

Open Door Forum Newsletter

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Hot Announcements!

Hospital Inpatient PPS Proposed Rule and FY 2004 Rates

The proposed rule for the Hospital Inpatient Prospective Payment System (PPS) FY 2004 payment rates is on display at the Federal Register and will be published May 19. This proposed rule discusses proposed revisions to the Medicare acute care hospital inpatient PPS for operating and capital costs for discharges on or after October 1. In addition, this proposed rule includes proposed changes for FY 2004 for other inpatient hospitals and costs excluded from the hospital inpatient PPS. To review the rule in its entirety, please click here: www.cms.gov/providers/hipps/frnotices.asp

May 19: Physicians Advisory Council

The Practicing Physicians Advisory Council (PPAC) meeting will take place on Monday, May 19 from 8:30 to 5 pm ET in Washington, DC at the Hubert H. Humphrey Building in Room 800 (click here for map: www.hhs.gov/about/hhhmap.html). For more information, visit the PPAC web page at: <http://qa.cms.hhs.gov/faca/ppac/>

Stats of the Month!

3,212 teleconference lines were open to individual and group participants and more than 471 guests visited with the CMS Administrator and policy leaders during the Open Door Forums held in the months of March & April.

To date, more than 19,000 guests have participated in the forums since October 2001!

Town Hall Meeting to Discuss the Inpatient Rehabilitation Facility Proposed Rule

The March 28 Federal Register (Volume 68, Number 60 / Page 15206-15207) announced details of the May 19 CMS Town Hall Meeting to discuss the inpatient rehabilitation facility (IRF) prospective payment system (PPS). The IRF-PPS regulation implementing the payment system for FY'04 is now on display at the Federal Register and will be published May 16. The town hall meeting will discuss the IRF patient classification system and payment systems, the IRF patient assessment instrument, and the requirements for a hospital or a unit of a hospital to be classified as an IRF.

Beneficiaries, providers, physicians, inpatient rehabilitation facilities staff, industry representatives, and other interested parties are invited to this meeting to present views regarding the IRF PPS. Individuals who wish to attend must contact August Nemeck of the Division of Institutional Post Acute Care at (410) 786-0612 or at: ANemeck@cms.hhs.gov as soon as possible.

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Links to Other Resources: Our newsletter may link to other federal agencies and private organizations. You are subject to those sites' privacy policies. Reference in this newsletter to any specific commercial products, process, service, manufacturer, or company does not constitute its endorsement or recommendation by the U.S. Government, HHS or CMS. HHS or CMS is not responsible for the contents of any "off-site" resource referenced.



The three-hour town hall meeting will begin 10 am ET in the auditorium at the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

Please be sure to visit www.cms.hhs.gov/providers/irfpps/default.asp to receive more details and important information on the town hall meeting including an agenda, handouts to be used during the discussions, registration requirements,

Home Health Quality Initiative Update

Since taking office, Secretary Thompson has made health care quality improvement among his highest priorities. As part of HHS' quality agenda, the Secretary announced the Home Health Quality Initiative (HHQI) on May 1. The HHQI rolled out with the launch of Home Health Compare (www.medicare.gov/HHCompare/home.asp). Newspaper ads in eight pilot states (MA, FL, MO, NM, OR, SC, WV, WI) went live the next day. This initiative allows consumers to compare home health quality data among home health agencies in the pilot states - with a nationwide rollout planned for the Fall.

Home health agencies can calculate the quality measure rates that will appear on Home Health Compare in Phase I and/or the national rollout using the Conversion calculator for OBQI Report rate to Home Health Compare rate posted on the HHQI website (www.cms.hhs.gov/quality/hhqi). All non-Phase I states can also review their demographic data on Home Health Compare and begin to make revisions. For changes or corrections to the demographic information displayed on Home Health Compare please contact the State Survey Agency OSCAR/ASPEN Coordinator in your state. Contact information for the State Survey Agency OSCAR/ASPEN Coordinator is available on the HHQI website. For more information or questions about the quality measure information, please contact the QIO in your state.

CMS Creates Medical Technology Council

CMS has created a Medical Technology Council (MTC). The MTC's primary responsibility is to address issues that relate to the coordination of coverage, coding and payment for specific health care technologies and services. The MTC will expedite resolution of these issues by consulting with affected CMS components, identifying potential problems, developing appropriate resolutions, clarifying component responsibilities, establishing time frames for completion of the tasks involved, and follow through to resolution.



Tom Grissom, Director of CMS' Center for Medicare Management, and Sean Tunis, MD, Director of the Office of Clinical Standards and Quality, will chair the MTC. The MTC will meet monthly or on an as needed basis.

New Enrollment Policy for Providers & Suppliers

CMS recently announced in the Federal Register Friday, April 25 (Volume 68, Number 80 / Page 22063-22112) its new enrollment policy that will simplify requirements and continue to ensure that only qualified health-care providers and suppliers are enrolled in Medicare.

The regulation will consolidate enrollment criteria and ensure consistency in the process. One of the primary requirements will be that all providers and suppliers (both new and those already in the program) complete the Medicare Provider/Supplier Enrollment Application, form CMS 855 and to attest to the accuracy of the information reported to CMS every three years. CMS feels that the new form will simplify the enrollment process while ensuring important program integrity safeguards.

M+C Appeal & Grievance

CMS recently published a final rule with comment period regarding improvements to the Medicare+Choice (M+C) appeal and grievance procedures. It establishes new notice and appeal procedures for enrollees when an M+C organization decides to terminate coverage of provider services.

As a response to comments received from the January 24, 2001 proposed rule, which was published as a required element of an agreement entered into between the parties in *Grijalva v. Shalala*), to settle a class action lawsuit.

This rule also specifies a Medicare-participating hospital's responsibility for issuing discharge or termination notices under both the original Medicare and M+C programs, amends the Medicare provider agreement regulations with regard to beneficiary notification requirements, and amends M+C enrollee grievance procedures.

For more information on the rule, please visit the April 4 *Federal Register* (Volume 68, Number 65 / Pages 16651-16669). Also note that CMS has established a special electronic mailbox at: Grijalva/NODMARQuestions@cms.hhs.gov for you to have questions answered.



Expanded Coverage: Magnetic Resonance Angiography

The Centers for Medicare & Medicaid Services (CMS) announced that it intends to expand diagnostic options for certain Medicare beneficiaries by making Magnetic Resonance Angiography (MRA) available to patients with abdominal and pelvic vascular disease under certain clinical circumstances.

"By expanding MRA access, we are improving the quality of life for many Medicare beneficiaries," CMS Administrator Tom Scully said.

Magnetic resonance angiography (MRA) is a non-invasive diagnostic test that uses magnetic resonance imaging (MRI). For more details, please click here to read the CMS News Release in its entirety:

www.cms.gov/ncdr/trackingsheet.asp?id=51

Capitated Disease Management Demonstration

CMS would like to remind you of the Capitated Disease Management Demonstration designed to test models aimed at beneficiaries who have one or more chronic conditions that are related to high costs to the Medicare program, such as stroke, congestive heart failure, or diabetes. Moreover, we are also testing models that include the dual eligible and frail elderly. Enrollment is rapidly increasing –so, don't delay!

Further goals and objectives of this demonstration include the use of disease management interventions and payment for services based on full capitation (with risk sharing options) to improve the quality of services furnished to specific eligible beneficiaries, including the dual eligible and the frail elderly; manage expenditures under part A and B of the Medicare program; and encourage the formation of specialty plans that market directly to Medicare's sickest beneficiaries.

For more information and resources regarding the demonstration, for which proposals must be submitted by May 29, overviews, and demonstration materials, please click here: www.cms.gov/healthplans/research/CDM.asp

Please be sure to click here: www.dmaa.org/PDFs/CMSAnnounces03-3879.pdf for a description of the demonstration design and selection process, and informs interested parties on how to apply for the Capitated Disease Management Demonstration.

HIPAA Notes!

Administration Simplification

CMS' Office of HIPAA Standards and our Regional Office counterparts are working hard to educate covered entities and others about compliance with key upcoming deadlines. By law, covered entities that filed before October 16, 2002 for a one-year extension to comply with the HIPAA electronic transactions and code sets requirements, now have until October 16 to comply. However, Congress requires that these entities begin testing their systems no later than April 16 in preparation for meeting the October deadline for HIPAA Administrative Simplification and we encourage providers to begin testing NOW.



CMS is proud to host a one hour roundtable conference call on May 29. The call in number for the 2 pm ET call is: **(877) 381-6315** and the conference ID # is **426913**. Participation is free.

Please stay tuned to the updated website for more information on free events, free products, and new rules by going to www.cms.hhs.gov/hipaa/hipaa2/default.asp

Privacy

If you have a question about the Privacy Rule, please be sure to review the DHHS Office of Civil Right's responses to Frequently Asked Questions (FAQs) and Privacy Guidance at the following web-site: www.hhs.gov/ocr/hipaa/

You may also submit an e-mail to: OCRPrivacy@hhs.gov. Although individual responses will not be provided, OCR will address concerns of general interest through development of new FAQs or other guidance for inclusion on our web site. As an alternative, you may call the HIPAA toll-free number at: **(866) 627-7748**.

MDS 3.0 Announcements

MDS 3.0 Validation Contract Awarded

On April 10, CMS awarded a contract to Rand Corporation for the refinement and validation of the Minimum Data Set (MDS) 3.0 long term care resident assessment instrument used in over 17,000 nursing homes certified to participate in the Medicare and Medicaid programs. Co-principal investigators include Debra Saliba, MD, MPH of Rand and Joan Buchanan, PhD, Department of Health Care Policy, Harvard Medical School. Both investigators bring to this effort extensive MDS, nursing home health outcomes and validation knowledge and experience. Other subcontractors include Laura Palmer and the Colorado Foundation for Medical Care, the Quality Improvement Organization for Colorado, to identify and coordinate the onsite validation nurses and field-testing. Joan Kwiatkowski and Care Link staff, are subcontracting to develop MDS 3.0 instructions, tools, and revisions to the MDS 3.0 manual.

Draft MDS 3.0 Instrument Posted on CMS Web

CMS has posted a copy of the Draft MDS 3.0 on their website for review at: www.cms.hhs.gov/providers/nursinghomes/nhi/DraftMDS30.pdf. The Draft MDS 3.0 instrument was revised based on comments received in 2002 from the nursing home industry, professional groups, individual providers and expert panels. This draft document was placed on the web to allow providers, interested industry, advocate or professional groups, and individuals opportunity for review prior to the Town Hall Meeting scheduled for June 2 from 1 to 4 pm ET. A notice of the Town Hall Meeting will be put into the Federal Register. At that time, CMS will provide details on where to send comments.

CMS Leadership Update

CMS announced on April 8 the selection of Tom Gustafson, the Center for Medicare Management's (CMM) former Hospital and Ambulatory Policy Group (HAPG) Director, to the position of Deputy Director, CMM. Tom replaced Liz Cusick who retired on May 2 after 30 years of service.

Liz Richter, formally the Director, Financial Services Group in the Office of Financial Management assumed the duties as CMM's HAPG Director on May 12.



Hot Transmittals & Resources!

AB- 03-047: *Subject: Single Drug Pricer (SDP) Clarifications*
www.cms.gov/manuals/pm_trans/AB03047.pdf

AB-03-054: *Screening Pap Smear & Pelvic Exam Code*
www.cms.gov/manuals/pm_trans/AB03054.pdf

AB-03-057: *Implementation of the Financial Limitation for Outpatient Rehabilitation Services*
www.cms.gov/manuals/pm_trans/AB03057.pdf

A-03-021: *RHC & FQHC Payment Rate Increases, Coverage and Payment of Diabetes Self-Management Training Services and Medical Nutrition Therapy Services*
www.cms.gov/manuals/pm_trans/A03021.pdf

A-03-023: *Implementation of the Temporary Equalization of Urban and Rural Standardized Payment Amounts Under IPPS*
www.cms.gov/manuals/pm_trans/A03023.pdf

A-03-030: *Provider-based Status On or After October 1, 2002*
www.cms.gov/manuals/pm_trans/A03030.pdf

B-03-028: *Durable Medical Equipment Regional Carriers – ICD-9-CM Coding*
www.cms.gov/manuals/pm_trans/B03028.pdf

B-03-029: *Managed Care Reasonable Charge Data Disclosure Requirements for Ambulance Services*
www.cms.gov/manuals/pm_trans/B03029.pdf

B-03-037: *Excluding from HH CB Edits Claims for Therapy Services Rendered by Physicians*
www.cms.gov/manuals/pm_trans/B03037.pdf

S&C 03-18: *Physician delegation of tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)*
www.cms.gov/medicaid/ltcsp/sc0318.pdf

Special Forum Notes

Thanks !

CMS would like to thank the Powell Valley Medical Center in Wyoming and the American Medical Association for hosting the Physician Open Door Forum and Geisinger Health Systems in Pennsylvania for hosting both the Rural Health and the Skilled Nursing Facility / Long Term Care Open Door Forums in April. Their generosity in these regards is immeasurable.

On the Road!

As special guests of the National Rural Health Association (NRHA), CMS will host the May 16 Rural Health forum from Salt Lake City Utah. And as special guests of the Indiana State Medical Association (ISMA), the May 19 Physician forum will be held in Indianapolis, IN. Be sure to register at the Open Door Forum web-page at: www.cms.gov/opendoor/listservs.asp to receive your invitation.

New Ambulance Open Door Forum

The ambulance open door forum will replace the bi-weekly industry conference calls that CMS has been conducting since the implementation of the ambulance fee schedule. In addition, the ambulance open door forum, as opposed to either the bi-weekly industry conference calls or the ambulance "Q" web site, will be the vehicle for communicating questions to CMS about ambulance issues. The ambulance services website, containing responses to questions received to date on the ambulance fee schedule implementation, is located at: www.cms.hhs.gov/suppliers/ambulance

For any information regarding the CMS Open Door Forum Initiative, please feel free to visit the home-page at: www.cms.hhs.gov/opendoor

