



The Pulse of CMS

“A quarterly regional publication for health care professionals”
Serving Delaware, Maryland, Pennsylvania, Virginia, West Virginia and the District of Columbia.

Kansas Governor Kathleen Sebelius Sworn In as HHS Secretary

Kathleen Sebelius was sworn in as the 21st Secretary of the Department of Health and Human Services (HHS) on April 29, 2009. The Secretary governs one of the largest civilian departments in the federal government with more than 67,000 employees. HHS is the principal agency for protecting the health of all Americans by providing effective health and human services, especially for those who are least able to help themselves.

Secretary Sebelius has over 20 years of experience in state government and has been a leader on health care issues for over a decade. She was first elected governor of Kansas in 2003 and was reelected in 2006. Throughout her tenure, Sebelius was lauded for her record of bipartisan accomplishment. She worked tirelessly to grow the state's economy and to create jobs, to ensure that every Kansas child received a quality education, and to improve access to quality and affordable health care.

As governor, Sebelius expanded Kansas' newborn screenings, put a renewed emphasis on childhood immunization, and increased eligibility for children's health coverage. More than 59,000 additional children were enrolled in health coverage during her time in office. Sebelius also worked closely with Kansas first responders and law enforcement to prepare for natural disasters and other emergencies. In 2005, *Time* magazine named her one of the nation's top five governors.

Prior to her tenure as governor, Secretary Sebelius spent eight years serving as the Kansas State Insurance Commissioner. In that capacity, Sebelius turned her department into a steadfast advocate for Kansas consumers and helped senior citizens save more than \$7 million on prescription drugs. She also won praise for her role in drafting a proposed national bill of rights for patients. Previously, she was a member of the Kansas House of Representatives from 1986-1994.

Secretary Sebelius has been married to Gary, a federal magistrate judge, for 34 years. They have two sons, Ned and John.

DMEPOS Competitive Bid Program Moving Forward

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, made limited changes to the competitive bidding program for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), including a requirement that the Secretary conduct a second competition to select suppliers for Round 1 in 2009. The Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment period (IFC) on January 16, 2009. The rule incorporates into existing regulations specific statutory requirements contained in MIPPA related to the competitive bidding program.

The Administration delayed the effective date for the IFC to allow CMS officials the opportunity for further review of the issues of law and policy raised by the rule. Based upon its review and on the need to ensure that CMS is able to meet the statutory deadlines contained in MIPPA, the Administration has concluded that the effective date should not be further delayed. The rule became effective April 18, 2009. However, there will be no immediate effect on the Medicare DMEPOS benefit, and Medicare beneficiaries may continue to use their current DMEPOS suppliers at this time.

In the upcoming weeks, CMS will be issuing further guidance on the timeline for and bidding requirements related to the Round 1 re-bid. In finalizing these guidelines, CMS will continue to seek input from all affected stakeholders to ensure program implementation consistent with the legislative requirements.

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H1N1 Flu Update

For the most current information about the H1N1, visit the [Centers for Disease Control and Prevention \(CDC\) website](http://www.cdc.gov). You will find consumer and provider fact sheets, current information, and steps you can take to protect yourself against infection.

At the CDC site you also will be able to download a widget that you can post to your own website to help your membership get the most current and accurate information.



Draft Minimum Data Set (MDS) 3.0 Posted

A draft version of the MDS 3.0 item set has been posted. It can be accessed on the [CMS website](#). The final version is still scheduled for publication in October 2009.

Please Note: This is a draft version of the item set and should not be used for training purposes. The final version of the item set, data specifications, and Resident Assessment Instrument (RAI) manual are scheduled for publication on the [MDS 3.0 web page](#) in October 2009. As additional information becomes available, it will be posted on the MDS 3.0 section of the CMS website.

HIPAA 5010 Resources Available

The implementation of HIPAA 5010 presents substantial changes in the content of the data which providers submit with their claims as well as the data available to them in response to their electronic inquiries. The [Special Edition MLN Matters article](#) alerts providers of these HIPAA changes and how they need to plan for their implementation.

CMS will host a national education conference call on June 9, 2009 from 2:30-4:30 PM ET to address the implementation of HIPAA Version 5010. This call is being conducted for all Medicare fee-for-service providers. The call will give a general overview of the transition to HIPAA Version 5010 and address some of the exceptions and situations you may encounter as the new version is implemented. A presentation will be given and CMS subject matter experts will be available to answer questions. A PowerPoint presentation will be posted on the [CMS 5010 Webpage](#) prior to the call.

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to receive the call-in data. This registration is solely to reserve a phone line, NOT to allow participation. If you cannot attend the call, replay information will be available.

Registration will close at 2:30 p.m. ET on June 8, 2009, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

To register for the call, participants need to go to the [CMS events registration page](#).

CMS Announces Pilot Program to Improve Quality Across Care Settings

CMS has announced that 14 communities around the nation have been chosen for the Agency's Care Transitions Project, seeking to eliminate unnecessary hospital readmissions.

The goal of the Care Transitions Project is to improve health care processes so that patients, their caregivers, and their entire team of providers have what they need to keep patients from returning to the hospital for ongoing care needs. By promoting seamless transitions from the hospital to home, skilled nursing care, or home health care, this community-wide approach seeks not only to reduce hospital readmissions, but also to yield sustainable and replicable strategies that achieve high-value health care for Medicare beneficiaries.

Communities in the following regions have been selected to participate in the project: Providence, R.I.; Upper Capitol Region, N.Y.; Western Pennsylvania; Southwestern New Jersey; Metro Atlanta East, Ga.; Miami; Tuscaloosa, Ala.; Evansville, Ind.; Greater Lansing Area, Mich.; Omaha, Neb.; Baton Rouge, La.; North West Denver, Colo.; Harlingen, Texas; and Whatcom County, Wash. The work of the Care Transitions

Project will respond to the unique needs of each of the 14 communities.

Each of the Care Transitions communities is led by a state Quality Improvement Organization (QIO). QIOs work throughout the country as part of CMS's quality program to help health care providers, consumers and stakeholder groups to refine care delivery systems to make sure all Medicare beneficiaries get the high-quality, high-value health care they deserve.

CMS will monitor the success of this project by watching the rates at which patients in these communities return to the hospital. Re-admission rates for hospitals have been tracked by CMS for some time and will be available to consumers later this year through the [Hospital Compare Website](#).

The Care Transitions Project will continue in all 14 communities through summer 2011. For more information about the [Care Transitions Project](#), visit the CMS website. To learn more about the work that QIOs are doing across the country, visit the [QIO page of the CMS website](#).

Medicare to Test Payment Incentives to Improve Care in Nursing Homes

Medicare officials announced a new, four-state demonstration to determine if cash incentives will improve the quality of care and efficiency of operations in nursing homes. Nursing homes in Arizona, Mississippi, New York, and Wisconsin will be asked to participate.

Facilities joining the Nursing Home Value-Based Purchasing demonstration will be awarded points for performance on quality measures in four areas: nurse staffing, avoidable hospitalizations, resident outcomes, and the scope and severity of deficiency citations the home has received during inspections. Nursing homes with the highest scores or the greatest improvement in their score will be eligible for a performance payment.

Savings generated by improved performance, such as reducing the number of avoidable hospitalizations, will fund state pools from which

payments will be made to qualified nursing homes.

Nursing homes wishing to participate in the demonstration will be randomly assigned to a demonstration group or a comparison group. Medicare officials anticipate that at least 100 nursing facilities in each state will apply to be part of this demonstration. The demonstration is expected to run from July 2009 through June 2012, at which time its effectiveness will be evaluated to inform possible changes to Medicare payment policy.

CMS will mail an application kit to each Medicare-certified nursing home in the demonstration states.

Outreach Schedule for Recovery Audit Contractors Available

CMS has posted the outreach schedule for the Recovery Audit Contractor (RAC) program. The schedule is arranged according to the four regional jurisdictions which have been established to implement the full RAC program. Additional events will be added to this list and posted on the CMS website as they are confirmed. The schedule of the events can be viewed on [the RAC page of the CMS website](#). A map of the jurisdictions and general implementation timeline also can be view on the [RAC page](#).

New Fact Sheet Available for FQHCs

The revised *Federally Qualified Health Center Fact Sheet* (April 2009), which provides information about Federally Qualified Health Center (FQHC) designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC payments; and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is now available to download from the CMS website at [Medicare Learning Network website](#).

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CMS Proposes Payment and Policy Updates for Inpatient Rehabilitation Facilities

CMS issued a proposed rule on April 28, 2009 that would update payment rates and clarify the framework for Medicare patient selection and care in inpatient rehabilitation facilities (IRFs) during fiscal year (FY) 2010. The proposed rule would apply to more than 200 freestanding IRFs and over 1,000 IRF units in acute care hospitals, and would be effective for discharges occurring on or after October 1, 2009.

The proposed rule's patient selection and care provisions are intended to ensure that Medicare beneficiaries who need the intensive rehabilitation services provided in IRFs continue to have access to high quality care. In addition to the proposed rule, CMS is posting draft revisions to the Medicare Benefit Policy Manual (MBPM) for public comment. This draft provides detailed policy guidance regarding the selection of patients for admission to IRFs, as well as the development and implementation of individual treatment plans.

Comments on the draft MBPM revisions may be submitted through a link that will be supplied on the CMS website, rather than through the [www.regulations.gov](#) site used for the submission of comments on proposed regulatory language. CMS intends to issue final updated MBPM policies concurrently with the issuance of the final IRF prospective payment system (PPS) rule.

The proposed revisions would clarify requirements for preadmission screening to determine whether a patient should receive rehabilitation services in an IRF or in another, less-intensive setting, post-admission treatment planning, and ongoing care coordination throughout the inpatient stay.

Since 2002, Medicare has paid rehabilitation hospitals and rehabilitation units in acute care hospitals for inpatient stays under the IRF PPS. The payment rates set by the IRF PPS for rehabilitation therapy services are higher than would be paid for

services in other settings. This is because these patients have more severe and more complex medical conditions that need more intensive and coordinated rehabilitation services.

To be paid under the IRF PPS, each facility must demonstrate on an annual basis that at least 60 percent of its total patient population had either a principal or secondary diagnosis that falls within one or more of the qualifying conditions designated in the regulations governing IRFs, commonly referred to as "the 60 Percent Rule." CMS is also proposing to require submission of IRF patient assessment data on Medicare Advantage patients in IRFs as well.

In other provisions, CMS projects that the payment rate update for IRFs will be 2.4 percent in FY 2010, based on the Rehabilitation, Psychiatric, and Long-term Care (RPL) market basket, and that, if finalized as proposed, the market basket update would increase total payments to IRFs in FY 2010 by \$140 million. Also, CMS is proposing to set the outlier threshold for FY 2010 at \$9,976, which would increase overall IRF payments by an additional \$10 million. The total increase in IRF payments under this proposed rule is \$150 million.

CMS will accept comments on the proposed rule until June 29, 2009, and will address all comments in a final rule to be issued by August 1, 2009.

The proposed rule went on display on April 28, 2009 at the Office of the Federal Register's Public Inspection Desk and will be available under "Special Filings" on the [Federal Register website](#).

For more information, including information about how to submit comments on the draft MBPM provisions, visit the [CMS website](#).

In the Spotlight... Two New CMS Websites



[Economic Recovery Act of 2009](#)

[Stop Medicare and Medicaid Fraud](#)

E-Prescribing Update: New Internet Content

CMS is pleased to announce that two new section pages have been created on the 2009 Electronic Prescribing (E-Prescribing) Incentive Program web page on the CMS website.

E-Prescribing Measure Section page: This page contains several resources including: Measure Specifications, new Claims-Based Reporting Principles, and a Sample E-Prescribing Claim. To access these resources, visit http://www.cms.hhs.gov/ERxIncentive/06_E-Prescribing_Measure.asp on the CMS website.

Educational Resources Section page: This page contains MLN Matters articles, E-Prescribing Incentive Program fact sheets, a link to Medicare's Practical Guide to the E-Prescribing Incentive Program, and information on how to receive continuing education credit related to the E-Prescribing Incentive Program. To access these resources and information, visit http://www.cms.hhs.gov/ERxIncentive/09_Education_Resources.asp on the CMS website.

New and updated information will continually be added, so please visit the [E-Prescribing Incentive Program web page](#) on the CMS website on a frequent basis.

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Medicare Expands Coverage of PET Scans as a Cancer Diagnostic Tool

CMS has issued a final national coverage determination (NCD) to expand coverage for initial testing with positron emission tomography (PET) for Medicare beneficiaries who are diagnosed with and treated for most solid tumor cancers. This NCD removes a clinical study requirement for PET scan use in these patients.

Since 2005, Medicare coverage of PET scans for diagnosing some forms of cancer and guiding treatment has been tied to a requirement that providers collect clinical information about how the scans have affected doctors' treatment decisions. This information was gathered through the National Oncologic PET Registry (NOPR) observational study. This NCD removes the requirement to report data to the NOPR when the PET scan is used to support initial treatment (or diagnosis and "staging") of most solid tumor cancers.

This decision applies to PET scans used to support initial diagnosis and treatment for most types of solid tumor cancers. It also expands

coverage of PET scans for subsequent follow up testing in beneficiaries who have cervical or ovarian cancer, or who are being treated for myeloma, a cancer that affects white blood cells. For these cancers, NOPR data collection will no longer be required.

It is important to note that this decision still requires clinicians to report data to the NOPR when using PET scans to monitor the progress of treatment or remission of cancer in some cases. Although the evidence generated by the NOPR study helped CMS determine that PET scans are useful in helping guide treatment when cancer is first diagnosed, scientific evidence is not as strong in showing that PET scans are as useful in making subsequent treatment decisions for some types of cancer.

More information about the types of cancer covered by this new policy is available in CMS' final decision memorandum. Read the final decision on [the CMS Website](#).



Observation Care Services

Observation care services provided in a hospital emergency room must be reasonable and necessary to be covered by Medicare. In most cases, the decision by the admitting physician (and the care team) to discharge a patient following resolution of the reason for the observation care or to admit the beneficiary as an inpatient can be made in less than 48 hours. In only **rare** and **exceptional** cases do reasonable and necessary outpatient observation services span more than 48 hours.

The appropriate physician must be diligent and complete the order for admission based on the

clinical assessment, or document the need for outpatient services prior to the patient leaving the hospital. Communication with the patient and their family concerning these decisions and assuring that the appropriate documentation has been completed is necessary so post-acute care Medicare benefits in a skilled nursing facility (SNF) can be secured if medically necessary. In the **rare** and **exceptional** cases that span three or more days, and no inpatient admission order is completed, this exception must be properly communicated to the patient and their family so they are aware that the potential 100 day SNF benefit will **not** be available.

For further information concerning outpatient observation services, please review the CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 290 or access the link on the [CMS Manuals website](#).

Information Disclaimer:

The information provided in this newsletter is intended only to be general summary information to the Region III 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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