCH patient during the interruption, is the responsibility of the LTCH. This policy is in accord with legal requirements that an LTCH must provide such services either directly or "under arrangements" with the facility that actually provides the service, and no additional payment by Medicare would be made. If the interruption exceeds 3 days but is within the applicable fixed day period, Medicare payments to the LTCH are governed by the greater than 3 day interrupted stay policy. Under this policy, the entire LTCH hospitalization, both before and after the interruption, is seen as one episode of care, generating one LTC-DRG payment; however, the intervening provider receives a separate payment under the applicable prospective payment system.

The proposed rule discusses CMS efforts to address recommendations affecting LTCHs in the June 2004 Medicare Payment Advisory Commission (MedPAC) Report to Congress. Specifically, MedPAC recommended that CMS more clearly define the role of LTCHs in the inpatient continuum of care by establishing facility and patient criteria and that Medicare's Quality Improvement Organizations play a larger role in reviewing LTCH admissions for medical necessity and for compliance with any facility and patient criteria. The proposed rule describes a recent contract awarded to Research Triangle

Institute, International to research the feasibility of implementing the Commission's recommendations, as well as CMS's ongoing monitoring of LTCHs under the new PPS. CMS is not revising the LTC-DRGs and relative weights at this time. Because the LTC-DRGs and their relative weights are related to the inpatient hospital DRGs, those changes will be made at the same time as the hospital IPPS update on October 1, 2005.

The proposed rule will be published in the February 3, 2005 Federal Register. Comments will be accepted until March 29, and a final rule will be published later this spring. This rule proposes that the payment rates and policies be effective for discharges on or after July 1, 2005, through June 30, 2006.

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More Detailed Information on CMS' Flu Demonstration:

Medicare beneficiaries who get the flu can get assistance to help pay for antiviral medicines under a demonstration project announced by CMS Administrator Mark B. McClellan, MD, PhD. Dr. McClellan stated, "There are prescription drugs that have been proven to prevent the flu and its serious complications, and Medicare is taking steps to make these drugs more affordable." He went on to state, "This demonstration project will provide useful evidence on how prescription drug coverage affects the health and costs for Medicare beneficiaries ahead of the drug benefit in 2006."

The Influenza Treatment Demonstration provides coverage to all Medicare beneficiaries, (including traditional Part B, Medicare Advantage, and Drug Discount Card participants), for FDA-approved drugs for the treatment and targeted prevention of influenza. Medicare will cover up to two prescriptions for Amantadine; Zanamivir; Oseltamivir; and Rimantadine, and their generic equivalents, when prescribed by a qualified physician or allied health professional. Treatment must be for beneficiaries with symptoms of influenza, as prevention if they are exposed to diagnosed influenza or to a beneficiary in an institution where there has been an outbreak of influenza. However, the demonstration does not cover these anti-viral drugs for general prophylactic use.

The demonstration is effective for dates of service through May 31, 2005. For more information, please go to:
http://www.cms.hhs.gov/researchers/demos/flu .

For provider information, please visit the Medlearn Website to view the Medlearn Matters article at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3696.pdf

or contact FLUMEDDEMO@CMS.HHS.GOV .

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Beneficiary-Related Information:

The following publications have recently arrived at the CMS Warehouse:

1) Publication Number: 11100 "Staying Healthy-Medicare's Preventive Services" - English (Publication Date: December, 2004);

2) Publication Number: 11061-S "The Facts About Medicare Advantage"- Spanish (Publication Date: June, 2004);

3) Publication Number: 11080 "The Facts About Medicare Preferred Provider Organizations"- English (Publication Date: August, 2004);

4) Publication Number: 11080-S "The Facts about Medicare Preferred Provider Organizations" - Spanish (Publication Date: August, 2004);

5) Publication Number: 10969-B "Medicare and Home Health Care" - Braille(Revision Date: August, 2004); and

6) Publication Number: 10128-B "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services" - Braille (Revision Date: August, 2004).

You may place an order to obtain additional copies of the publications listed above, by using the CMS Warehouse Reorder Form in the CMS Publication Mailing List at http://www.cms.fu.com/mailinglist . When ordering publications, please remember to:
-- Update contact information and shipping address information on the edit user information screen;
-- Print the verification screen after you order the publications; and
-- Use the "HELP" button at the top or bottom of the screen if you have questions about ordering publications or updating information on the Publication Mailing List. For other questions, please contact mailpubs@cms.hhs.gov .

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Hope you're having an enjoyable evening!

Valerie

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February 3, 2005

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The direct URL is,
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or the "Fact Sheet" links can be used from the IRF home page at,
http://www.cms.hhs.gov/providers/irfpps/default.asp .

Best regards,

Valerie

Hello again! The news items today should be of particular interest to physicians, limited license practitioners, and pharmacies.

HHS PROPOSES NEW MEDICARE E-PRESCRIBING RULES
HHS Secretary Mike Leavitt recently announced new proposed regulations that will support electronic prescriptions for Medicare when the prescription drug benefit takes effect in January 2006.

"These proposed e-prescription rules would set standards to help Medicare, physicians and pharmacies take advantage of new technology that can improve the health care of seniors and persons with disabilities." Secretary Leavitt said.
"We are committed to widespread use of e-prescribing as quickly as possible," said Mark B. McClellan, M.D., Ph.D., administrator of the Centers for Medicare & Medicaid Services (CMS). "In issuing these proposed rules today, seven months ahead of the deadline set by the Medicare Modernization Act (MMA), we are laying the foundation for having major e-prescribing standards in place when the Medicare drug benefit begins.

The proposed e-prescribing regulations will adopt standards for:

- Transactions between prescribers and dispensers for new prescriptions, prescription refill request and response, prescription change request and response, prescription cancellation request and response, and related messaging and administrative transactions.

- Eligibility and benefits inquires and responses between drug prescribers and prescription drug plans.

- Eligibility and benefits inquiries and responses between dispensers and Part D sponsors.

- Formulary and benefit coverage information, including information on the availability of lower cost, therapeutically appropriate alternative drugs, if certain characteristics are met.

To view the entire press release:
http://www.hhs.gov/news/press/2005pres/20050127.html

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MEDICARE EXPANDS COVERAGE OF IMPLANTABLE DEFIBRILLATORS

CMS recently announced that it is expanding Medicare coverage of implantable cardioverter defibrillators (ICDs), a move expected to save thousands of lives a year.

"Our expanded coverage for devices to prevent sudden death in people with heart disease will save thousands of lives each year and improve the quality of life for America's seniors," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "By increasing the use of defibrillators we are striking a blow against the leading cause of death among older Americans."

"This coverage decision demonstrates our determination to save lives by making prompt coverage decisions using new medical evidence, and to improve the evidence available to doctors and patients to help them get the greatest benefits while avoiding unnecessary risks and costs," McClellan said.

CMS also announced that it proposes to expand Medicare coverage of ultrasound stimulation for non-healing fractures to beneficiaries enrolled in comparative prospective clinical trials. Both decisions provide for developing further evidence that will lead to more informed medical decisions, resulting in higher quality care and greater value in health care spending. The expansion will increase the number of Medicare beneficiaries eligible for an ICD by one-third, to nearly 500,000. CMS expects to provide this therapy to at least 25,000 additional patients in the first year of coverage, potentially saving up to 2,500 lives.

Coronary heart disease is the single most common cause of death in the United States. Sudden death, frequently from heart arrhythmias, is estimated to account for approximately 50 percent of all coronary heart disease deaths. An ICD is implanted in a patient's chest to monitor the heart's rhythm and deliver an electrical shock when a life-threatening arrhythmia is detected.

The expanded ICD coverage was prompted by results of a well-designed trial, labeled the Sudden Cardiac Death in Heart Failure Trial (SCD-HeFT), sponsored by the National Heart, Lung and Blood Institute. It is a prospective, randomized trial to compare the effectiveness of medication, implantable defibrillators and placebo on survival in patients with heart failure.

Based on the clinical trial results, published in the New England Journal of Medicine on January 20, 2005, the decision provides coverage for the population studied in the trial, including patients with heart failure and poor function of their left ventricle. In addition, careful analysis of the new data from this trial in combination with data from all previous ICD trials showed that patients with a certain finding on electrocardiograms of their heart, called a narrow QRS, may also derive a small but measurable, significant benefit from having an ICD.

As part of the coverage decision, CMS will require the submission of specific demographic, clinical, provider and device data into a data registry at the time of the procedure. This process will ensure that patients are receiving high quality, medically

necessary care, and will also provide valuable new information about the optimal use of ICDs. The ICD Abstraction Tool is available on the Quality Network Exchange, a system that hospitals currently use to abstract and send quality measures to CMS.

CMS is working with cardiology specialty societies, product manufacturers, health plans and experts from the clinical community to develop a follow-on registry that will continue to collect the important data that the QNET registry has collected as well as other data that will answer additional important questions on the use of ICDs. Leaders from the ICD industry have also agreed to support additional studies that will address some of the remaining questions on the optimal use of ICDs, including identification of patient populations that benefit most from ICDs.

"Support for practical studies as part of our coverage decisions is designed to ensure that patients are getting the beneficial care they need, and to provide additional evidence to help doctors and patients get the most out of new technologies," McClellan said. "We want to deliver high quality care while also developing better information about which patients benefit most from having an ICD."

"With more accurate information, clinicians can do more to ensure that patients at the highest risk who can benefit most from the device can get them," said Sean Tunis, M.D., the chief medical officer for CMS. "We will continue to work with experts and stakeholders to identify the best ways to support the development of this information to help our beneficiaries get even better care."

Some future Medicare coverage decisions may also link coverage to the collection of additional prospective clinical data. The CMS Council on Technology and Innovation is developing a draft guidance document on this policy approach in order to ensure that this aspect of the coverage process reflects a systematic, science-based approach that is predictable and transparent. An open door forum on this topic will be held on Feb 14 2005 to obtain public input on linking coverage to practical trials and registries, prior to the development of the draft guidance. In addition, comments on this approach can be submitted through the CTI website at http://www.cms.hhs.gov/providers/cti. The initial draft guidance will be issued by March 31, 2005, at which time additional public feedback will be solicited.

CMS has determined that the national coverage determination (NCD) for ICDs meets the significant cost threshold of the Social Security Act and CMS regulations. Thus, CMS will make payments on a fee-for-service basis through the Medicare fiscal intermediaries and carriers through December 31, 2005. Medicare Advantage organizations are not required to assume risk for the costs of this service r benefit until the contract year for which payments are appropriately adjusted to take into account the cost of the service. Medicare Advantage enrollees will be liable for any applicable coinsurance under original fee-for-service Medicare.

The proposed Medicare coverage decision on ultrasound stimulation for fractures, also announced today, would expand coverage for fractures that have not been healing

properly (nonunion fractures) when the provider is participating in and patients are enrolled in a comprehensive prospective clinical trial approved by Medicare. Ultrasound stimulation, a non-invasive treatment of nonunion fractures, has been covered for Medicare beneficiaries since 2000. A nonunion fracture is a fracture that has had no visible or x-ray signs of healing for at least three months and healing will not proceed without some type of intervention. The proposed coverage expansion would remove a requirement that surgery must have failed before ultrasound can be used as a treatment only if the beneficiaries is enrolled in a prospective comparative clinical trial with the goals of monitoring, evaluating, and improving clinical outcomes.

CMS will accept public comment on the proposed NCD regarding ultrasound stimulation proposal for 30 days and will publish a final decision within 90 days.

Medicare coverage decisions and proposed coverage decisions can are available on the CMS web site at www.cms.hhs.gov/coverage. This press release can also be found at this website
http://www.cms.hhs.gov/media/press/release.asp?Counter=1331.

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MEDICARE TO COVER APREPITANT (EMEND®) AS PART OF A THREE-DRUG REGIMEN FOR CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING

CMS recently announced that it intends to cover the oral drug aprepitant for the treatment of chemotherapy-induced nausea and vomiting (CINV) in patients who do not respond to the standard drugs used to treat these symptoms that often occur with some anti-cancer chemotherapeutic drugs.

Because evidence in clinical trials has shown that aprepitant is more effective for the treatment of CINV when used in combination with other anti-emetic (anti-vomiting) drugs, aprepitant would be covered by Medicare only when used in combination with two standard anti-emetics drugs, a 5-HT3 antagonist and dexamethasone.

"We are continuing to work to keep our coverage up-to-date with advances in medical technology that improve beneficiary health," said CMS Administrator, Dr. Mark McClellan, MD, PhD. "This new drug coverage will provide important help for some patients undergoing chemotherapy who don't respond to the usual nausea treatments."

Generally Medicare does not cover drugs that are self-administered by the patient, such as oral drugs. However, the law provides coverage for oral drugs used to treat CINV if the oral anti-emetic drug functions as a replacement for the intravenous drugs that would have otherwise been administered. In this case, the combination of the three drugs will replace the intravenous drugs that would otherwise be necessary.

CMS is aware that aprepitant may likely have other uses beyond those consistent with the part B proposed benefit category determination. Beginning January 1, 2006, aprepitant for these other uses will be covered under Medicare Part D, the new prescription drug

benefit created by the Medicare Modernization Act of 2003 (MMA). As a result, aprepitant would be covered under part B for the indications specified in the proposed National Coverage Decision (NCD) and under part D for others. Based on the NCD guidelines, it will then be up to the provider to determine whether aprepitant is prescribed under part B or part D. Part D indications may likely represent the largest proportion of the use of aprepitant by Medicare beneficiaries.

Specifically under this draft NDC, CMS is proposing that Medicare cover aprepitant when it is used as part of a three-drug anti-emetic regimen used to treat the nausea and vomiting caused when patients undergo treatment with anti-cancer chemotherapeutic drugs that fall into level 5 on the Hesketh's classification system of anti-cancer chemotherapeutic agents that are highly likely to cause nausea and vomiting. In addition, these patients have not responded to standard antiemetic regimens that did not include aprepitant.

CMS is requesting public comments on the proposed national coverage determination available for review online by clicking on the link, "Aprepitant for Chemotherapy-Induced Emesis" on the CMS coverage website:
http://www.cms.hhs.gov/mcd/index_list.asp?list_type=nca

This press release can also be found at
http://www.cms.hhs.gov/media/press/release.asp?Counter=1307

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MEDICARE BEGINS PERFORMANCE-BASED PAYMENTS
New Demonstration Program Tests Financial Incentives for
Improved Quality and Coordination in Large Group Practices

CMS recently announced new initiatives to pay health care providers for the quality of the care they provide to seniors and people with a disability, reflecting an Administration commitment to reward innovative approaches to get better patient outcomes at lower costs.

"Better care should be rewarded, and thanks to growing support from health care providers and other stakeholders, we have better approaches to doing so than ever before," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "It is time that we pay for the quality of the health care provided to our beneficiaries, not simply the amount. We are working to apply this in every setting in which Medicare and Medicaid pays for care."

As another step in its efforts to make higher payments for quality, CMS today announced that ten large physician groups across the U.S. will participate in the first pay-for-performance initiative for physicians under the Medicare program. The Physician Group Practice demonstration gives physician groups an opportunity to demonstrate that improving care in a proactive and coordinated manner also saves money.

Currently, Medicare reimburses physicians and other health care providers on the number and complexity of the services provided to patients. There is good evidence that by anticipating patient needs, especially for patients with chronic diseases, health care teams that partner with patients can intervene before expensive procedures and hospitalizations are required. The Physician Group Practice demonstration is designed to encourage this and other preventive efforts.

"Not only is there a growing consensus that providers who furnish better care should be rewarded, there should be an agreement on how to reward those providers," said Dr. McClellan. "Our new pay-for-performance initiative for physicians reflects hard work by physicians, consumer advocates, and other health care payers and purchasers to develop valid measures of quality and efficiency, and to use them effectively to support better care."

During the three-year Physician Group Practice project, CMS will reward ten physician groups in various communities across the nation that improve patient outcomes by coordinating care for chronically ill and high cost beneficiaries in an efficient manner. The physician groups participating in the demonstration are: Dartmouth-Hitchcock Clinic, Bedford, New Hampshire; Deaconess Billings Clinic, Billings, Montana; The Everett Clinic, Everett, Washington; Geisinger Health System, Danville, Pennsylvania; Middlesex Health System, Middletown, Connecticut; Marshfield Clinic, Marshfield, Wisconsin; Forsyth Medical Group, Winston-Salem, North Carolina; Park Nicollet Health Services, St. Louis Park, Minnesota; St. John's Health System, Springfield, Missouri; and the University of Michigan Faculty Group Practice, Ann Arbor, Michigan.

CMS will assess both quality performance and quality improvement under the demonstration. The quality measures that will be used focus on common chronic illnesses in the Medicare population, including congestive heart failure, coronary artery disease, diabetes mellitus, hypertension, as well as preventive services, such as influenza and pneumococcal pneumonia vaccines and breast cancer and colorectal cancer screenings.

Under the demonstration, physician groups will continue to be paid on a fee-for-service basis. Physician groups will implement care management strategies designed to anticipate patient needs, prevent chronic disease complications and avoidable hospitalizations, and improve quality of care. Depending on how well these strategies work in improving quality and avoiding costly complications, physician groups will be eligible for performance payments.

Physician groups were selected through a competitive process. Groups were selected based on technical review panel findings, organizational structure, operational feasibility, geographic location, and implementation plan. The multispeciality groups have at least 200 physicians and include freestanding group practices, integrated delivery systems, faculty group practices and independent practitioner associations.

"Effective performance-based payments have shown results in the private sector, and CMS has already started programs and demonstrations to reward quality improvement in hospitals," Dr. McClellan said. "By bringing the same kind of enhanced support for better quality to physicians, we are reaching the providers that have the greatest impact on decisions about patient care. This approach has great potential for improving care for our beneficiaries and strengthening the Medicare program."

CMS is conducting or developing additional programs that use incentive payments to further improve the quality of health care available to patients, including the following:

• The Hospital Quality Initiative in which nearly all hospitals in the U.S. are being paid higher rates for submitting data that reports on the level of recommended care provided and will include patient perspectives on the quality of care received;

• The Premier Hospital Quality Incentive demonstration, in which approximately 280 hospitals are being paid bonuses for achieving high performance in treating five clinical conditions;

• The Medicare Chronic Care Improvement Program, Medicare's first large-scale pay-for-performance program to reduce health risks for defined populations of chronically ill beneficiaries;

• The Medicare Care Management Performance demonstration, which will test methods to promote the use of health information technology for improving the quality of care for chronically ill Medicare patients;

• The development and utilization of standard performance measures in every setting; and

• Additional disease management and coordinated care initiatives for beneficiaries with certain chronic conditions or high costs.

CMS is continuing to collaborate with a wide range of other public agencies and private organizations who have a common goal of improving quality and avoiding unnecessary health care costs, including the National Quality Forum, the Joint Commission of the Accreditation of Health Care Organizations, the Agency for Health Care Research and Quality, the American Medical Association, and many other organizations. CMS is also providing technical assistance to a wide range of health care providers through its Quality Improvement Organizations.

In addition to the initiatives for hospitals, physicians, and physician groups described above, CMS is also exploring opportunities in nursing home care - building on the progress of the Nursing Home Quality Initiative - and is considering approaches for home health and dialysis providers as well. Finally, recognizing that many of the best opportunities for quality improvement are patient-focused and cut across settings of care, CMS is pursuing pay-for-performance initiatives to support better care coordination for patients with chronic illnesses.

Further information on the demonstration is available at
http://www.cms.hhs.gov/researchers/demos/pgp.asp

I hope you enjoy your day.

Valerie

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February 15, 2005

Hello everyone. Today I have two important items to bring to your attention ~

1. Contractor Provider Satisfaction Survey

I recently sent you a note regarding a Medicare Contractor Provider Satisfaction Survey that CMS launched in January. In that note, I asked for your help in getting the word out about the survey--and I'm here to ask for that help again! The response rate so far has been lower than expected so we're asking that you send the following message to your association members:

"Medicare Contractor Provider Satisfaction Survey - Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) recently announced the launch of the Medicare Contractor Provider Satisfaction Survey (MCPSS), a new initiative designed to collect data on provider satisfaction with and perceptions about the services provided by Medicare Fee-for-Service (FFS) contractors. The MCPSS was sent to a random sample of approximately 8,200 Medicare FFS providers in January 2005.

The survey gives providers the opportunity to rate their Medicare contractor on seven administrative functions: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider reimbursement. CMS highly values the opinions of the Medicare physician and provider community and understands the important role that FFS contractors play in representing the Medicare program to providers. The MCPSS represents an important opportunity for providers to be heard.

Westat, a survey research firm, is administering the MCPSS. Providers who received the survey notification packet can access the survey instrument on a secure Internet Web site or may request a paper copy and submit their responses via mail or fax. All information collected will be kept completely confidential, and individual providers will not be identified. Data collection for the pilot will continue through March 31, 2005. If you received a survey notification packet, please complete and submit your survey responses as soon as possible.

For questions regarding the MCPSS, please contact the MCPSS information line at 1-888-863-3561 or MCPSS@westat.com. For further information and updates, please visit http://www.cms.hhs.gov/providers/mcpss/default.asp ."

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2. Modified Edits for Matching Claims Data to Beneficiary Records

In October 2004, CMS made a software change to require an exact match on beneficiary First Initial, Surname, and Health Insurance Claim Number submitted on the claim. Since this change was implemented, the number of denials because of name/number mismatch has tripled. As a result, we have issued a Special Edition *Medlearn Matters* article to provide clarification on what providers need to do to avoid this type of claim denial. This article can be viewed at www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0516.pdf .

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As always, thank you very much for your help in getting information out to Medicare providers through your association members.

Best regards,

Valerie

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February 25, 2005

Good morning, everyone. As I prepare to dig out from the latest snowfall, I thought I'd pass along these items of interest--

OF PARTICULAR INTEREST TO PHYSICIANS AND HOSPITALS

We recently published *Medlearn Matters* Special Edition article SE0517, which describes a new tool available for registering patients with Implantable Cardioverter Defibrillators. Please be sure to view this article at:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0517.pdf .

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MEDICARE CONTRACTING REFORM UPDATE

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires CMS to take the necessary steps between now and 2011 to implement Medicare Contracting Reform (MCR). Although health care delivery in the United States has evolved with four decades of advances in medicine and technology, the contracting portion of Medicare's fee-for-service administrative structure has not.

MCR will bring standard contracting principles to Medicare such as competition and performance incentives that the government has long applied to other federal programs under the Federal Acquisition Regulation. CMS is required to replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. The law directs CMS to conduct full and open competitions for new Medicare Administrative Contractors (MACs), who will perform the work currently being handled by
fiscal intermediaries, carriers, regional home health intermediaries,and durable medical equipment regional carriers in administering the Medicare fee-for-service program.

The MMA also requires CMS to submit a Report to Congress that describes the plan for implementation of MCR. CMM released the Report to Congress on February 7, 2005. The report describes the steps the Secretary intends to take to implement the MAC authority, resources and funding including the associated savings resulting from this implementation, and
key accomplishments to date. To view the Report to Congress, visit the MCR website:
http://www.cms.hhs.gov/medicarereform/contractingreform/.

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COORDINATION OF BENEFITS UPDATE

The Centers for Medicare & Medicaid Services (CMS) is consolidating the Medicare claims crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement (COBA) initiative. A Special Edition Medlearn Matters article (SE0504) has been written to inform you of system changes to implement a
switch from 1) Medicare intermediaries, carriers, and Durable Medical Equipment Regional Carriers (DMERCs) crossing supplemental claims to supplemental insurers to

2) a single entity, the Coordination of Benefits Contractor (COBC), doing the same from one location. To view the Medlearn Matters article, go the following link: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0504.pdf.

For more information about Implementation of the Consolidated Coordination of Benefits Agreement Program, go the following page on the CMS Website:
http://www.cms.hhs.gov/medicare/cob/coba/coba.asp .

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CMS ANNOUNCES NEW, MORE SPECIFIC CODES FOR WHEELCHAIRS

In its continuing effort to improve Medicare coverage and payment for power wheelchairs and scooters, while protecting the Medicare program and taxpayers from abuse, the Centers for Medicare & Medicaid Services (CMS) recently released draft coverage criteria for these devices, as well as new codes to ensure proper payment. These steps were outlined in our Modern Mobility Initiative announced last April.

Medicare's proposed coverage criteria would rely on clinical guidance for evaluating whether a beneficiary needs a device to assist with mobility, and if so, what type of device is needed.
CMS plans to publish the final NCD in March and to provide guidance on how to use and document the new criteria.

CMS is also establishing new billing codes for power wheelchairs and scooters to assure that Medicare pays appropriately for these devices. To better reflect the range of power mobility products now available on the market, Medicare will expand the number of codes used for billing from 5 to 49. The more detailed coding will help facilitate getting the right products to patients and improve Medicare's ability to pay suppliers appropriately. The codes will go into effect on January 1, 2006.

The proposed National Coverage Decision will be posted on the CMS Website at www.cms.hhs.gov/coverage. Comments on the proposed NCD will be accepted until March 7, 2005. A description of the new billing codes for wheelchairs will be posted on the CMS Website at www.cms.hhs.gov/suppliers/dmepos.

You can view the press release online at:
http://www.cms.hhs.gov/media/press/release.asp?Counter=1345

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Looking forward to spring, I send you my best regards,

Valerie

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