



The Pulse of CMS

"A quarterly regional publication for health care professionals"

Serving Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi and Tennessee.

Medicare Prescription Drug Benefit Open Enrollment Has Begun!!!
November 15, 2005 - May 15, 2006

Physician Voluntary Reporting Program Launched

Beginning in January 2006, Medicare will enable physicians to voluntarily report information to CMS about the quality of care they provide to Medicare beneficiaries. The Physician Voluntary Reporting Program (PVRP) builds on Medicare's comprehensive efforts to improve substantially the health of beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations and improving the quality of health care delivered.

Under the voluntary program, physicians who choose to participate will help capture data about the quality of care provided to Medicare beneficiaries in order to identify the most effective way to use the quality measures in routine practice.

As part of the first phase, CMS will begin to collect the information through the use of a dedicated set of Healthcare Common Procedure Coding System (HCPCS) codes, called G-codes, which will supplement the claims data doctors currently submit to CMS with clinical data. This clinical data

will then be used to measure the quality of services provided to Medicare patients. CMS anticipates that these G-codes will serve as an interim step until the electronic submission of data through electronic health records replaces this process.

CMS will provide feedback to the physicians who submit the data by the summer of 2006 about the level of their performance based on the submitted data. The goal is to use this feedback to assist physicians in improving their data accuracy, reporting rate, and clinical care. CMS will also seek input from participating physicians on ways to improve the ease of reporting and usefulness of the quality measures, such as by promoting reports and analysis through electronic medical record systems.

CMS has worked in conjunction with many organizations to develop the performance measures, including the National Quality Forum (NQF), the Ambulatory Care Quality Alliance, the AMA Physician Consortium for Quality Improvement, the National Committee for Quality Assurance (NCQA), and RAND.

More information, including the 36 evidence-based measures, can be found on the [CMS website](#).

Combating Part D Fraud and Abuse

CMS is expanding its efforts in fighting fraud and abuse in Medicare by using state of the art systems and expertise to prevent problems before they occur in the new Medicare prescription coverage. Through a three-pronged approach, CMS will fight fraud and abuse and help people with Medicare protect themselves even before the new drug coverage begins on January 1. The approach uses new and innovative techniques to monitor and analyze data to help identify fraud; work with law enforcement, prescription drug plans, consumer groups and other key partners to protect consumers and enforce Medicare's rules; and provide basic tips for consumers so they can protect themselves.

CMS has contracted with Health Integrity, LLC (a wholly owned subsidiary of Delmarva Foundation) as the first Medicare Rx Integrity Contractor (MEDIC). These specialized contractors possess specialized skill sets that enable them to find fraud, waste and abuse in the new prescription drug program. The initial phase of contracting will allow consumers, providers and advocacy organizations to report cases of potential fraud for investigation by Health Integrity relating to enrollment, eligibility and marketing activities.

Examples of the types of complaints to be investigated may be found on [Health Integrity's website](#), or they can also be contacted by calling (877)7SafeRx (1-877-772-3379) or by fax at (410) 819-8698.

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Part D Webtools Now Available

To learn more about the Medicare Prescription Drug Coverage and to help Medicare patients enroll in a drug plan, please visit the following sites on the web:

- ? [Medicare Prescription Drug Plan Finder](#)
- ? [Formulary Finder](#)
- ? [Landscape of Local Plans](#)



Flu Vaccinations in Nursing Homes

Nursing homes serving Medicare and Medicaid patients will have to provide immunizations against influenza and pneumococcal disease to all residents if they want to continue in the programs. Nursing homes will also be required to educate residents and/or residents' families about the advantages and possible disadvantages of receiving the vaccines.

About two million Americans, most age 65 years or older, live in long-term care facilities. People aged 65 years and older account for more than 90 percent of influenza-related deaths in the United States. Elderly nursing home residents are particularly vulnerable to influenza-related complications.

"Improving immunization is a key element of our quality improvement strategy—a strategy that is focused on preventing illnesses and complications in the first place," said Mark B. McClellan, M.D., Ph.D., Administrator of CMS.

As a Medicare condition of participation, long-term care facilities must ensure that each resident is:

- ? offered influenza immunization annually;
- ? immunized against influenza unless medically contraindicated or when the resident or the resident's legal representative refuses immunization;
- ? offered pneumococcal immunization once if there is no history of immunization; and
- ? immunized against pneumococcal disease unless medically contraindicated or when the resident or the resident's legal representative refuses immunization.

"Vaccines against these diseases are effective in preventing hospitalizations and death," said Dr. McClellan. "However, many at-risk people are not getting the vaccines they need. This initiative will be critical to maintaining high-quality care in the nation's long-term care facilities."

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Helping Dual Eligibles Transition to Medicare Part D

When the Medicare Prescription drug benefit takes effect on January 1, 2006, a major change will take place for the approximately 6 million low-income Medicare beneficiaries who currently receive prescription drug coverage through their states' Medicaid programs. Known as "full-benefit dual eligibles," these beneficiaries will now qualify for Medicare drug coverage with little or no annual deductibles and monthly premiums, and with co-payments of a few dollars for most drugs. Protections are in place to help ensure that no full-benefit dual eligible beneficiary will go without coverage when the new benefit goes into effect.

Full-benefit dual eligibles will have the opportunity to join a Medicare prescription drug plan in their area from now until December 31. However, if they take no action on their own, CMS will enroll them in a Medicare prescription drug plan effective January 1, 2006 to ensure that there is no stoppage in coverage during the transition period. These full-benefit dual eligibles have the opportunity to switch plans at any time so that they may always have access to a plan in their area that best meets their needs.

CMS conducted the auto-assignment of full-benefit dual eligibles into plans earlier this fall. Plans that were eligible to accept these beneficiaries were those that were offering the

standard benefit and whose monthly premiums were below the threshold for that state. Letters were sent to the 6.1 million beneficiaries who fall into this category to inform them that Medicaid will no longer be providing their prescription drug coverage starting January 1. Information regarding the plan to which they were assigned was also provided, with an explanation that they still have the option of enrolling in a plan of their choice before December 31.

Additionally, full-benefit dual eligibles automatically qualify for the extra help that is available to help offset out-of-pocket costs, such as the annual deductible, monthly premiums, as well as help with covering most costs to prevent any coverage gap associated with the standard benefit. The Social Security Administration sent letters to these beneficiaries in the summer informing them of their automatic qualification and that they did not need to apply for the extra help. However, they would still have to enroll in a plan to receive their drug benefit before December 31 or be automatically enrolled into a pre-assigned plan.

CMS' strategy for transitioning dual eligibles from Medicare to Medicaid can be found on the [CMS website](#).

Legislative Corner: Budget Reconciliation

As the end of the fall session approaches, Congress currently is in the process of budget reconciliation negotiations. Under the Congressional Budget Act (CBA) of 1974, Congress was given the authority to implement budget resolution policies that impact permanent spending and revenue programs. The concept is to assist with reducing the overall deficit by reducing spending, increasing revenue, or both. Congress has directed committees to recommend changes in statute to achieve the levels agreed to in the budget resolution and has now recommended legislative language that has been packaged into bills by both the House and Senate.

The Congressional committees with jurisdiction over the Medicare and Medicaid programs (the Senate Finance, the House Ways & Means and House Energy & Commerce Committees) have been in discussions to reach agreements on the bills. The Senate passed a bill in November containing provisions on several key issues such as payment for prescription drugs under Medicaid,

state financing under Medicaid, improvements to the State Children's Health Insurance Program (SCHIP), pay-for-performance under Medicare, a minimum update for physician services and a one year moratorium on therapy caps. The House passed a bill in November that focused on modifications to the Medicaid program, including payment for prescription drugs, state flexibility in benefit packages and Katrina-related health care relief.

Staff members from all three committees are currently in conference deliberations and are working to reach a final consensus. The CMS Office of Legislation continues to monitor and keep the Agency apprised of current activity as the 109th Congress enters the last month of its first session. The second session of the 109th Congress will reconvene the third week of January 2006.

Status on the Congressional Moratorium on Outpatient Therapy Caps Announced

Congress established a moratorium on the financial limitations on outpatient therapy services on December 8, 2003. This moratorium was extended through December 31, 2005. The caps will be implemented again in January 1, 2006, unless there is legislation to re-establish the moratorium before that time. This means that in 2006, Medicare will impose a financial limit of about \$1,750 on the amount of care that Medicare enrollees can receive from independently practicing physical, speech and occupational therapists. The amount applies for physical therapy and speech-language pathology combined, and for occupational therapy alone. Therapy services received in an outpatient hospital department will not have a financial limitation. More information about therapy services can be found at <http://www.cms.hhs.gov/providers/therapy/>

Corrected versions of the 2006 Medicare & You handbook are now available on the [medicare.gov](http://www.medicare.gov) website

CMS Clarifies Exceptions and Appeals Process for Part D Plans

The new Medicare prescription drug benefit contains an exceptions and appeals process so that beneficiaries have access to the prescription drugs they need. Doctors will play an important role in the process, as they will be called upon to provide proof of medical necessity on behalf of their patients. All prescription drug plans are required to have a coverage determination process that provides enrollees with the opportunity to challenge the exclusion of a particular drug from a plan's formulary or the placement of a drug on a higher cost-sharing tier.

Generally, plans must grant exceptions for drugs not on the formulary when they determine that it is medically necessary to do so. If the exception request involves a plan's tiered cost-sharing issue, the Part D drug being prescribed may be covered if the prescribing physician determines that the preferred drug for treatment of the same condition would not be as effective as the preferred drug or would have adverse effect for the enrollee, or both. If a plan makes an unfavorable coverage determination such as denying an exception request, the enrollee or his or her authorized representative, or in expedited cases, the prescribing physician) may appeal the plan's decision.

The plan must notify the enrollee and the prescribing physician involved, as appropriate, of its determination as expeditiously as the enrollee's health condition requires, but no later than 24 hours for expedited requests, or 72 hours for standard requests, after receipt of the request for a coverage determination or receipt of the physician's oral supporting statement for exceptions requests. A plan must provide an expedited coverage determination if it determines, or the enrollee's prescribing physician indicates, that applying the standard timeframe for making a determination may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. If a plan does not make its determination within the appropriate timeframe, it must forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe.

The provider services staffs in the regional offices are available to address any concerns doctors may have about the exceptions and appeals process. Please contact any of the staff listed on page 2 for more information.

Appeals Process

Level	Action	Standard Appeal	Expedited Appeal
1	Redetermined by Part D plan	If the Part D plan's initial coverage determination is unfavorable, an enrollee may request a redetermination and the plan has up to 7 days to make its decision.	Same as standard, except the time frame is up to 72 hours for the plan to make its decision.
2	Reconsideration by Independent Review Entity (IRE)	If the Part D plan's redetermination is unfavorable, an enrollee may request a reconsideration by an IRE, which is a CMS contractor that reviews determinations made by a plan. The IRE has up to 7 days to make its decision.	Same as standard, except the time frame is up to 72 hours for the IRE to make its decision.
3	Administrative Law Judge (ALJ)	If the IRE's reconsideration is unfavorable, an enrollee may request a hearing with an ALJ if the amount in controversy requirement is satisfied.	Not applicable.
4	Medicare Appeals Council (MAC)	If the ALJ's finding is unfavorable, the enrollee may appeal to the MAC, and entity within the Department of Health & Human Services that reviews ALJ's decisions.	Not applicable.
5	Federal District Court	If the MAC's decision is unfavorable, the enrollee may appeal to a Federal District Court, if the amount in controversy requirement is satisfied.	Not applicable.

Need Clarification on the Differences Between Part B and Part D Drugs?

Go to the [Medlearn website](http://www.medicare.gov) for a *Medlearn Matters* article that discusses Part B and Part D drugs, as well as vaccines administered in doctors' offices.

Coming in December...The New CMS Website!!!

HHS Repatriation Plans for Katrina Evacuees

Due to strong interest from healthcare providers regarding displaced individuals, including the medically fragile, who want or need to return to their home states to be near their families, the Department of Health and Human Services (HHS) has developed a plan to repatriate all displaced Katrina or Rita hurricane evacuees back to their home states of Louisiana, Mississippi or Texas.

The HHS Medical Travel Center will arrange transportation for evacuees who require en-route medical care and/or medical transport, to include a non-medical attendant, to an institution or to a private residence, as appropriate. If the evacuee's originating medical facility is not available in the home state or if the residence and community medical infrastructure is not suitable, the evacuee will be allowed to travel to an interim location within the continental United States. The HHS Medical Travel Center will then return the evacuee to their home of record when a medical facility is available or the evacuee can return to a safe community/home environment.

Skilled Nursing Facilities and hospital discharge planners will work with HHS contractor, CareFlite, to coordinate the transports of approximately 1,000 – 6,000 evacuees. There are three modes of transport available to the evacuees - *ground ambulance, air ambulance and commercial airline* with medical support. It is very important to note that evacuees who would like to be transported back to their home states should contact FEMA to get their disaster registry numbers, as this number is necessary to take advantage of HHS' transportation services. Additionally, they need to complete a medical necessity form.

Hospitals and other providers, who provided medical care to the evacuees, may be reimbursed in many ways such as: **1) Existing Health Care Insurance** - Many evacuees have existing health insurance coverage. Providers should bill an evacuee's private health insurer, if one exists; **2) Medicare** - Many evacuees are covered under the Medicare program. Providers should contact their local Medicare carrier or fiscal intermediary, if they have questions regarding Medicare reimbursement for evacuee health care; **3) NDMS** - Some evacuees received medical treatment via the National Disaster Medical System (NDMS). At the request of FEMA, CMS is developing payment mechanisms for those patients who entered NDMS hospitals via the Federal Coordinating Centers as part of the NDMS evacuation. Specific on how to submit claims is available at www.cms.hhs.gov; **4) Medicaid** - Many evacuees will qualify for Medicaid, either because they were eligible in their home state, or because they are now eligible because of a loss of income

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National Provider Identifier: What YOU Need to Know

On May 23, 2005, CMS instituted a system whereby all health care providers, including Medicare providers, can apply for a new identifier, known as the National Provider Identifier, or NPI. Healthcare providers should apply for their NPIs as soon as it is practicable for them to do so. This will facilitate the testing and transition processes and will also decrease the possibility of any interruption in claims payment. Providers may apply for an NPI in one of three ways:

1. An easy [web-based application](#) process is available;
2. A paper application may be submitted to Fox Systems, Inc., the entity that assigns the NPI (the Enumerator). A copy of the application, including the Enumerator's mailing address, is available [at their website](#). A copy of the paper application may also be obtained by calling 1-800-465-3203 or TTY 1-800-692-2326.
3. With provider permission, an organization may submit a request for an NPI on behalf of a provider via an electronic file.

What Providers Can Do to Prepare for NPI Implementation

- ? Watch for information from the health plans with which you do business on the implementation/testing of NPIs in claims, and, eventually, in other standard transactions.
- ? Check with your billing services, vendors, and clearinghouses about NPI compliance

and what you need to do to facilitate the process.

- ? Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims.
- ? Check in your area for collaborative organizations working to address NPI implementation issues on a regional basis among the physicians, hospitals, laboratories, pharmacies, health plans, and other impacted parties.

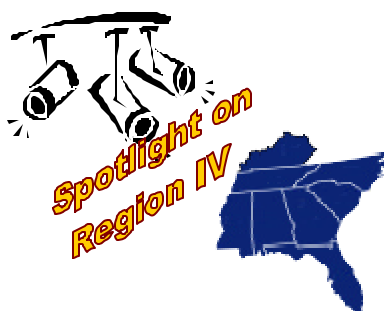
Resources for Additional Information

Coming Soon---CMS has developed a [Medlearn web page](#) on NPI for Medicare FFS providers, which houses all Medicare fee for service educational resources on NPI, including links to all Medlearn Matters articles, frequently-asked-questions, and other information. CMS will widely publicize the launch of this web page in the coming weeks.

You may also visit the [CMS HIPAA webpage](#) regularly for the latest information about the NPI, including Frequently Asked Questions, announcements of roundtables, conferences, and guidance documents regarding the NPI.

A flowchart is available on [the CMS website](#) that helps to establish whether one is a covered entity under the administrative simplifications of HIPAA.

A helpful tool that provides an overview of the NPI and the application process for obtaining an NPI is available on the [Medlearn site](#).



"The Pulse" will highlight data and facts pertaining to the states in Region IV. This quarter we feature Tennessee in the spotlight. Keep your eye out for more interesting facts from the other states in the region in upcoming issues!

Did you know...

TN spent \$3,808 per capita on health care in 1998?

TN ranked 16th in health spending in the nation?

TN ranks 29th in the nation for percent of population 65 and over?

TN ranks 16th highest in median age?

TN ranks 17th in Medicare spending per enrollee?

Medicare Part D Calendar

OCTOBER 2005	NOVEMBER 2005	DECEMBER 2005
<ul style="list-style-type: none"> ? Medicare & You Handbooks mailed to all Medicare households ? People who have both Medicare & Medicaid will get information about how they will be automatically enrolled if they do not choose a plan by Dec. 31st 2005 	<ul style="list-style-type: none"> ? Enrollment for Medicare Prescription Drug Plans begins on November 15th. People can enroll by calling the company offering the plans, through www.medicare.gov, or by calling 1-800-MEDICARE. 	<ul style="list-style-type: none"> ? People who enroll in a plan by December 31st, 2005 prescription drug coverage will begin on January 1, 2006.
<p>Initial Enrollment begins November 15, 2005</p>		
JANUARY 2006	FEBRUARY 2006	MARCH 2006
<ul style="list-style-type: none"> ? Medicare Prescription Drug Coverage begins January 1 for those who enrolled in a plan by December 31, 2005 ? Medicare begins to provide prescription drug coverage for those who have both Medicare and full Medicaid coverage. 	<p style="color: red; font-weight: bold;">Initial Enrollment continues.</p> <ul style="list-style-type: none"> ? For people who enroll January 1, 2006 – May 15th, 2006 their Medicare prescription drug coverage begins the 1st day of the month after enrolling. 	
APRIL – MAY 2006		
<ul style="list-style-type: none"> ? Medicare will send a reminder to those who have not enrolled in a Medicare prescription drug plan. ? May 15th is the last day to enroll in a Medicare prescription drug plan ? Facilitated enrollment of those who qualify for extra financial help and have not chosen a plan; coverage begins June 1st, 2006. 		
<p>Initial Enrollment ends May 15th, 2006</p>		
NOVEMBER 15, 2006 – DECEMBER 31, 2006 and beyond		
<ul style="list-style-type: none"> ? Annual Open Enrollment Period November 15th – December 31st of every year ? Coverage will begin on January 1st of the following year. 		

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and/or resources. CMS has approved Medicaid waivers for many states. Under these waivers, effective retroactively to August 24, 2005, evacuees who have been displaced from their homes as a result of the Hurricane will be provided the opportunity to enroll through a streamlined process to receive services under the Medicaid/SCHIP programs in whatever State they now physically reside. Medicaid/ SCHIP providers

should work with their States to submit claims and receive payment;
5) Uncompensated Care - Through the waiver process, CMS is working with States with large numbers of evacuees to put in place processes for handling those claims that would otherwise been uncompensated. Providers should contact their State for information on how to submit these claims. The CMS has more information at <http://www.cms.hhs.gov/emergency/>.

A HHS fact sheet titled, *Fact sheet for transportation of evacuees with medical needs*, has more detailed information on the process and procedure, which is available at <http://www.hhs.gov/katrina/factsheet.html>. You may also contact CareFlite, the contractor selected to coordinate this effort at 1-866-753-9344 or jadams@careflite.org.

Calendar of Events

- December 17: Meeting with Congressman John Lewis, Atlanta, GA
- December 20: Meeting at Sarasota Memorial Hospital, Sarasota, FL
- December 23: Telemiami TV "Buenos Dias Miami: & WSUA 1260 AM Caracol "La Voz de la Comunidad, Miami, FL
- January 23-24: Pay for Performance Summit, Atlanta, GA

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Information Disclaimer:

The information provided in this newsletter is intended only to be general summary information to the Region IV provider community. It is not intended to take the place of either the written law or regulations.

Links to Other Resources:

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