CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2012 Updates

Session Objectives

- This training session will help you to
  - Discuss important legislation
  - Identify CMS's goals and initiatives that support them
  - Communicate program changes
    - Medicare
    - Medicaid
    - Other

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

2. Medicare Program Updates

- Medicare
  - Program Enrollment Numbers
  - Updates to Original Medicare
    - DMEPOS Competitive Bidding Program
  - Updates to Medicare Advantage (Part C)
  - Updates to Medicare Prescription Drug Coverage (Part D)

2012 Enrollment (in millions)

Medicare	Medicaid	Children's Health Insurance Program

48.6M
• 36.7M Original Medicare
• 11.9M Medicare Advantage
• 35.6M get Part D Rx benefits
  ▫ 29.4M in Part D
  ▫ 6.2M through Retiree Drug Subsidy
  ▫ 10.7M low-income have drug coverage
	57M	5M+

9.2M Medicare and Medicaid Eligible		

Updates on Certain Benefits in Original Medicare

- Outpatient Mental Health Care Costs
- Therapy Caps Exceptions
- Preventive Services Update
- DMEPOS Competitive Bidding Program Round 2

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 AWV?
  - 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 AWV subject to regular billing

Annual Wellness Visit

- 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

- 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

- Obesity = body mass index (BMI) ≥30kg/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
    - Must lose 6.6 lbs in first 6 months to continue
- No cost if provider accepts assignment

DMEPOS Competitive Bidding Program

- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program

DMEPOS Competitive Bidding Program

- 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

- 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 recompete

DMEPOS Competitive Bidding: Round 2

- Competitive Bidding Program will expand
  - Round 2
    - 91 Metropolitan Statistical Areas (MSAs)
    - Target effective date July 1, 2013
- Visit 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

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

Who is Affected by Competitive Bidding?

- 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
- Medicare Advantage enrollees use plan suppliers

Using Contract Suppliers

- 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

- Call 1-800-MEDICARE (1-800-633-4227)
  - TTY users call 1-877-486-2048
- Visit the Medicare Supplier Directory
  - www.medicare.gov/supplier
    - Look for star icon
      - Identifies Competitive Bidding Program suppliers and products

Target Date Timeline for Round 2

- **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 I: Round 2 MSAs

Connecticut

- Bridgeport-Stamford-Norwalk, CT
- Hartford-West Hartford-East Hartford, CT
- New Haven-Milford, CT

Maine: None

Massachusetts

- Boston-Cambridge-Quincy, MA-NH
- Providence-New Bedford-Fall River, RI-MA
- Springfield, MA
- Worcester, MA

New Hampshire

- Boston-Cambridge-Quincy, MA-NH

Rhode Island

- Providence-New Bedford-Fall River, RI-MA

Vermont: None

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

Delaware

- Philadelphia-Camden-Wilmington, PA-NJ-DE-MD

District of Columbia

- Washington-Arlington-Alexandria, DC-VA-MD-WV

Maryland

- Baltimore-Towson, MD
- Philadelphia-Camden-Wilmington, PA-NJ-DE-MD
- Washington-Arlington-Alexandria, DC-VA-MD-WV

Pennsylvania

- Allentown-Bethlehem-Easton, PA-NJ
- New York-Northern New Jersey-Long Island, NY-NJ-PA
- Philadelphia-Camden-Wilmington, PA-NJ-DE-MD
- Scranton-Wilkes-Barre, PA
- Youngstown-Warren-Boardman, OH-PA

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

Region IV: Round 2 MSAs

Alabama

- Birmingham-Hoover, AL

Florida

- Cape Coral-Fort Myers, FL
- Deltona-Daytona Beach-Ormond Beach, FL
- Jacksonville, FL
- Lakeland-Winter Haven, FL
- North Port-Bradenton-Sarasota, FL
- Ocala, FL
- Palm Bay-Melbourne-Titusville, FL
- Tampa-St. Petersburg-Clearwater, FL

Georgia

- Atlanta-Sandy Springs-Marietta, GA
- Augusta-Richmond County, GA-SC
- Chattanooga, TN-GA

Region IV: Round 2 MSAs

Kentucky

- Huntington-Ashland, WV-KY-OH
- Louisville/Jefferson County, KY-IN

Mississippi

- Jackson, MS
- Memphis, TN-MS-AR

North Carolina

- Asheville, NC
- Greensboro-High Point, NC
- Raleigh-Cary, NC
- Virginia Beach-Norfolk-Newport News, VA-NC

Region IV: Round 2 MSAs

South Carolina

- Augusta-Richmond County, GA-SC
- Charleston-North Charleston-Summerville, SC
- Columbia, SC
- Greenville-Mauldin-Easley, SC

Tennessee

- Chattanooga, TN-GA
- Knoxville, TN
- Memphis, TN-MS-AR
- Nashville-Davidson-Murfreesboro-Franklin, TN

Region V: Round 2 MSAs

Illinois

- Chicago-Joliet-Naperville, IL-IN-WI
- St. Louis, MO-IL

Indiana

- Chicago-Joliet-Naperville, IL-IN-WI
- Indianapolis-Carmel, IN
- Louisville/Jefferson County, KY-IN

Michigan

- Detroit-Warren-Livonia, MI
- Flint, MI
- Grand Rapids-Wyoming, MI

Minnesota

- Minneapolis-St. Paul-Bloomington, MN-WI

Region V: Round 2 MSAs

Ohio

- Akron, OH
- Columbus, OH
- Dayton, OH
- Huntington-Ashland, WV-KY-OH
- Toledo, OH
- Youngstown-Warren-Boardman, OH-PA

Wisconsin

- Chicago-Joliet-Naperville, IL-IN-WI
- Milwaukee-Waukesha-West Allis, WI
- Minneapolis-St. Paul-Bloomington, MN-WI

Region VI: Round 2 MSAs

Arkansas

- Little Rock-North Little Rock-Conway, AR
- Memphis, TN-MS-AR

Louisiana

- Baton Rouge, LA
- New Orleans-Metairie-Kenner, LA

New Mexico

- Albuquerque, NM

Oklahoma

- Oklahoma City, OK
- Tulsa, OK

Region VI: Round 2 MSAs

Texas

- Austin-Round Rock-San Marcos, TX
- Beaumont-Port Arthur, TX
- El Paso, TX
- Houston-Sugar Land-Baytown, TX
- McAllen-Edinburg-Mission, TX
- San Antonio-New Braunfels, TX

Region VII: Round 2 MSAs

Iowa

- Omaha-Council Bluffs, NE-IA

Kansas

- Wichita, KS

Missouri

- St. Louis, MO-IL

Nebraska

- Omaha-Council Bluffs, NE-IA

Region VIII: Round 2 MSAs

Colorado
- Colorado Springs, CO
- Denver-Aurora-Broomfield, CO

Montana: None

North Dakota: None

South Dakota: None

Utah
- Salt Lake City, UT

Wyoming: None

Region IX: Round 2 MSAs

Arizona

- Phoenix-Mesa-Glendale, AZ
- Tucson, AZ

California

- Bakersfield-Delano, CA
- Fresno, CA
- Los Angeles-Long Beach-Santa Ana, CA
- Oxnard-Thousand Oaks-Ventura, CA
- Sacramento-Arden-Arcade-Roseville, CA
- San Diego-Carlsbad-San Marcos, CA
- San Francisco-Oakland-Fremont, CA
- San Jose-Sunnyvale-Santa Clara, CA
- Stockton, CA
- Visalia-Porterville, CA

Region IX: Round 2 MSAs

Guam: None

Hawaii

- Honolulu, HI

Nevada

- Las Vegas-Paradise, NV

Samoa: None

Region X: Round 2 MSAs

Alaska: None

Idaho

- Boise City-Nampa, ID

Oregon

- Portland-Vancouver-Hillsboro, OR-WA

Washington

- Portland-Vancouver-Hillsboro, OR-WA
- Seattle-Tacoma-Bellevue, WA

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

- 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

- 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

Low-Performing Medicare Advantage Plans

- Changes for low-performing plans in 2013
  - No online enrollment for low-performing plans
    - Must contact plan directly to enroll
      - e.g., as required for many Special Needs Plans, Cost Plans
  - Enrolled beneficiaries may use Special Enrollment Period to move to a higher quality plan
    - Will receive mailing from CMS
- CMS has option to terminate low-performing contracts starting in 2015

Low Enrollment Medicare Advantage Plans

- CMS sent notices to low enrollment MA plans
  - Special Needs Plans (SNPs) w/less than 100 enrollees
  - Non-SNPs with less than 500 enrollees
- Plans may submit justification for renewal
- CMS will limit renewal for plans with sustained very low enrollment
  - Less than 25 enrollees

Dual Eligible Special Needs Plan (D-SNP) Updates

- SNPs for people with Medicare and Medicaid
  - May offer new supplemental benefits to better integrate care and keep beneficiaries in their homes
    - Non-skilled in-home support services
    - In-home food delivery
    - Supports for caregivers
    - Adult day care services
    - Home assessments and modifications
  - New benefits must be provided at no cost
- Effective January 1, 2013

Dual Eligible Special Needs Plan (D-SNP) Updates

- SNPs for people with Medicare and Medicaid
  - Must have contracts with state Medicaid agencies in the states in which they operate by July 1, 2012
    - If not, plan(s) will be terminated for 2013
      - Affected beneficiaries
        - Will be disenrolled to Original Medicare and auto-enrolled in benchmark PDP
        - Have ongoing SEP to choose another plan
- Effective January 1, 2013

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

- 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

Benefit Parameters	2012	2013
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
Extra Help Copayments	**2012**	**2013**
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

- 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

- 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
    - 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		

Low-Performing Medicare Drug Plans

- Plans that receive average summary rating of less than 3-Stars for 3 years in a row
  - Ratings are on Medicare Plan Finder
  - Low-performing plans designated with icon 
  - *Medicare & You* doesn't have full, updated ratings
- Changes for low-performing plans in 2013
  - No online enrollment
    - Must contact plan directly to enroll
  - Enrolled beneficiaries may use SEP to move to a higher quality plan
    - Will receive letter from CMS
- CMS may terminate contracts starting in 2015

Benzodiazepines and Barbiturates

- Will be removed from Medicare's excluded drug list and included as Part D-covered drugs
  - Benzodiazepines
  - Barbiturates
    - When used in the treatment of
      - Epilepsy
      - Cancer
      - Chronic mental health disorder
- Effective January 1, 2013

Part D Coverage in Long-Term Care Facilities

- 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)

- 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
  - 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

- 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

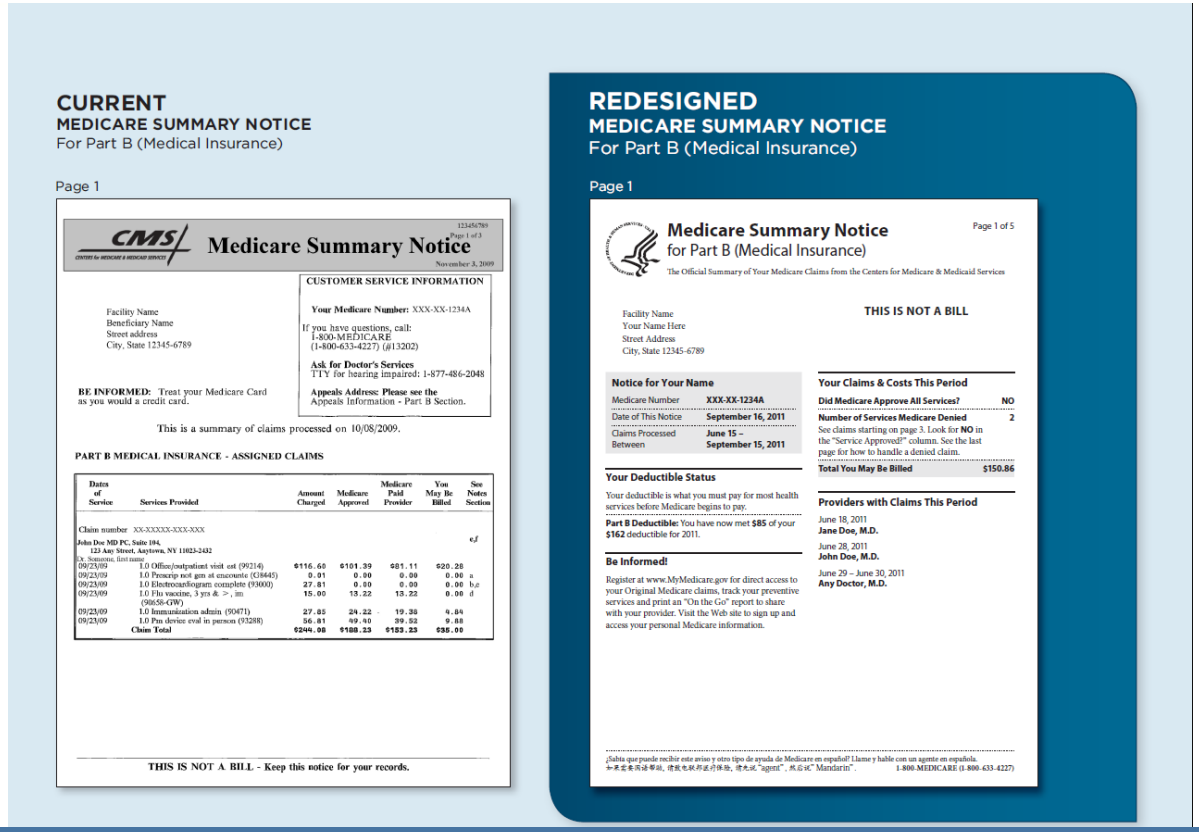
Prior Authorization of PMD Demonstration

- 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

- 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

CMS Medicare Summary Notice

November 3, 2009

Facility Name
Beneficiary Name
Street address
City, State 12345-6789

CUSTOMER SERVICE INFORMATION

Your Medicare Number: XXX-XX-1234A

If you have questions, call:
1-800-MEDICARE
(1-800-633-4227) (#13202)

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 10/08/2009.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number XX-XXXXX-XXX-XXX						e,f
John Doe MD PC, Suite 104, 123 Any Street, Anytown, NY 11023-2432						
Dr. Someone, first name						
09/23/09	1.0 Office/outpatient visit est (99214)	$116.60	$101.39	$81.11	$20.28	
09/23/09	1.0 Prescrip not gen at encounte (G8445)	0.01	0.00	0.00	0.00	a
09/23/09	1.0 Electrocardiogram complete (93000)	27.81	0.00	0.00	0.00	b,g
09/23/09	1.0 Flu vaccine, 3 yrs & > , im (90658-GW)	15.00	13.22	13.22	0.00	d
09/23/09	1.0 Immunization admin (90471)	27.85	24.22	19.36	4.84	
09/23/09	1.0 Psn device eval in person (93288)	56.81	49.40	39.52	9.88	
	Claim Total	$244.08	$188.23	$153.23	$35.00	

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)

Page 1 of 5

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

Facility Name
Your Name Here
Street Address
City, State 12345-6789

THIS IS NOT A BILL

Notice for Your Name

Medicare Number	XXX-XX-1234A
Date of This Notice	September 16, 2011
Claims Processed Between	June 15 – September 15, 2011

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 **$85** of your **$162** deductible for 2011.

Be Informed!

Register at www.MyMedicare.gov for direct access to your Original Medicare claims, track your preventive services and print an "On the Go" report to share with your provider. Visit the Web site to sign up and access your personal Medicare information.

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 Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed	$150.86

Providers with Claims This Period

June 18, 2011
Jane Doe, M.D.

June 28, 2011
John Doe, M.D.

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

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
1-800-MEDICARE (1-800-633-4227)

Side-by-side comparison at www.cms.gov/apps/files/msn_changes.pdf

Improvement to PDP/MA-PD Complaint System

- Online complaint form on www.medicare.gov
- Used to track and report to Congress on
  - Number and types of complaints
  - Geographic variations
  - Timeliness of responses
  - Resolution of complaints
- Plans must provide a link to the form on their websites
  - Effective January 1, 2012

4. CMS Goals and Initiatives

- CMS' goals
  - Better health care
    - Test new care models
    - Improve coordination of care across settings
  - Better health
  - Reduced costs through quality improvement
  - Improve the coordination of care for people with both Medicare and Medicaid
  - Keep people living in the community rather than institutions

Helping to Achieve CMS' Goals and Initiatives

- Center for Medicare & Medicaid Innovations
  - Focus on
    - Primary Care Transformation
    - Accountable Care Organizations
    - Bundled Payment for Care Improvement
    - Initiatives Focused on the Medicaid Population
    - Capacity to Spread Innovation
- Medicare-Medicaid Coordination Office
  - Focus on
    - Those enrolled in Medicare and Medicaid

Primary Care Transformation

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

Note: Checked items will be discussed

Primary Care Transformation

- 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

- 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

- 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

- 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)?

- 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)

- 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

- 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

- 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

- 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

- 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

- 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

- 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

- 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
    - 32Pioneer 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

- ✓Partnership for Patients
- ✓Community-Based Care Transitions
- ✓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

Visit
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

- 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

- Center for Consumer Information & Insurance Oversight (CCIIO) funding opportunities
  - http://cciio.cms.gov/resources/fundingopportunities/index.html#eig
  - Examples include
    - The Consumer Support and Information
    - Affordable Insurance Exchanges
    - Health Market Reforms
    - Consumer Operated and Oriented Plan (CO-OP) Program

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