



The Pulse of CMS

“A quarterly regional publication for health care professionals”

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

Applications for Extra Help with Drug Costs Now Available

Medicare beneficiaries who have limited resources now have the opportunity to apply for extra help in covering their prescription drug costs when the new Medicare prescription drug benefit takes effect in January. Starting in June, millions of Medicare beneficiaries who may be eligible for the extra help will be mailed an *Application for Help with Medicare Prescription Drug Plan Costs*. This application should be filled out and returned to the Social Security Administration now, even though enrollment for the new Medicare Health Plans and Prescription Drug Plans will not begin until November. Also, other Medicare beneficiaries who think they may qualify can obtain an application for the extra help either directly from their local Social Security office, state Medicaid office, or by calling 1-800-772-1213. Beginning July 1, the application will be available online at www.socialsecurity.gov.

We are asking the provider community to help us to get the word out to seniors. It is estimated that more than 13 million Medicare patients could benefit from this extra help. Please refer your Medicare population to the above listed resources, or to 1-800-MEDICARE, or on the web at www.medicare.gov.

CMS Announces Plans for the New National Provider Identifier

The Centers for Medicare & Medicaid Services (CMS) has announced the availability of a new identifier for use in standard electronic health care transactions. The National Provider Identifier (NPI) will be the single provider identifier, replacing the multiple provider identifiers currently used for each health plan with which health care providers do business. This identifier, which implements a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), must be used by most HIPAA covered entities, including health plans, health care clearinghouses, and health care providers that conduct electronic transactions for which the Secretary has adopted a standard (i.e., standard transactions).

CMS is now beginning to implement the NPI. On January 23, 2004, the Secretary published a Final Rule that adopted the NPI as this identifier. As of the compliance dates listed below, HIPAA-covered entities must use NPIs to identify health care providers in standard transactions. These transactions include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices. Health care providers include individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and group practices. Health care providers who transmit health information electronically in connection with any of

the standard transactions are required by the NPI Final Rule to obtain NPIs, even if they use business associates, such as billing agencies, to prepare the transactions.

Starting May 23, 2005, all health care providers can apply for their National Provider Identifier. The NPI will eventually replace health care provider identifiers in use today in standard health care transactions. All HIPAA-covered entities except small health plans must begin using the NPI on **May 23, 2007**; small health plans have until May 23, 2008. For additional information, and to complete an application, visit <https://nppes.cms.hhs.gov> on the web. It is important to note that the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006. Other health plans with whom you do business will instruct you as to when you may begin using the NPI in standard transactions.

Also, an instructional web tool, called the “NPI Viewlet,” is now available for viewing on the [MedLearn page](#) and under “HIPAA Latest News” on the [HIPAA page](#) on CMS’ website. This tool, designed for all health care providers, provides an overview of the NPI, a walkthrough of the application, as well as live links to the National Plan and Provider Enumeration System’s (NPPES) website where the learner can apply for an NPI.

Sign Up for the Open Door Forums

The “Open Door Forums” provide an opportunity for live dialogue between CMS and the provider community at large, in order to understand and then help find solutions to contemporary program issues. The Open Door Forums continue to serve as one of the many ways for the agency and our healthcare partners to advance our combined goal of delivering quality healthcare for our nation’s seniors and beneficiaries with disabilities. There are currently fourteen individual Open Door Forums being held regularly on a monthly, bimonthly or quarterly basis. CMS also continues to hold Special Forums throughout the year, to independently discuss new and important program topics. Go to the Open Door Forum website and sign up for the forums that are of interest to you and receive information for each call.

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Medicare Stop Smoking Program Wraps Up

The Medicare Stop Smoking Program (MSSP) was a limited scope demonstration project conducted between October 2002 and October 2004 as part of CMS' Healthy Aging Initiative. It was intended to compare the impact of offering different types of benefits for smoking cessation services on quit rates. Those benefit options were:

- Reimbursement for provider counseling only
- Reimbursement for provider counseling + FDA-approved prescription or nicotine replacement pharmacotherapy
- A telephone counseling quitline + reimbursement for nicotine replacement therapy
- Usual care (smoking cessation information)

The Medicare Stop Smoking Program demonstration went live in October 2002. Over the twelve month enrollment period 7,350 Medicare beneficiaries voluntarily participated in the demonstration from seven states--Alabama, Florida, Missouri, Ohio, Oklahoma, Nebraska, and Wyoming. All participants had access to MSSP benefits for one year from the date of enrollment. Each participant provided baseline information at the time of enrollment and was asked to complete follow-up questionnaires at 6-months and 12-months. The response rate for 6-month follow-up was approximately 64%.

Data received from the 12-month questionnaire are being analyzed and will be compared to data collected in the 6-month questionnaire. It is expected that results from the demonstration will be available in June 2005

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Hospital Compare Website Now Available for Quality Info

For the first time, hospital quality information is available to the public at a new consumer website called the [Hospital Compare](#). Unveiled on April 1, 2005, *Hospital Compare* is the result of a public-private partnership between hospitals, government agencies, quality experts, purchasers, consumer groups and other health care organizations, known collectively as the Hospital Quality Alliance (HQA).

Hospital Compare provides consumers with standardized assessments of the care that nearly 4,200 hospitals around the country provide to patients, based on valid and reliable measures that have been shown to reflect quality of care. The seventeen measures currently reported on *Hospital Compare* include ten "starter" measures, plus any additional measures that many hospitals have also voluntarily reported. The measures reflect recommended treatments for three conditions—heart attack, heart failure and pneumonia. The seventeen hospital quality

measures on *Hospital Compare* have gone through years of extensive testing for validity and reliability by CMS and its Quality Improvement Organizations (QIOs), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the HOA and researchers. The hospital quality measures are also endorsed by the National Quality Forum, a national standards setting entity.

The ultimate goal is for this set of measures to be reported by all hospitals, and accepted by all purchasers, oversight and accrediting entities, payers and providers. In the future, additional quality measures will be added to *Hospital Compare* as well as information about patients' experiences.

More information about *Hospital Compare* can be found on the [Hospital Quality Initiative](#) page of the CMS website.

CMS Medicare Fee-for-Service Contractors Meet Deep in the Heart of Texas

San Antonio, TX, was the scene of the second annual CMS Provider Customer Service Program Conference, held May 9-12 at the San Antonio Marriott Rivercenter. As in past years, representatives from all of the Medicare fee-for-service contractors were in attendance to discuss issues relating to provider communications and education and provider inquiries. The conference featured presentations on more than 50 topics in both plenary and breakout sessions, a majority of which were offered by contractor staff that gave them the opportunity to share ideas, get to know one another and teach best practices. Additionally, a special track was devoted to the Provider Relations Research Specialists (PRRS) that have been working to answer complex inquiries that come from the provider community. This track enabled contractors to share their day-to-day experiences and the impact of their work on the flow of provider inquiries.

Among the highlights of the conference was the announcement that CMS will extend the call center training pilot to all contractors in the near future. Since last year, a small group of call centers has participated in a pilot program whereby the centers were permitted to close their telephone lines for up to eight hours per month in order to train staff. The overall goal was to offer more accurate answers to provider inquiries and improved customer service.

Results of the pilot were so positive that the decision was made to grant all call centers up to eight hours a month to provide training. More information will be made available as details of the program are announced.

Regional Office staff had the opportunity to meet with the contractors that do business within their respective region for an afternoon breakout session to discuss provider communications and inquiries issues, as well as other topics. There were over 30 participants that attended the Region IV breakout sessions including one of the Vice Presidents and Assistant VPs from the contractor sites. The sessions were very informal and interactive that produced lessons learned and more innovative ways to enhance provider customer service. Of all the topics shared, the new "fee policy" resulted in the most feedback. There was also quite a bit of feedback on the proposed changes to call center standards regarding timeliness of answering calls. Overall, the session allowed Region VI to gain insight on the topics presented from various perspectives prior to finalizing the requirements for FY 2006. The contractors greatly appreciated the opportunity to voice their opinions and concerns in an open forum.

Transition to Medicare Administrative Contractors Underway

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) mandated that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B fee-for-service programs with a new Medicare Administrative Contactor, or "MAC" authority. This change is the key component of Medicare contracting reform. It is intended to improve Medicare's administrative services to beneficiaries and providers, while bringing Medicare the standard contracting principles which have long applied to other federal programs under the Federal Acquisition Regulation.

Using competitive procedures, Medicare will replace its [current claims payment contractors](#) - fiscal intermediaries and carriers - with new contract entities called Medicare Administrative Contractors (MACs). MMA requires that CMS re-compete and transition all work to MACs by 2011.

The first of the full and open competitions will be for the Durable Medical Equipment (DME) claims workloads. The DME MAC Request for Proposal (RFP) was released to [Federal Business Opportunities](#) on April 15, 2005. A Pre-Proposal Conference was held on April 27, and CMS received Notice of Intent to Submit Proposals from interested parties by May 4.

CMS decided to start the Medicare contractor reform initiative with the DME MAC contracting because the workload of the four current DMERCs is stable. We will know who has been selected by the end of 2005.

CMS Helps Promote "Rural Health and All That Jazz"

CMS participated in the 28th Annual Conference of the National Rural Health Association held this year in New Orleans from May 18-21, 2005. This year's conference theme was "Rural Health and All That Jazz." Dr. Randy Farris, CMS Regional Administrator for the Dallas Regional Office, made two presentations at the conference. During the "Medicare Update" session, he shared the podium with David Worgo from CMS Central Office and Dr. Mary Wakefield, Commissioner of MEDPAC (Medicare Payment Advisory Committee). Dr. Farris gave an overview of the provisions of the new Medicare prescription drug benefit. For the "Coffee Chat" session, Dr. Farris gave a more detailed explanation of the drug benefit. In both sessions he stressed the need for CMS to partner with rural providers to provide people with Medicare in rural areas with information and enrollment assistance for the new drug benefit.

The CMS Rural Health Coordinators from most of the ten regional offices exhibited Medicare education materials to the 900 NRHA conference attendees. This also gave staffers the opportunity

to interact with their rural provider partners and answer any questions they had regarding the Medicare program. Also, many CMS staff took the conference and exhibit as an opportunity to network with new partners to prepare for the rollout of the prescription drug benefit.

CMS also arranged to have the monthly CMS Rural Health Open Door Forum held onsite at the conference, chaired in person by the CMS Administrator's Special Assistant, Dr. Richard Lawlor. This call, as well as the "Medicare Update" session, was held to standing-room-only audiences.

The representatives from CMS always welcome the opportunity to work with the National Rural Health Association and look forward every year to participating in the annual conference. Next year's annual conference will be held in Reno, NV, May 16-19, 2006.

MMA Partner Toolkit Now Online!!

There is now a comprehensive web toolkit designed to equip community-level organizations with the materials needed to provide clear, accurate information and assistance to their clients on the Medicare prescription drug coverage. The toolkit is developed with basic, straightforward information that can be easily conveyed to beneficiaries. Go to the [CMS Partner Center](#) on the website to view and download the materials or to order a copy of the toolkit.

Region IV Looking To Expand Outreach

The Atlanta Regional Office is working hard to expand outreach efforts in preparation of the implementation of the Medicare prescription drug benefit in January 2006. We are continuously looking for partnering opportunities with the provider community in order to give you the information you need to help seniors become informed for the very important decision they will have to make starting in November 2005. If you have are a member of a group or organization that would benefit from a partnership with the CMS Atlanta Regional Office, please sign up for our new partnership list serv(s) by visiting <http://list.nih.gov> and "browsing" available lists under the letter "A." Select the partnership list serve which corresponds to your state and subscribe. The Atlanta Regional Office will use these list servs to disseminate valuable outreach products, information and partnership opportunities for provider organizations.



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

Did you know...

- AL spent \$3,630 per capita on health care in 1998?
- AL ranked 28th in health spending in the nation?
- AL ranks 24th in the nation for percent of population 65 and over?
- AL ranks 16th in Medicare spending per enrollee?
- AL ranks 22nd highest in median age?

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Legislative Corner: Capitol Hill Looks at Quality

The CMS Office of Legislation has been receiving a number of requests from Capitol Hill for briefings and updates regarding CMS' quality initiatives, especially as they relate to the concept of payment-for-performance. As the movement toward pay-for-performance in the health care system gains momentum, the Hill appears to be increasingly interested in programs that provide incentives for providing high quality care by rewarding the best performers.

Last month, CMS Administrator Mark B. McClellan, M.D., Ph.D., announced that early results from the Premier Hospital Quality Incentive demonstration show that financial incentives can improve care. This CMS pay-for-performance demonstration project involving 270 hospitals will track hospital performance and financially reward hospitals that score in the top 20% on identified measures.

CMS is conducting or developing additional programs that use incentive payments to improve quality of care, including:

- *The Physician Group Practice demonstration project*, the first pay-for-performance initiative involving physicians under the Medicare program. Ten large physician groups across the U.S. will participate in this demonstration;

- *The Hospital Quality Initiative*, under which nearly all U.S. hospitals are being paid higher rates for submitting quality data;
- *The Medicare Chronic Care Improvement Program*, Medicare's first large-scale pay for performance program designed to reduce health risks for defined populations of chronically ill beneficiaries;
- *The Medicare Care Management Performance Demonstration*, which will test methods that promote the use of health information technology for improving the quality of care of chronically ill Medicare patients; and
- Additional disease management and coordinated care initiatives for beneficiaries with certain chronic conditions or high costs.

Given the amount of interest in quality and pay-for-performance on the Hill, there is much speculation that the Congress will introduce legislation later this year.

Calendar of Events

- June 30- July 2: Exhibit at Medical Association of Alabama, Destin, FL
- July 5-7: Speech at West Florida HC Association, Fort Lauderdale, FL
- July 11: Exhibit at Georgia Association for Home Health Agencies, St. Simons, GA
- July 14: Speech at the Association of South Carolina Oncology Managers, Columbia, SC
- July 16: Exhibit at the Florida Nurse Practitioner Network, Orlando, FL
- July 22: Speech at the Southeastern Coalition of Oncology Practices, Naples, FL
- July 26: Speech and Exhibit at the Welmont Health Systems-Wesley UMC, Johnson City, TN
- July 26-28: Exhibit with Florida Public Health, Sarasota, FL

- July 27-29: Healthcare Financial Management Association of Georgia, Hilton Head, SC
- July 28: Speech at the University of Miami, Coral Gables, FL
- August 9: Speech at the Georgia Hospital Association (GHA), Marietta, GA
- August 11-13: Speech & Exhibit at the Alabama Hospice Organization, Huntsville, AL
- August 12-14: Speech & Exhibit at the Alabama Independent Drugstore Association, Orange Beach, AL
- August 18-19: Exhibit at Louisiana Rural Health Association, Gulfport, MS
- August 24: Exhibit with "Today's Caregiver" magazine, Atlanta, GA
- August 26: Speech at the Georgia Hospital Association, St. Simons Island, GA
- August 31- September 2: Speech & Exhibit at the South Carolina Health Care Managers Association, Myrtle Beach, SC
- Speech & Exhibit at the Kentucky Association for Homes and Services for the Aging, Louisville, KY