U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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The Pulse of CMS

"A quarterly regional publication for health care professionals"
Serving Arkansas, Louisiana, New Mexico, Oklahoma and Texas.

CMS Responds in the Wake of Hurricane Katrina

The Centers for Medicare & Medicaid Services expresses the deepest sympathies to those devastated by the effects of Hurricane Katrina. In the wake of the destruction inflicted on the Gulf Coast, CMS has acted to ensure that the Medicare, Medicaid and SCHIP programs will accommodate the emergency health care needs of both beneficiaries and providers. The agency has taken many steps to ease some of the operating procedures, including many documentation requirements, to assist in the delivery of needed health care services to beneficiaries that have been displaced around the country. A full summary of the actions taken by CMS can be found on the website.

Additionally, guidelines have been established to help providers in the affected areas get in touch with their respective fiscal intermediaries and carriers. If you are a provider that processes claims through the following Medicare contractors, please go to the website for instructions on how to get in touch with them:

- Trispan, Mutual, Cahaba MS, Cahaba AL, Cahaba IA, Palmetto, Arkansas BCBS, TrailBlazer Health Enterprises, UGS, Riverbend GBA

For a complete overview of the relief efforts underway not only at CMS, but at the Department of Health & Human Services, and for a daily-updated list of FAQs, please go to the CMS website.

National Provider Identifier...

Inside this Issue...

NPI
National Provider Identifier
Sign up NOW!
https://nppes.cms.hhs.gov
Deadline date is May 23, 2007

Over 50,000 providers have already received their numbers
Have you?
For more information about NPI visit our website at
www.cms.hhs.gov/hipaa/hipaa2

Medicare & Medicaid Programs Turn 40!

On Saturday, July 30, we celebrated the 40th anniversary of the enactment of the Medicare and Medicaid programs.

Harry S. Truman was the first U.S. President to propose a prepaid health insurance plan. On November 19, 1945, in a special message to Congress, President Truman outlined a comprehensive, prepaid medical insurance plan for all people through the Social Security system. The plan, dubbed "National Health Insurance," included physicians, hospitals, nursing, laboratory, and dental services. Medical insurance benefits for those in need were financed from Federal revenues. Nearly twenty years later on July 30, 1965, President Lyndon Johnson signed into law—with Harry Truman at his side—an amendment to the Social Security Act creating the Medicare and Medicaid programs.

Medicare was the responsibility of the Social Security Administration (SSA), while Federal assistance to the State Medicaid programs was administered by the former Social and Rehabilitation Services (SRS). SSA and SRS were agencies in the Department of Health, Education, and Welfare (HEW).

In 1977, the Health Care Financing Administration (HCFA) was created under HEW to effectively coordinate Medicare and Medicaid. In 1980 HEW was divided into the Department of Education and the Department of Health and Human Services (HHS), with HCFA falling under the purview of HHS. In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).

Since the beginning, Medicare and Medicaid have provided health care for millions of people with disabilities, working families, the elderly, children, and moms-to-be. As Medicare and Medicaid turn 40, the next phase of the programs is right around the corner: the new Medicare prescription drug benefit.

MMA Mobile Office Tour Visits Region VI

HHS Secretary Michael Leavitt and CMS Administrator Mark McClellan. M.D., Ph.D., visited five cities in Region VI as part of the Medicare Mobile Office Tour (MOT) to promote the prescription drug benefit. Regional Director (RD) Linda Penn participated in each of the visits and Intergovernmental Affairs (IGA) Specialist Ashlea Quinonez provided support for press relations. Office of the RD and CMS staff supported each visit by inviting partners, arranging sites, and providing logistical site support.

On August 22, the Dallas-Fort Worth MOT event was held at the Lewisville Medical Center north of Dallas. Congressman Michael Burgess (R-TX) hosted the meeting and joined Secretary Leavitt and Dr. McClellan in asking partners to help inform seniors about the new benefit. Lewisville Mayor Gene Carey offered welcoming remarks. Both the partners meeting and the community meeting were well attended and covered by local television and radio stations.

The next day, the MOT traveled to New Orleans, Baton Rouge, and Houston, holding partner and community meetings in each city. In New Orleans, Dr. Kevin Stephens, the city's health director, attended on behalf of Mayor Ray Nagin. Congressman William Jefferson, State Representative Arthur Morrell, and City Councilwoman Cynthia Morrell attended the community event at the Ponchartrain Park Senior Center.

The Baton Rouge MOT included a strong partner meeting with about 45 participants and a community event at the Bishop Robert E. Tracy Center. Governor Kathleen Blanco participated in the meetings. Other attendees included Health and Hospitals Secretary Dr. Fred Cerise, Executive Director of the Governor's Office of Elderly Affairs Godfrey White, Executive Director of the Governor's

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Open Letter to Partners: Where to Go for Prescription Drug Materials

The Medicare Modernization Act (MMA) contains a number of substantive changes that will help your patients who are Medicare beneficiaries. Among the changes are a new prescription drug benefit, coverage for preventive checkups, improvements to Medicare managed care (Medicare Advantage) plans, and a retiree options program that allows employer health plans to preserve and/or expand retiree drug coverage. CMS is actively working on an educational campaign to provide information about these new features to our nation's 43 million Medicare beneficiaries.

A good source of information about MMA and Medicare prescription drug coverage can be found at http://www.cms.hhs.gov/medicarereform/pdbma/provider.asp. This website contains a wealth of information including timelines, issue papers, and information about eligibility and enrollment. We have also finalized a provider toolkit, which is available at our Partner Center on the web.

As our educational campaign progresses, we will provide you with more information about prescription drug coverage. If you'd like to be automatically notified as soon as new beneficiary educational materials are made available, you can sign up for a mailing list at http://www.cms.hhs.gov/mailinglists/. Scroll down to PART_D_COV_ BENE_EDU and click on the "subscribe" button.

We look forward to working with you to educate Medicare beneficiaries and their caregivers. If you have any questions regarding the Medicare Modernization Act and the new Medicare prescription drug coverage, please do not hesitate to call us. Our contact info is located on page ___.

We look forward to partnering with you to spread the word about this important coverage.

Legislative Corner: Health Information Technology

Last April, the President made healthcare quality and safety a priority by setting a goal for most Americans to have an electronic health record (EHR) by 2014. An EHR allows for entry and storage of a wide variety of patient information in electronic format, and subsequent access to this information by healthcare providers, patients, and other authorized users. The ability to share health information in a secure environment has the potential to improve patient safety, as well as the quality, effectiveness, and efficiency of patient care.

As Congress reconvenes for the fall legislative session, health information technology (IT) is likely to be at the forefront of many healthcare-related debates. Over the past year, Congress has expressed considerable interest in the work that the Department of Health and Human Services (HHS) has done to promote the adoption and use of health IT. This summer alone, the Secretary of HHS, the National Coordinator for Health IT, and the Administrator of CMS have all participated in numerous hearings on the Hill to discuss healthcare quality, pay-for-performance, and health IT. To date this year, at least 20 pieces of legislation have been introduced in the House and Senate related to the development of health IT standards and/or the use of health IT for the purposes of quality measurement, reporting, and performance improvement. We expect that additional legislation will be introduced this fall.

HHS has no shortage of health IT activities to talk about. In the past few months, HHS has created the American Health Information Community (AHIC) and released four requests for proposals (RFPs), all focused on developing common EHR standards and building a Nationwide Health Information Network. In addition, CMS is developing the Medicare Care Management Performance Demonstration (MMA Section 649), a three-year pay-for-performance demonstration with physicians to promote the adoption and use of health IT to improve the quality of patient care for chronically ill Medicare patients.

The CMS Office of Legislation will be monitoring all of this activity carefully in the coming months, as the adoption of health IT will be integral to improving healthcare quality and transforming our payment systems over the next few years to reward providers for the quality of care they are giving to beneficiaries.

New Options for In-Office Drug Administration

Beginning with drugs administered on or after January 1, 2006, physicians will be given a choice between buying and billing Part B drugs under the average sales price system, or obtaining these drugs from vendors selected in a competitive bidding process.

Section 303 (d) of the Medicare Modernization Act (MMA) requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs. Physicians can decide to order the drugs they need to administer to their patients from vendors, who in turn will bill Medicare for the drugs and bill the patients for any coinsurance or deductibles.

The new program will apply to physician-injectable drugs covered under Medicare's Part B program that are commonly provided incident to the physician's service. Of approximately 440 drugs that are billed incident to a physician service and paid under Part B, 181 drugs will be included in the CAP, accounting for 85 percent of all Medicare spending on physician injectable drugs. Physicians will be given an opportunity once a year to elect to participate in the program and to choose a vendor to be the physician's primary source for the Part B drugs included in the CAP.

For physicians choosing to participate in the program, obtaining drugs for their patients will be straightforward: they no longer have to buy the drugs, collect the co-payments, or bill Medicare for the drug. After electing to participate in CAP and selecting one of the available vendors, physicians will order the drugs needed for specific beneficiaries from the vendor and administer them to the beneficiaries. Physicians will bill Medicare only for the service of administering the drugs. The vendors, rather than the physicians, will bill Medicare for the drugs and will be responsible for collecting any deductibles and coinsurance on the drugs from the beneficiary or a third party insurer such as Medigap after the drugs have been administered.

For more information, please go to http://www.cms.hhs.gov/providers/drugs/compbid/default.asp

CMS Proposes 3.2 Percent Increase in Hospital Payments

CMS announced that acute care hospitals will receive a 3.2 percent inflation update in Medicare payment rates in 2006 for outpatient services under a proposed Outpatient Prospective Payment System (OPPS) rule announced July 18. Sole community hospitals in rural areas will receive an additional 6.6 percent payment adjustment, a result from a study authorized by the Medicare Modernization Act of 2003 (MMA).

Also in keeping with reforms in outpatient payment stemming from the MMA, CMS is proposing to pay for most Part B drugs, biologicals, and radiopharmaceuticals administered in hospital outpatient departments based on competitive market prices. These drugs are primarily injectible drugs administered by clinicians and used to treat cancer and other conditions. They are currently paid at 83 percent of the average wholesale price (AWP) - a price that is often significantly higher than prices charged in the market. The new proposed payment at 106 percent of the manufacturer's average sales price (ASP) reflects the pricing methodology already used for drugs administered in the physician's office. Payment rates would be updated quarterly.

The changes to the payment rates and increased volume of services contribute to an overall increase in projected payments to over 4,200 hospitals for Medicare outpatient services of $27.5 billion in 2006, compared to projected payments of $26.1 billion in 2005, an increase of 5.4 percent.

"Today's proposed rule will help ensure that beneficiaries have access to quality services in the hospital outpatient setting no matter where they live," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "In addition, the proposed rule …contains a number of changes designed to make sure that Medicare makes efficient use of taxpayer money through more accurate payments for drugs…in hospital outpatient departments."

The proposed rule was published in the *Federal Register* on July 25th. Comments will be accepted until Friday, September 16, 2005, and a final rule is scheduled to be published by November 1, 2005. More info….website.

Update on Demonstration Projects

CMS conducts and sponsors a number of innovative demonstration projects to test and measure the effect of potential program changes. These demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Evaluation projects validate research and demonstration findings and help to monitor the effectiveness of Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Click on the links below for more information.

Requests for Information • Frequent Hemodialysis Network Clinical Trials	Open Solicitations • Medicare Health Care Quality Demonstration • Demonstration Project for Medical Adult Day Services
Active Demonstrations Accepting Enrollment • Medicare Replacement Drug Demonstration • Home Health Independence Demonstration • Medicare Lifestyle Modification Program Demonstration	Upcoming Demonstrations • Bundled Case-Mix Adjusted Payment System for ESRD • Consumer-Directed Chronic Outpatient Services • Senior Risk Reduction Program

Expanded Efforts to Improve Payment Accuracy

As part of its responsibility to oversee the Medicare Trust fund, CMS monitors the accuracy of Medicare fee-for-service (FFS) payments. CMS combines two error rate programs to define the overall Medicare Error rate. The two error rate programs are:

- The Comprehensive Error Rate Testing (CERT) program which calculates the error rate for Carriers (Part B services), Durable Medical Equipment Carriers (DMERCs – Durable medical equipment and supplies) and Fiscal Intermediaries (FIs – Part A services), and
- The Hospital Payment Monitoring Program (HPMP) which calculates the error rate for the Quality Improvement Organizations (QIOs – inpatient acute care).

Since 1996, the Department of Health and Human Services (HHS) annually determined the error rate for FFS claims. From 1996 until 2002, the HHS Office of the Inspector General (OIG), using a sample size of about 6,000 claims, conducted the process used to measure Medicare payment error rates. The measured error rate declined from 13.8 percent in 1996 to 6.3 percent in 2002. As part of the agency's enhanced efforts to improve payment accuracy, CMS began calculating the Medicare FFS error rate in 2003 and estimated improper claim

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Medication Therapy Management: A New Opportunity for Providers

Like the rest of the Medicare prescription drug benefit, medication therapy management (MTM) will be a new service for Medicare. Plans offering the new Medicare drug benefit will be required to have a medication therapy management program to ensure that drugs prescribed for targeted beneficiaries are appropriately used to optimize therapeutic outcomes and reduce the risk of adverse events. CMS will allow plans flexibility in choosing how to design their specific programs, and determining who will be able to provide MTM services within their plan.

The MTM program will also be coordinated with other chronic care management and disease management programs operating in other parts of Medicare, and will be developed in cooperation with pharmacists and physicians.

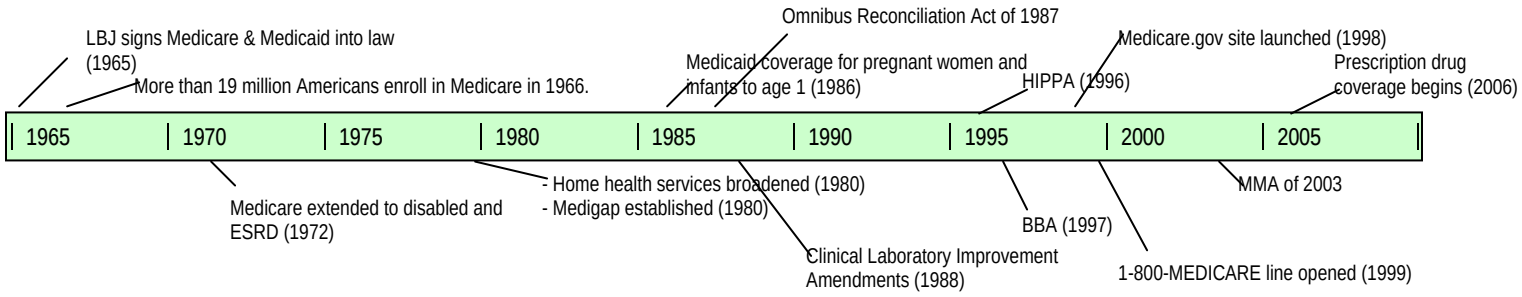
MTM sessions may include "brown bag" consults where patients are asked to gather all their medicines in a bag and bring them in for the pharmacist to review. They will serve several purposes, including:

- letting the pharmacist see all the medications the patient is taking so they can spot dangerous combinations of drugs;
- giving the pharmacist an opportunity to explain to patients the proper way to take their medications; and
- letting the beneficiary ask questions and receive feedback from the pharmacist.

CMS has established the level of annual costs likely to be incurred by an enrollee for covered part D drugs at $4,000, which will serve as a cost threshold for MTM programs. In order to qualify for services, enrollees will also need to satisfy specific plan requirements regarding the chronic diseases and number of covered part D drugs that comprise a plan's specific medication therapy management program. In general, it will be directed at patients who have multiple chronic conditions, are taking multiple medications and are likely to meet the cost threshold.

Targeted beneficiaries will not be responsible for any direct cost sharing associated with the MTM services provided by their plan. This should encourage all beneficiaries who qualify for these services to take advantage of this new Medicare benefit.

Major Events In Medicare & Medicaid



Mobile Tour (cont'd)

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Office of Disability Affairs Louis Prejean, Louisiana Department of Insurance Executive Counsel James Donelon, and representatives from Senators Mary Landrieu and David Vitter.

The Houston MOT included an exceptional partner meeting with about 50 participants and a community event at Windsor Village United Methodist Church. Attendees came equipped with information regarding what they are already doing to educate and prepare to enroll beneficiaries. They also discussed future outreach plans. Harris County Judge Robert Eckles and representatives from Congressman Tom DeLay and Houston Mayor Bill White participated in the event.

On August 24, the MOT conducted partner and community meetings at the Mayfair Center in Oklahoma City. Over 55 participants attended the partner meeting. U.S. Congressman Ernest Istook, State Senators Bernest Cain and Cliff Branan, Director of the Oklahoma Human Services Department Howard Hendrick, Health Commissioner Dr. James Michael Crutcher, and State Medicaid Director Dr. Lynn Mitchell attended. Prior to the meetings, RD Linda Penn represented the Secretary and did a live radio interview and a live segment on the KWTV morning show.

Payment Accuracy (cont'd)

Continued from previous page

payments using a methodology approved by the OIG. Since 2003, the OIG has assisted CMS in developing, reviewing, and formulating further actions based on the more extensive data collection.

The new CERT program is proving effective in assessing an overall national error rate, payment error rates for the individual contractors, and provider compliance error rates which measure how well providers prepare claims for submission to the reviewers. Contractors are able to use the data from the CERT results to help focus their medical review efforts on those issues that appear to drive the error rates.

Some of the issues found in the new CERT process were the lack of accurate contact information for individual providers and lack of understanding of the CERT process by the provider community, resulting in denial of claims for which medical records had not been received. All Medicare contractors have developed plans to address these problems. Extensive education has been undertaken to ensure that all providers understand the purpose of the CERT program and that requests for medical records are permissible under HIPAA regulations and do not require a separate authorization from the patient. Their efforts have been rewarded by significant improvements in provider response to requests for medical records from the CERT contractor.

Each contractor may include information on the CERT program and accompanying error rates on their individual Medicare websites. Providers may access information from the website or by calling their individual contractor.

Calendar of Events

October 4: Denton County Medical Society Meeting, Argyle, TX

October 4: Arkansas Pharmacists Association District Meeting, North Little Rock, AR

October 5: Congressman David Vitter Medicare Town Hall, Winnsbor, LA

October 6: Arkansas Pharmacists Association District Meeting, Russellville, AR

October 10-11: Louisiana Rural Health Association, Lafayette, LA

October 10-12: Arkansas Conference on Aging, Hot Springs, AR

October 14: Oklahoma Society of Health Systems Pharmacists, Oklahoma City, OK

October 16: Western Medicaid Pharmacy Administrators Association Meeting, Oklahoma City, OK

October 18: El Paso Medical Society Meeting, El Paso, TX

October 20: Tyler Medical Society Meeting, Tyler, TX

October 25: Fort Worth Medical Society Meeting, Abilene, TX

October 26: Abilene Medical Society Meeting, Abilene, TX

November 2: Austin Medical Society Meeting, Austin, TX

November 3: San Antonio Medical Society Meeting, San Antonio, TX

November 10: Texas National Association of Social Workers Conference, Galveston, TX

November 12: Southern Medical Association Annual Assembly, San Antonio, TX

November 16: Galveston Medical Society Meeting, Texas City, TX

November 30" Dallas Medical Society Meeting, Dallas, TX

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