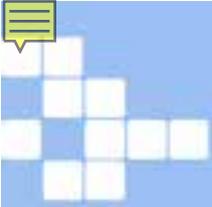


# 2012 Updates

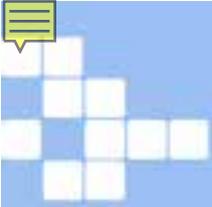


Alaska



# Lessons

1. Important Legislation
2. Medicare Updates
  - i. Original Medicare
  - ii. Medicare Advantage
  - iii. Medicare Prescription Drug Coverage
3. Fighting Fraud and Abuse
4. Agency Goals and Initiatives



# 1. Important Legislation

§ Most of the information in this presentation relates to

- Two laws that are collectively called the Affordable Care Act
  - Patient Protection and Affordable Care Act
  - Health Care and Education Reconciliation Act of 2010
- Middle Class Tax Relief and Job Creation Act of 2012

# 2012 Enrollment (in millions)

Medicare	Medicaid	Children's Health Insurance Program
48.6M <ul style="list-style-type: none"><li>• 36.7M Original Medicare</li><li>• 11.9M Medicare Advantage</li><li>• 35.6M get Part D Rx benefits<ul style="list-style-type: none"><li>◻ 29.4M in Part D</li><li>◻ 6.2M through Retiree Drug Subsidy</li><li>◻ 10.7M low-income have drug coverage</li></ul></li></ul>	57M	5M+
<b>9.2M Medicare and Medicaid Eligible</b>		

# Outpatient Mental Health Care

## § After Part B deductible

- For visits to diagnose condition
  - You pay 20% of Medicare-approved amount
- For outpatient treatment (such as psychotherapy)

In this year	You pay
2012	40%
2013	35%
2014	20%

# 2012 Therapy Cap Extension

Type of Therapy	Annual Limit
Physical and Speech-Language Pathology	\$1,880 Combined
Occupational Therapy	\$1,880

§ Exceptions process extended through 12/31/12

§ The manual medical review exceptions process

- Effective October 1, 2012
- Guidance pending

□ Caps apply to payment for therapy provided in a hospital outpatient department



# Annual Wellness Visit

---

## § Who is eligible?

- Must have Part B for longer than 12 months, or 12 months after Welcome to Medicare Preventive Visit

## § One visit every 12 months

## § Who can furnish an AWW?

- Physician
- Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist
- Medical professional or team of medical professionals under direct supervision of a physician

## § No cost if qualified and participating health professional accepts assignment

- Services not included in AWW subject to regular billing



# Annual Wellness Visit

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## § What is included

- Health risk assessment
- Medical/family history
- List of providers/suppliers involved in care
- Review of functional ability, level of safety, risk factors for depression
- Blood pressure, height, and weight measurements
- Written screening schedule
- Personalized health advice
- Referrals for health education and preventive counseling to help you stay well



# Alcohol Misuse Screening & Counseling

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## § Annual screening

- Up to 4 face-to-face counseling sessions if you
  - ◻ Misuse alcohol
  - ◻ Does not meet criteria for alcohol dependence
  - ◻ Are competent and alert when counseled
- Counseling must be furnished
  - ◻ By a qualified primary care provider
  - ◻ In a primary care setting

## § No cost if provider accepts assignment



# Cardiovascular Disease (CVD) Risk Reduction Visit

---

- § One CVD risk reduction visit per year
  - Provided by a primary care provider in a primary care setting
- § The visit includes the following components
  - Encouraging aspirin use if benefits outweigh risks
  - Screening for high blood pressure
  - Intensive behavioral counseling to promote healthy diet
- § No cost if provider accepts assignment



# Annual Depression Screening

---

## § Screening in primary care setting

- With staff-assisted depression care supports
- To assure accurate diagnosis
- Effective treatment and
- Follow-up

## § Various screening tools are available

- Choice of tool at discretion of clinician

## § No cost if provider accepts assignment



# Obesity Screening and Counseling

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§ Obesity = body mass index (BMI)  $\geq 30\text{kg/m}^2$

§ Benefit consists of

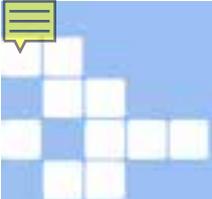
- Screening for obesity using BMI measurement
- Dietary (nutritional) assessment
- Intensive behavioral counseling

§ Coverage includes

- One face-to-face visit every week for the first month
- Then every other week for months 2-6
- Then every month for months 7-12

    q Must lose 6.6 lbs in first 6 months to continue

§ No cost if provider accepts assignment



# DMEPOS Competitive Bidding Program

§ Durable Medical Equipment, Prosthethics,  
Orthotics and Supplies (DMEPOS) Competitive  
Bidding Program



# DMEPOS Competitive Bidding Program

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- § Part B covered equipment and supplies
- § Saves money for taxpayers and People with Medicare
- § Beneficiaries generally must use contract suppliers
  - In certain areas
  - For certain products



# DMEPOS Competitive Bidding: Round 1

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§ Round 1 began January 1, 2011 in 9 areas

    □ Parts of CA, FL, IN, KS, KY, MO, NC, OH, PA, SC, TX

§ First year savings = \$202.1 million

§ Contract recompetete

§ Visit [www.cms.gov/DMEPOSCompetitiveBid](http://www.cms.gov/DMEPOSCompetitiveBid)



# Products Included in Competitive Bidding Program Round 1 Rebid

Oxygen, oxygen equipment, and supplies

Enteral nutrients, equipment, and supplies

Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs), and related supplies and accessories

Hospital beds and related accessories

Walkers and related accessories

Support surfaces (Group 2 mattresses and overlays) (in Miami area only)

Standard power wheelchairs, scooters, and related accessories

Complex rehabilitative power wheelchairs and related accessories (Group 2)

Mail-order diabetic supplies

\*

# Products Included in Competitive Bidding Program Round 2\*

Oxygen, oxygen equipment, and supplies

Enteral nutrients, equipment, and supplies

Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs), and related supplies and accessories

Hospital beds and related accessories

Walkers and related accessories

Support surfaces (Group 2 mattresses and overlays)

Standard (power ***and manual***) wheelchairs, scooters, and related accessories

***Negative pressure wound therapy pumps and related supplies and accessories***

*\*Changes from Round 1 to Round 2 in Bold Italics*



# National Mail Order Program for Diabetic Testing Supplies

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- § Targeted to go into effect at the same time as Round 2
- § Includes all parts of the United States:
  - q The 50 States
  - q The District of Columbia
  - q Puerto Rico
  - q The US Virgin Islands
  - q Guam
  - q American Samoa



# Who is Affected by Competitive Bidding?

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§ Beneficiaries who have Original Medicare and

- Live in a Competitive Bidding Area (CBA), or
- Obtain competitive bid items while visiting a CBA

§ To find out if ZIP code is in a CBA

- Call 1-800-MEDICARE (1-800-633-4227)
  - TTY users should call 1-877-486-2048
- Visit [www.medicare.gov/supplier](http://www.medicare.gov/supplier)

§ Medicare Advantage enrollees use plan suppliers



# Using Contract Suppliers

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§ Must use contract supplier for products included in Competitive Bidding Program if living in, or visiting, a CBA

## § Exceptions

- Keep renting from “Grandfathered” supplier
- Doctors and hospitals can supply certain items (e.g., walkers (Rounds 1 and 2) and folding manual wheelchairs (Round 2))
- Nursing facility can supply items directly if it is a contract supplier



# Identifying Contract Suppliers

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§ Call 1-800-MEDICARE (1-800-633-4227)

- TTY users call 1-877-486-2048

§ Visit the Medicare Supplier Directory

- [www.medicare.gov/supplier](http://www.medicare.gov/supplier)

q Look for star icon

§ Identifies Competitive Bidding Program suppliers and products



# Target Date Timeline for Round 2

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## § **Fall 2012**

CMS announces single payment amounts, begins contracting process

## § **Spring 2013**

CMS announces contract suppliers, begins contract supplier education campaign

## § **Spring 2013**

CMS begins supplier, referral agent, and beneficiary education campaign

## § **July 1, 2013**

Target date for implementation of DMEPOS Competitive Bidding Program Round 2 and National Mail-order Program contracts and prices

# Round 1 Competitive Bidding Areas (CBAs)

California	Riverside, San Bernardino, Ontario
Florida	Miami, Fort Lauderdale, Pompano Beach
Florida	Orlando, Kissimmee
Missouri and Kansas	Kansas City
North and South Carolina	Charlotte, Gastonia, Concord
Ohio	Cleveland, Elyria, Mentor
Ohio, Kentucky, Indiana	Cincinnati, Middletown
Pennsylvania	Pittsburgh
Texas	Dallas-Fort Worth, Arlington

# Region II: Round 2 MSAs

## New Jersey

- Allentown-Bethlehem-Easton, PA-NJ
- New York-Northern New Jersey-Long Island, NY-NJ-PA
- Philadelphia-Camden-Wilmington, PA-NJ-DE-MD

## New York

- Albany-Schenectady-Troy, NY
- Buffalo-Niagara Falls, NY
- New York-Northern New Jersey-Long Island, NY-NJ-PA
- Poughkeepsie-Newburgh-Middletown, NY
- Rochester, NY
- Syracuse, NY

**Puerto Rico:** None

**Virgin Islands:** None

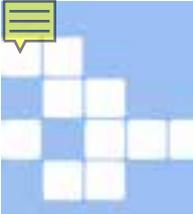
# Region III: Round 2 MSAs

## Virginia

- Richmond, VA
- Virginia Beach-Norfolk-Newport News, VA-NC
- Washington-Arlington-Alexandria, DC-VA-MD-WV

## West Virginia

- Huntington-Ashland, WV-KY-OH
- Washington-Arlington-Alexandria, DC-VA-MD-WV



# Medicare Advantage (Part C) Updates

- § Payments to Medicare Advantage Plans
- § Low-Performing Medicare Advantage Plans
- § Low Enrollment Medicare Advantage Plans
- § Special Needs Plan (SNP) Updates



# Payments to Medicare Advantage Plans

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## § Benchmarks vary

- MA payments will be aligned with Original Medicare payments on average at the county level

## § MA benchmarks reduced in 2012

- Phased in over 2, 4, or 6 years depending on level of payment reductions

## § The Medical Loss Ratio (MLR) Standard requires that 85% of funds must be spent on health care

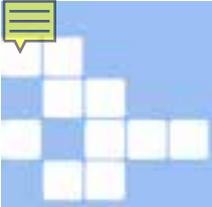
- Effective 2014



# Low-Performing Medicare Advantage Plans

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- § Plans that receive average Part C or D summary rating of less than 3-Stars for 3 years in a row
  - Indicates organization's substantial failure to comply with its Medicare contract
- § Ratings are on Medicare Plan Finder
  - Low-performing plan symbol (added in 2010) 
  - Pre-enrollment warning message (added in 2011)
- § *Medicare & You* doesn't have full, updated ratings
- § Watch for misuse of plan ratings



# Medicare Prescription Drug Coverage (Part D) Updates

- § 2012 Calendar Highlights
- § Standard Part D Benefit Parameters
- § Coverage Gap Discount Program
- § Income-Related Premium Adjustment Amount
- § Low-Performing Medicare Drug Plans
- § Coverage of Benzodiazepines and Barbiturates
- § Part D Coverage in Long-Term Care Facilities
- § Cost-Sharing for Individuals Receiving HCBS
- § Improvement to Complaint System



# 2012 Calendar Highlights

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- § September 16 – CMS mails the *Medicare & You* handbook
- § September 30 – Plans must provide Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) to members
- § October 1 – Plans may begin marketing
- § October 1 (tentative) – 2013 plan data to be displayed on the Medicare Plan Finder (MPF)
- § October 11 (tentative) – Plan ratings updated on MPF
- § October 15 – Medicare's Open Enrollment Period begins
- § December 7 – Open Enrollment ends
- § January 1, 2013 – CY 2013 plan benefit period begins

# Standard Part D Benefit Parameters

<b>Benefit Parameters</b>	<b>2012</b>	<b>2013</b>
Deductible	\$320	\$325
Initial Coverage Limit	\$2,930.00	\$2,970.00
Out-of-Pocket Threshold	\$4,700.00	\$4,750.00
Total Covered Drug Spending at OOP Threshold	\$6,730.39	\$6,954.52
Minimum Cost-Sharing in Catastrophic Coverage	\$2.60/\$6.50	\$2.65/\$6.60
<b>Extra Help Copayments</b>	<b>2012</b>	<b>2013</b>
Institutionalized	\$0	\$0
Receiving Home and Community-Based Services	\$0	\$0
Up to or at 100% Federal Poverty Level (FPL)	\$1.10/\$3.30	\$1.15/\$3.50
Full Extra Help	\$2.60/\$6.50	\$2.65/\$6.60
Partial Extra Help (Deductible/Cost-Sharing)	\$65/15%	\$66/15%



# Part D Coverage Gap Discount Program

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## § If you reach the coverage gap in 2012

- You get a 50% discount on covered brand-name drugs
  - Counts toward TrOOP
- You get 14% coverage on generic drugs
- The total cost you paid (plus the 50% discount the drug company paid) counts toward catastrophic coverage
- Dispensing fees are not subject to the 50% discounted

## § Additional savings in coverage gap each year

- Until 2020

# Improved Coverage in the Coverage Gap

Year	What You Pay for Brand Name Drugs in the Coverage Gap	What You Pay for Generic Drugs in the Coverage Gap
2012	50%	86%
2013	47.5%	79%
2014	47.5%	72%
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

Note: Dispensing fees are not subject to the 50% discount.



# Medicare Prescription Drug Coverage Premium

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§ A small group must pay a higher premium

- Based on income
- Fewer than 5% of all people with Medicare
- Uses same thresholds used to compute income-related adjustments to Part B premium

    q As reported on your IRS tax return from 2 years ago

§ Must pay if you have Part D coverage

- Will be notified by Social Security if required to pay

# Income-Related Monthly Adjustment Amount (IRMAA)

If Your Yearly Income in 2010 was		In 2012 You Pay
File Individual Tax Return	File Joint Tax Return	
\$85,000 or less	\$170,000 or less	Your Plan Premium (YPP)
\$85,000.01 – \$107,000	\$170,000.01 – \$214,000	YPP + \$11.60*
\$107,000.01 – \$160,000	\$214,000.01 – \$320,000	YPP + \$29.90*
\$160,000.01 – \$214,000	\$320,000.01 – \$428,000	YPP + \$48.10*
Above \$214,000	Above \$428,000	YPP + \$66.40*
*per month		



# Benzodiazepines and Barbiturates

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§ Will be removed from Medicare's excluded drug list and included as Part D-covered drugs

- Benzodiazepines
- Barbiturates

    q When used in the treatment of

        § Epilepsy

        § Cancer

        § Chronic mental health disorder

§ Effective January 1, 2013



# Part D Coverage in Long-Term Care Facilities

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## § Beneficiaries who live in LTC facilities

- Part D-covered brand-name drugs must be dispensed in increments of 14-days or less
  - e.g., instead of 30-day supply
  - Some exceptions (e.g., antibiotics)
- Intended to reduce amount of unused drugs
- Cost-sharing can't be more than a 30 day fill

## § Effective January 1, 2013



# Individuals Receiving Home and Community-Based Services (HCBS)

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§ No cost-sharing for Part D covered drugs

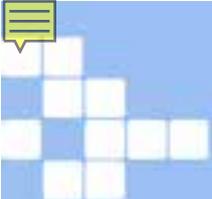
- For people who have

- ◻ Medicare and full Medicaid coverage

- ◻ Receive HCBS, and

- ◻ Would be institutionalized if not receiving HCBS

§ Effective January 1, 2012



## 3. Fighting Fraud and Abuse

### § Tax dollars saved

- Over \$4 billion recovered by the end of 2011

### § Nine Anti-fraud HEAT Strike Force teams

- In fraud hot spots around the country
- Hundreds of convictions
- Criminals have billed Medicare hundreds of millions

### § Senior Medicare Patrol [www.smpresource.org](http://www.smpresource.org)

- Reached 1.5 million with critical information

### § CMS is now using technology similar to that used in the financial services sector to identify fraud in Medicare billings



# Fraud and Abuse Prevention

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- § New steps to keep criminals on the defensive
- Tougher screenings for health care providers
  - Site visits
  - Keep fraudulent providers out of programs
    - ◻ Medicare
    - ◻ Medicaid
    - ◻ CHIP
  - Providers identified as higher risk subject to more thorough screening



# Prior Authorization of PMD Demonstration

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- § A new prior authorization process is being tested for Power Mobility Devices (PMDs)
  - Scooters and power wheelchairs
- § Intended to develop improved methods for investigating/prosecuting fraud
- § Pilot in states with high incidence of improper and fraudulent claims
  - CA, IL, MI, NY, NC, FL, and TX
- § Scheduled to begin Summer 2012
  - 3 year demonstration



# Redesigned Medicare Summary Notice

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- § Includes several new beneficiary-friendly features
  - How to check for important facts/potential fraud
  - Snapshot of deductible/payment/services/providers
  - Clearer language
  - Definitions of all terms used in the form
  - Larger fonts throughout to make it easier to read
  - Information on covered preventive services
- § Now available on MyMedicare.gov
- § Paper copies start mailing in early 2013

# Redesigned Medicare Summary Notice

## CURRENT MEDICARE SUMMARY NOTICE For Part B (Medical Insurance)

Page 1

**Medicare Summary Notice**

December 6, 2009

**CUSTOMER SERVICE INFORMATION**

Your Medicare Number: XXX-XX-12345

If you have questions, call:  
 1-800-MY-MEDICARE  
 (1-800-633-4227) (TDD) 1-800-633-4227

Ask for Doctor's Services  
 TTY for hearing impaired: 1-877-486-2048

Appeals Address: Please see the  
 Appeals Information - Part B Section.

**BE INFORMED:** Treat your Medicare Card as you would a credit card.

This is a summary of claims processed on 10/05/2009.

**PART B MEDICAL INSURANCE - ASSIGNED CLAIMS**

Code of Service	Service Provided	Amount Charged	Medicare Approval	Medicare Paid	You Must Be Paid	Net Patient Liability
<b>Claim number: 00-000000-000000</b>						
Jane Doe, M.D., Suite 100 100 Main Street, Jackson, MS 39201						
00210	1.0 Office/outpatient visit (PT14)	80.00	50.00	50.00	30.00	30.00
00220	1.0 Therapy and gym at insurance (Class)	20.00	0.00	0.00	0.00	20.00
00230	1.0 Diagnostic radiology procedure (XRAY)	10.00	0.00	0.00	0.00	10.00
00240	1.0 Diagnostic radiology procedure (XRAY) (Other)	10.00	0.00	0.00	0.00	10.00
00250	1.0 Inpatient admission (DART)	10.00	0.00	0.00	0.00	10.00
00260	1.0 Outpatient admission (DART)	10.00	0.00	0.00	0.00	10.00
<b>Claim Total</b>		<b>130.00</b>	<b>50.00</b>	<b>50.00</b>	<b>30.00</b>	<b>80.00</b>

THIS IS NOT A BILL - Keep this notice for your records.

## REDESIGNED MEDICARE SUMMARY NOTICE For Part B (Medical Insurance)

Page 1

**Medicare Summary Notice**  
for Part B (Medical Insurance)

The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

Page 1 of 1

Facility Name: \_\_\_\_\_  
 Your Name (Last): \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State (ZIP): 12345-6789

THIS IS NOT A BILL

**Notice for Your Name**

Medicare Number: XXX-XX-12345

Date of This Notice: September 16, 2011

Claims Processed Between: June 15 - September 15, 2011

**Your Claims & Costs This Period**

Did Medicare Approve All Services? **NO**

Number of Services Medicare Denied: **2**

See claims starting on page 3. Look for "NO" in the "Service Approval" column. See the last page for how to handle a denied claim.

**Total You May Be Billed: \$100.00**

**Your Deductible Status**

Your deductible is what you must pay for most health services before Medicare begins to pay.

**Part B Deductible:** You have now met 50% of your \$162 deductible for 2011.

**Be Informed:**

Register at [www.MYMedicare.gov](http://www.MYMedicare.gov) for direct access to your Original Medicare claims, track your preventive services and give us "The Call" report to share with your provider. Visit the Web site to sign up and access your personal Medicare information.

**Providers with Claims This Period**

June 16, 2011  
 Jane Doe, M.D.

June 28, 2011  
 John Doe, M.D.

June 29 - June 30, 2011  
 Any Doctor, M.D.

Claims processed under your contract with the results of Medicare coverage? (Leave a blank cell in space in English.)  
 \* \* \* \* \*

Side-by-side comparison at  
[www.cms.gov/apps/files/msn\\_changes.pdf](http://www.cms.gov/apps/files/msn_changes.pdf)



# Helping to Achieve CMS' Goals and Initiatives

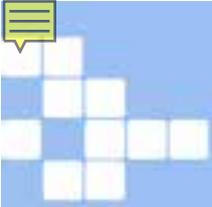
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## § Center for Medicare & Medicaid Innovations

- Focus on
  - q Primary Care Transformation
  - q Accountable Care Organizations
  - q Bundled Payment for Care Improvement
  - q Initiatives Focused on the Medicaid Population
  - q Capacity to Spread Innovation

## § Medicare-Medicaid Coordination Office

- Focus on
  - q Those enrolled in Medicare and Medicaid



# Primary Care Transformation

- ü Comprehensive Primary Care Initiative (CPC)
- § Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- ü Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- ü Independence at Home Demonstration
- § Graduate Nurse Education Demonstration

Note: Checked items will be discussed



# Primary Care Transformation

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## § Comprehensive Primary Care Initiative

- Support for better coordinated primary care
  1. Risk Stratified Care Management
  2. Access and Continuity
  3. Planned care for chronic conditions and Preventive care
  4. Patients and caregiver engagement
  5. Coordination of care across the medical neighborhood



# Primary Care Transformation

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## § Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration

- Encourage FQHCs to achieve Level 3 Patient Centered Medical Home recognition to
  - ◻ Improve effectiveness of medical teams
  - ◻ Help patients manage chronic conditions
  - ◻ Actively coordinate care for patients
- FQHCs receive monthly care management fee
- Up to 195,000 Medicare patients in demo

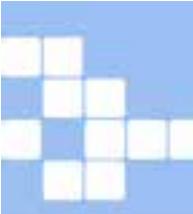


# Primary Care Transformation

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## § Independence at Home Demonstration

- Test providing services at home/Original Medicare
- Utilizes primary care teams
- Coordinates care across all settings
- Quality reporting is required



# Accountable Care Organizations and Other Shared Savings Initiatives

- § Medicare Shared Savings Program
- § Testing of the Pioneer ACO Model
- § Testing of the Advance Payment ACO Model
- § Physician Group Practice “PGP” Transition Demonstration



# Medicare Shared Savings Program Goals

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- § To facilitate coordination and cooperation
  - Among providers
  - For all services provided under Medicare FFS
- § To improve the quality of care
  - For Medicare Fee-For-Service (FFS) beneficiaries
- § To reduce unnecessary costs
- § To promote care accountability
  - For Medicare FFS beneficiaries
- § To encourage investment
  - In infrastructure and redesigned care processes



# What is an Accountable Care Organization (ACO)?

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- § Groups of health care providers and suppliers that
  - Work together to coordinate beneficiary care
  - Invest in infrastructure and redesigned, coordinated care processes
  - Agree to be held accountable for quality, cost, and overall care of fee-for-service beneficiaries assigned to them
  - Establish a mechanism for shared governance
  - Share in savings
- § A legal entity recognized and authorized under state law



# Accountable Care Organizations (ACOs)

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- § In order to receive shared savings  
Accountable Care Organizations (ACOs) must
  - Lower their growth in health care costs
  - Meet performance standards focused on
    - ◻ On quality of care
    - ◻ Putting patients first
- § Participation in an ACO is voluntary for providers



# Advance Payment ACO Model

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## § The Innovation Center is testing the Advance Payment ACO Model

- Provide additional support to physician-based and rural ACOs participating in the Medical Shared Savings Program.
- Will test whether pre-paying a portion of future shared savings will increase participation of physician-owned and rural ACO's.
- Payments will be recouped through shared savings earned by ACO.



# Pioneer ACO Model

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- § The Innovation Center is testing the Pioneer ACOs Model
  - Payment arrangements with higher risk and reward than in the SSP, including partial- and full capitation arrangements, as well as a transition from FFS to population-based payments
- § Designed for health care organizations and providers that are already experienced in coordinating care
- § Requires ACOs to create similar arrangements with other payers



# Pioneer ACO Model

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- § Expected to improve the health and experience of care for individuals, improve population health, and reduce the rate of growth in health care spending
- § CMS will publicly report the performance of Pioneer ACOs on quality metrics
- § 32 Participating ACOs announced in December 2011
- § First performance period began in January 2012.
- § Separate from the Medicare Shared Savings Program



# Quality Standards

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- § ACO must meet strict quality standards to ensure that savings are achieved through and providing care that is appropriate, safe, and timely
- § 33 quality measures in 2012 relating to
  - Care coordination and patient safety
  - Preventive health services
  - At-risk populations
  - The patient and caregiver experience of care
- § ACOs will be carefully monitored to ensure they meet the quality standards



# Beneficiary Communication

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## § Assigned beneficiaries will

- Be notified if their provider participates in an ACO
- Be informed their data may be shared with the ACO and may decline to have data shared



# Financial Performance

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## § ACO providers continue to be paid

- Under regular Medicare fee-for-service payment systems
- An annual risk adjusted expenditure target is calculated
  - ◻ Based on the historically assigned patient population
  - ◻ Updated by absolute growth in the national per capita expenditures for Parts A and B

## § ACOs may share in savings

- If actual assigned patient population expenditures
  - ◻ Are below the established benchmark
- Minimum savings rate (MSR) based on assigned patient population size must be exceeded to share savings



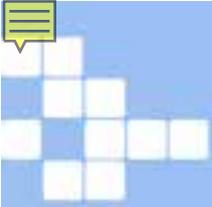
# ACOs/Shared Savings Initiatives Status

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§ As of April 1, 2012

- 154 total number of shared savings participants
  - ◻ 89 July start Shared Savings Program ACOs
  - ◻ 27 April start Shared Savings Program ACOs
  - ◻ 32 Pioneer Model ACOs
  - ◻ 6 Physician Group Practice Transition Demos

§ In all, more than 2.4 million beneficiaries receive care from providers participating in Medicare shared savings initiatives



# Capacity to Spread Innovation

- ü Partnership for Patients
- ü Community-Based Care Transitions
- ü Million Hearts
- § Innovation Advisors
- § Health Care Innovation Challenge

# Capacity to Spread Innovation

## § Partnership for Patients



- Share information on what works to keep patients from getting injured in the hospital and help them heal without complications

## § Community Based Care Transition Program

- Part of the Partnership for Patients
- To reduce hospital readmissions
- Maintain or improve quality of care across settings

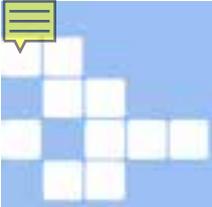
# Capacity to Spread Innovation

## § Million Hearts

- Aims to prevent 1 million heart attacks and strokes
- CDC-led focus on two goals over the next five years
  1. Empowering Americans to make healthy choices
    - Preventing tobacco use
    - Reducing sodium and trans fat consumption
  2. Improving care
    - Targeted focus on the “ABCS”
      - Aspirin for people at risk
      - Blood pressure control
      - Cholesterol management
      - Smoking cessation



[www.millionhearts.hhs.gov](http://www.millionhearts.hhs.gov)



# Other Initiatives

## § Hospital Readmissions Reduction Program

- Reduce avoidable hospital readmissions
- Readmissions cost Medicare billions of dollars annually
- Creates incentives for hospitals to reduce readmissions



# Other Initiatives

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## § Hospital Value-Based Purchasing

- Incentive payments based on performance for acute care hospitals beginning in FY 2013
- Performance is based on achievement and improvement on certain quality measures

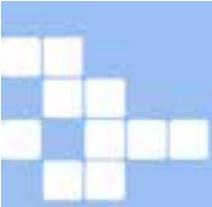


# Funding Opportunities

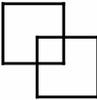
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## § Center for Consumer Information & Insurance Oversight (CCIIO) funding opportunities

- <http://cciio.cms.gov/resources/fundingopportunities/index.html#eig>
- Examples include
  - q The Consumer Support and Information
  - q Affordable Insurance Exchanges
  - q Health Market Reforms
  - q Consumer Operated and Oriented Plan (CO-OP) Program



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