CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 63

Date: NOVEMBER 12, 2004

SUBJECT: Home Health Services

I. SUMMARY OF CHANGES: This revision provides the following changes:

In Chapter 5, the CMS Central Office contact for HEDIS and QAPI Breast Cancer Screening questions is changed to:

Center for Beneficiary Choices
Division of Managed Care Policy
Medicare Plan Policy

NEW/REVISED MATERIAL - EFFECTIVE DATE: November 12, 2004
(Chapter 5)

In Chapter 17B, the date through which HMOs/CMPs may process claims for home health services is changed from services received before January 1, 2004, to services received under cost reports with periods beginning before January 1, 2005.

NEW/REVISED MATERIAL - EFFECTIVE DATE, January 1, 2005
(Chapter 17B)

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 5, Section 40.6/Minimum Performance Levels and Performance Goals
R	Chapter 5, Appendix A, National QAPI Project Operational Policy Letters/ 2002 - Breast Cancer Screening
R	Chapter 17B/ Section 300/ - Duplicate Payment Detection for Cost Contracting HCPPs and HMOs/CMPs

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

40.6 - Minimum Performance Levels and Performance Goals

(Rev. 63, 11-12-04)

While provisions at 42 CFR 422.152(c) permit CMS to establish minimum performance levels which must be met by contracting organizations, CMS has not yet established these levels. To establish minimum performance levels CMS must assure that organizations have had sufficient experience reporting specific measures on which levels would be set. When the accuracy and validity of submissions over time can be determined, CMS will be able to establish not only minimum performance levels but also set benchmarks for MCOs to achieve as specific goals.

Contacts

1	HEDIS Technical Specifications and Reporting and HEDIS Compliance Audit	MCOs should address all questions or requests for clarifications about the HEDIS technical specifications and audit to NCQA through its new Policy Clarification Support (PCS) Web page. The PCS page is accessible from the main NCQA Web site (http://www.ncqa.org). To access PCS, click on Support on the bottom of the gray bar along the left side of the NCQA home page and then click on Policy Clarification Support. The direct link for the PCS Web page is: http://www.ncqa.org/programs/faq/PCS.asp. From here, users can view Frequently Asked Questions (FAQ) and Policy Updates or submit a question to PCS staff. You can also reach NCQA through its Customer Support Line at (888) 275-7585. Questions about Medicare HEDIS not resolved through NCQA can be directed to *Division of Managed Care Policy (410) 786 1093, Medicare Plan Policy Group* in CMS' Center for Beneficiary Choices. When contacting CMS, MCOs should be prepared to tell CMS both the advice that they received from NCQA and the individual at NCQA with whom they spoke.
2	HOS	For technical questions regarding the Medicare Health Outcomes Survey program, please contact Chris Haffer in CMS' Center for Beneficiary Choices at (410) 786-8764. Questions relating to the vendors or survey protocol should be addressed to Oanh Vuong at NCQA at (202) 955-1777 or vuong@ncqa.org. For technical questions regarding the use of technical data or reports, please contact the HOS Information and Technical Support Telephone Line at HSAG at 1-888-880-0077 or via email at hos@azqio.sdps.org.
3	CAHPS	For technical questions regarding the MMC CAHPS Survey, please contact Amy Heller at (410) 786-9234 of CMS' Center for Beneficiary Choices or email CAHPS@cms.hhs.gov. For the Disenrollment Reasons Survey, please contact Chris Smith-Ritter at (410) 786-4636 or email CAHPS@cms.hhs.gov.
4	Demonstrations	For questions regarding policy and technical questions on the

Contacts

demonstration projects contact the assigned CMS project officer.

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Appendix A - National QAPI Project Operational Policy Letters

(Rev. 63, 11-12-04)

2002 - Breast Cancer Screening

Overview of the Breast Cancer Screening (BCS) Project

The main objective of this project is to decrease the morbidity and mortality associated with breast cancer in female Medicare beneficiaries enrolled in M+C Organizations. In order to accomplish this goal, it is important to increase the level of early detection of the disease by encouraging optimal use of mammography.

National BCS QAPI Project Specifications

This project will involve the use of the HEDIS® breast cancer screening measure as described by the NCQA in Volume 2 of its HEDIS 2002 Technical Specifications. *T*his measure considers the percentage of women age 52 through 69 years who were continuously enrolled during the measurement year and the preceding year, and who had a mammogram during the measurement year or the preceding year.
Baseline data for the project will use the Medicare HEDIS 2002 (measurement year 2001) reported rate filed through NCQA by June 28, 2002. M+C Organizations that do not report HEDIS 2002 because they do not meet minimum enrollment or contract effective date requirements will not have to participate in the 2002 BCS project since it is not likely they will have sufficient incidence to develop a baseline due to low enrollment. Re-measurement, after interventions, will use the HEDIS specifications in effect at that time. If the BCS measure has been rotated or if HEDIS is no longer being used at the point of re-measurement then HEDIS 2002 specifications will be used.

Rewarding High Performance

We recognize that some organizations have already achieved a high rate on screening by mammography and that opportunity for additional improvement would be difficult and costly to achieve. Therefore, CMS has decided that MCOs that have a reported rate at or above 80 percent for HEDIS 2001 (measurement year 2000) will be excused from performing the national BCS project and will have to perform only the M+C Organization selected project for this year. For HEDIS 2000 there were 61 HEDIS submissions which met or exceeded the 80 percent rate. Additionally, organizations that report a rate below 80 percent for HEDIS 2001, but report a rate at or above 80 percent for HEDIS 2002 (measurement year 2001) will be exempt from the 2002 national project.

Organizations that did not report HEDIS 2001, but report a rate at or above 80 percent for HEDIS 2002, will also be exempt from the 2002 national project.
Although CMS does not receive the annual HEDIS report from NCQA until approximately August 1, organizations are aware of their own rates several months earlier. Additionally, most M+C Organizations are aware of their previous BCS rates and are in a position to judge the effectiveness of previous interventions so they can determine the level of effort that will be required to achieve demonstrable improvement in the future. Therefore, using HEDIS 2002 for the baseline should not cause a problem for initiating the 2002 national project. Also, it will permit the use of data from the previous year, consistent with QAPI project provisions.

A list of organizations that do not have to perform the national project will be posted as an addendum to OPL 2001.133 at the CMS Web site about October 1st of 2002. This posting will inform the exempt M+COs that they are exempt based on data from HEDIS 2002 (measurement year 2001). A similar posting was made in 2001 for M+COs exempt based on data from HEDIS 2001 (measurement year 2000). The CMS will input the exemption into the M+C Quality Review Organization QAPI database.

Project Initiation and Implementation

CMS requires that the organization achieve demonstrable and sustained improvement in clinical care as a result of performing this project. Therefore, interventions must achieve improvement that is significant and sustained over time.

Organizations that are currently engaged in a similar BCS project as their internally selected project will need to follow guidance in section 1.3.3.3 of the QISMC document. This requires drawing a new baseline based on HEDIS 2002 (measurement year 2001) from which a re-measurement will be made while completing the previously initiated M+C Organization selected project. The national QAPI project will not affect the cycle of internal optional projects.

Support/Communication for Projects

We encourage M+C Organizations to work in collaboration with their local QIO as they seek appropriate interventions to improve mammography rates and reduce burden on providers of services. In addition to QIO support, we would like to alert MCOs about the Centers for Disease Control and Prevention's information resources on the Web at http://www.cdc.gov/cancer/nbccedp/. Another helpful site is located at http://cis.nci.nih.gov.

Please send any questions regarding this OPL/BCS project to your RO managed care staff, or to: *Division of Managed Care Policy (410) 786 1093, Medicare Plan Policy Group* in the Center for Beneficiary Choices.

*Kerlikowske, et al. JAMA 1993; 270(20): 2444-2450

**http://www.cancer.org/NBCAM_fastfacts.html (cited 2001 January 4)

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300 - Duplicate Payment Detection for Cost Contracting HCPPs and HMOs/CMPs

(Rev. 63, 11-12-04)

Several entities may have jurisdiction over the processing and payment of Part B bills for an HMO's/CMP's members. This could result in duplicate payments to either the physician, supplier, or to the enrollee. It is incumbent that HCPPs and HMOs/CMPs establish a system to preclude or detect duplicate payments.

Regardless of the claims option selected, HMOs/CMPs are required to process all non-provider Part B bills, with some exceptions. These exceptions, as noted below, are processed by the carrier or intermediary:

- Claims for services by an independent physical therapist;
- Claims for outpatient blood transfusions;
- Claims from physicians for dialysis and related services provided through an approved dialysis facility;
- *Claims for home health services under cost reports beginning on or after January 1, 2005*; and
- Hospice care by Medicare participating hospices, except:

    a. Services of the enrollee's attending physician if the physician is an employee or contractor of the organization and is not employed by or under contract to the member's hospice; and

    b. Services not related to the treatment of, or a condition related to, the terminal condition.

Duplicate payment detection is the responsibility of the HCPP or HMO/CMP, not the carrier. The HCPP or HMO/CMP should perform several duplicate check functions after it receives paid claims information. If the HCPP or HMO/CMP has not previously paid the claim, a copy of the claims information is filed in the beneficiary's history file. If the duplicate payment check reveals that the HCPP or HMO/CMP has already paid for the services:

- Contact the physician/supplier or enrollee to retrieve the overpayment;
- Record any collections as credits on the cost report;

- Notify CMS of unresolved overpayment situations; and
- Do not return payment to the carrier.