



# The Pulse of CMS

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

**THE AFFORDABLE CARE ACT HELPS TO COORDINATE AND IMPROVE HEALTHCARE  
(SEE PAGE 2 FOR DETAILS)**

## Lower Medicare Part B Premiums

The U.S. Department of Health and Human Services (HHS) announced that Medicare Part B premiums in 2012 will be lower than previously projected, and the Part B deductible will decrease by \$22. While the Medicare Trustees predicted monthly premiums would be \$106.60, premiums will instead be \$99.90. Earlier this year, HHS announced that average Medicare Advantage premiums would decrease by four percent and premiums paid for Medicare’s prescription drug plans would remain virtually unchanged.

Thanks to the Affordable Care Act (ACA), people with Medicare also receive free preventive services and a 50 percent discount on covered prescription drugs when they enter the prescription drug “donut hole.” This year, 1.8 million people with Medicare have received cheaper prescription drugs, while nearly 20.5 million Medicare beneficiaries have received a free Annual Wellness Visit or other free preventive services like cancer screenings.

Medicare Part B covers physicians’ services, outpatient hospital services, certain home health services, durable medical equipment, and other

items. In 2012, the “standard” Medicare Part B premium will be \$99.90. This is a \$15.50 decrease over the standard 2011 premium of \$115.40 paid by new enrollees and higher income Medicare beneficiaries and by Medicaid on behalf of low-income enrollees.

The majority of people with Medicare have paid \$96.40 per month for Part B since 2008, due to a law that freezes Part B premiums in years where beneficiaries do not receive cost-of-living (COLA) increases in their Social Security checks. In 2012, these people with Medicare will pay the standard Part B premium of \$99.90, amounting to a monthly change of \$3.50 for most people with Medicare. This increase will be offset for almost all seniors and people with disabilities by the additional income they will receive thanks to the Social Security COLA. For example, the average COLA for retired workers will be about \$43 a month, which is substantially greater than the \$3.50 premium increase for affected beneficiaries. Additionally, the Medicare Part B deductible will be \$140, a decrease of \$22 from 2011.

CMS also announced modest increases in Medicare Part A monthly premiums, as well as the deductible under Part A. Monthly premiums for Medicare Part A, which pays for inpatient hospitals, skilled nursing facilities, and some home health care, are paid by just the 1 percent of beneficiaries who do not otherwise qualify for Medicare. Medicare Part A monthly premiums will be \$451 for 2012, an increase of \$1 from 2011. The Part A deductible paid by beneficiaries when admitted as a hospital inpatient will be \$1,156 in 2012, an increase of \$24 from this year’s \$1,132 deductible.

## CMS Fraud Prevention Initiative

If you help people with Medicare, Medicaid, and the Children’s Health Insurance Program, you should know about an expanded federal government effort to reduce fraud and other improper payments in these health care programs to help ensure their long-term viability.

Significant progress in the fight against health care fraud has already been made, as shown by the federal government’s recovery of a record \$4 billion last year from people who attempted to defraud seniors and taxpayers. The CMS Fraud Prevention Initiative aims to ensure that correct payments are made to legitimate providers for covered appropriate and reasonable services in all federal health care programs.

Fraud prevention efforts focus on moving CMS beyond its former “pay and chase” recovery operations to a more proactive “prevention and detection” model that will help prevent fraud and abuse before payment is made. A good example is the recent CMS announcement that for the first time, through the use of innovative predictive modeling technology similar to that used by credit card companies, the agency will have the ability to use risk scoring techniques to flag high risk claims and providers for additional review and take action to stop payments and remove providers from the program when necessary.

As important as these aggressive new initiatives are, the first and best line of defense against fraud remains the health care consumer. You can help by making sure that Medicare beneficiaries have the information they need to identify and report suspected fraud. This information is available on the [CMS Fraud Prevention Initiative](#) website.

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## Provider Enrollment Revalidation Extended by Two Years

CMS recently announced that the requirement that providers revalidate their Medicare enrollment under provisions of the ACA has been extended through June 2015. The original revalidation effort was scheduled to be completed by March 23, 2013. The updated [Provider Revalidation MLN](#) provides complete details regarding the extension and revalidation process.

## Medicare Open Enrollment Period: Seniors Have More Benefits, Better Choices, and Lower Costs

The Medicare Open Enrollment Period, which began on October 15, has been expanded to last seven weeks and will end on December 7. This will give seniors and people with disabilities more time to compare and find the best plan that meets their unique needs.

People with Medicare can now review the 2012 quality ratings for Medicare Advantage health plans (Part C) and prescription drug plans (Part D) for the upcoming year. This year CMS, is highlighting plans that have achieved an overall quality rating of five stars with a high performer or "gold star" icon so people with Medicare can easily find high quality plans. People with Medicare can switch to an available five star plan at any time during the year.

Using the [Medicare's Plan Finder](#), people will see the enhanced star ratings for 2012. In addition to the enhanced star ratings for 2012 and new "gold star" icon, Plan Finder users will see an icon showing which plans received a low overall quality rating for the past three years.

In 2012, thanks to the ACA, additional benefits to people with Medicare include lower prescription drug costs through a 50 percent discount on covered brand name drugs in the coverage gap (also referred to as the "donut hole"), wellness checkups, and access to certain preventive care with no copayments. These benefits will be offered by all Medicare Advantage plans in 2012.

## The ACA: A Menu of Options for Improving Care

When doctors and other healthcare providers can work together to coordinate patient care, patients receive higher quality care, and lower costs are realized. Thanks to ACA, healthcare providers have a range of ways to partner with CMS to get new support and resources to do just that. There are options for healthcare providers of all sizes and types across the country.

**Partnership for Patients:** CMS has dedicated up to \$1 billion over three years to test care models to reduce hospital-acquired conditions and improve transitions in care. This public-private partnership supports the efforts of physicians, nurses, and other clinicians to make care safer and better coordinate patients' transitions from hospitals to other settings. The CMS Innovation Center will aid dissemination of proven methods for dramatically reducing both harm caused in hospitals and preventable hospital readmissions. To date, over 6,000 organizations, including more than 3,000 hospitals, have joined the Partnership for Patients and pledged to support its goals. The partnership has the potential to save 60,000 lives and reduce millions of preventable injuries and complications in patient care over the next three years and save up to \$50 billion over 10 years.

**Bundled Payments for Care Improvement:** The Bundled Payments for Care Improvement initiative seeks to improve patient care by fostering improved coordination through four broadly-defined, patient-centered approaches. Three models involve a retrospective bundled payment arrangement, and one model would pay providers prospectively. Through the Bundled Payments initiative, providers have great flexibility in selecting conditions to bundle, developing the health care delivery structure, and determining how payments will be allocated among participating providers.

**Comprehensive Primary Care Initiative:** This initiative will help primary care practices deliver high quality, coordinated patient-centered care in a handful of selected markets. In addition to regular fee-for-service payments, CMS will pay primary care practices a monthly fee for clinicians to: help patients with serious or chronic diseases follow personalized care plans; give patients 24-hour access to care and health information; deliver preventive care; engage patients and their families in their own care; and to work together with other doctors, including specialists, to provide better coordinated care. Under the initiative, Medicare will work with private and state health insurance plans to offer similar support to primary care practices that better coordinate care

for their patients.

### [Federally Qualified Health Center \(FQHC\) Advanced Primary Care Practice](#)

**Demonstration:** This demonstration evaluates the impact of advanced primary care practice on improving care, focusing on prevention, and reducing healthcare costs among Medicare beneficiaries served by Federally Qualified Health Centers (FQHC). It will assess the impact that additional support has on FQHCs' ability to transform their practice and become formally recognized as a patient-centered medical home. This demonstration, operated by the CMS Innovation Center in partnership with the Health Resources Services Administration, will test the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 Medicare patients.

### [Medicare Shared Savings Program for Accountable Care Organizations \(ACOs\)](#)

The Medicare Shared Savings Program will allow providers who voluntarily agree to work together to coordinate care for patients and who meet certain quality standards to share in any savings they achieve for the Medicare program. ACOs which elect to become accountable for shared losses have the opportunity to share in greater savings. ACOs will coordinate and integrate Medicare services, with success being gauged by roughly 30 quality measures organized in four domains. These domains include patient experience, care coordination and patient safety, preventive health, and at-risk populations. The higher the quality of care providers deliver, the more shared savings their Accountable Care Organization may earn, provided they also lower growth in health care expenditures. (Continued on page 4)

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## Open Enrollment for People Enrolled in Pre-Existing Conditions Insurance Plans

People currently enrolled in the federally-run Pre-Existing Condition Insurance Plan (PCIP), which operates in 24 states, including the District of Columbia, Delaware, Virginia, and West Virginia, will be allowed to switch plan options starting November 14, 2011 through December 12, 2011. This period will offer enrollees the ability to switch their plan option for plan year 2012.

By early November, current enrollees will receive a notice in the mail explaining their plan options, including the ability to switch their current plan option. If they are happy with their current plan option, they don't have to do anything. All enrollees will continue using the same PCIP ID card when they get healthcare services. A major change to PCIP for 2012 includes the reduction to the catastrophic maximum for in-network services in the Standard and Extended plans from \$5,950 to \$4,000. The Health Savings Account catastrophic maximum will increase from \$5,950 to \$6,050, in line with the IRS limit for 2012 for High Deductible Health Plans. The catastrophic maximum for out-of-network will remain at \$7,000 for all plans; however, the costs for covered services received both in-network and out-of-network will count towards both the in-network and out-of-network catastrophic limit.

The [PCIP](#) website provides details such as plan benefits and rates, as well as information on how to apply. The PCIP Call Center is also available Monday through Friday, from 8 a.m. to 11 p.m., Eastern Time at 1-866-717-5826 (TTY: 1-866-561-1604) to respond to inquiries.

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## Accountable Care Organizations (ACO): What Providers Need To Know

On October 20, 2011, CMS finalized new rules under the ACA to help doctors, hospitals, and other healthcare providers better coordinate care for Medicare patients through ACOs. ACOs create incentives for health care providers to work together to treat an individual patient across care settings, including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program (MSSP) will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Provider participation in an ACO is purely voluntary. In developing this final rule, CMS worked closely with agencies across the federal government to ensure a coordinated and aligned inter- and intra-agency effort to facilitate implementation of the Shared Savings Program. CMS encourages all interested providers and suppliers to review this final rule and consider participating in the Shared Savings Program.

Under the final rule, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the Medicare fee-for-service patients they serve. The goal of an ACO is to deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from a fee-for-service payment system in which different providers receive different, disconnected payments. The ACO will be a patient-centered organization where the patient and providers are partners in care decisions.

The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services: ACO professionals (i.e., practitioners meeting the statutory definition) in group practice arrangements; networks of individual practices of ACO professional; partnerships or joint practices of ACO professionals; hospitals employing ACO professionals; or other Medicare providers and suppliers as determined by the Secretary.

To participate in the Shared Savings Program, providers must come together to become a Medicare Accountable Care Organization (ACO) and the ACO must apply to CMS. An existing ACO will *not* be automatically accepted into the Shared Savings Program. To be accepted, ACOs must meet all eligibility and program requirements, must serve at least 5,000 Medicare fee-for-service patients, and agree to participate in the program for at least three years. Medicare providers who participate in an ACO in the Shared Savings Program will continue to receive payment under Medicare fee-for-service rules. Under the final rule, Medicare will continue to pay individual providers

and suppliers for specific items and services as it currently does under the Medicare fee-for-service payment systems. CMS will also develop a benchmark for each ACO to assess whether it qualifies to receive shared savings or if it can be potentially be held accountable for losses. The benchmark is an estimate of what the total Medicare fee-for-service Parts A and B expenditures for ACO beneficiaries would otherwise have been in the absence of the ACO, even if all of those services were not provided in the ACO. The benchmark will take into account beneficiary characteristics and other factors that may affect the need for health care services. This benchmark will be updated for each performance year within the agreement period.

CMS is implementing both a one-sided model (sharing savings, but not losses, for the entire term of the first agreement) and a two-sided model (sharing both savings and losses for the entire term of the agreement), allowing the ACO to opt for either model for their first agreement period. CMS believes this approach will provide an entry point for organizations with less experience with risk models to gain experience with population management before transitioning to a shared losses model. It also provides an opportunity for more experienced ACOs that are ready to share in losses to enter a sharing arrangement that provides a greater share of savings, but with the responsibility of repaying Medicare a portion of any losses.

CMS is encouraging providers to participate in the Shared Savings Program by setting the quality performance standard to reporting only for the first performance year of the ACO's agreement period and providing a longer phase in to performance over the second and third performance years. This means that ACOs will be eligible for the maximum sharing rate (60 percent for the two-sided model and 50 percent for the one-sided model) if the ACO generates sufficient savings and successfully reports the required quality measures (Continued on page 4).

## DMEPOS Competitive Bidding Program Expansion

CMS announced the next steps for the expansion of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program to include the Round 2 and the national mail-order competitions. The categories include:

- Oxygen, oxygen equipment, and supplies, Standard (power and manual) wheelchairs, scooters, and related accessories
- Enteral nutrients, equipment, and supplies
- Continuous Positive Airway Pressure devices and Respiratory Assist Devices and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Negative Pressure Wound Therapy pumps and related supplies and accessories, and
- Support surfaces (Group 2 mattresses and overlays)

A list of the specific items in each product category is available on the [Competitive Bidding Implementation Contractor](#) website; the specific ZIP codes in each Round two competitive bidding areas are also available on the CBIC website.

CMS will also be conducting a national mail-order competition for diabetic testing supplies at the same time as the Round 2 competition. The national mail-order competition will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

Providers are encouraged to prepare for bidding by updating their contact information and ensuring that they are licensed by their states, and that they are accredited for all items in the product category of their bid. Further information on the DMEPOS accreditation requirements, along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation, may be found at the CMS [Medicare Provider and Supplier Enrollment Overview](#) website.

## ACOs: What Providers Need to Know (Continued)

After the first year, the ACO must not only report but also perform well on selected quality measures. This flexibility will allow newly formed ACOs a grace period as they start up their operations and learn to work together to better coordinate patient care and improve quality.

CMS will measure quality of care using nationally recognized measures in four key domains: patient experience, care coordination/patient safety, preventive health, and at-risk population. These measures are aligned with the measures in other CMS programs such as the Electronic Health Records and the Physician Quality Reporting System. Eligible professionals in an ACO that successfully reports the quality measures required under the Shared Savings Program in any year of the program will be deemed eligible for the PQRS bonus, regardless of whether the ACO qualifies to share in savings.

Providers and suppliers who are already participating in another shared savings program or demonstration under fee-for-service Medicare, such as the

Independence at Home Medical Practice pilot program, will not be eligible to participate in a Shared Savings Program ACO.

If a group of providers and suppliers are already a self-contained financially and clinically integrated entity that has a board of directors or other governing body, the organization need not form a separate governing body or create a new legal entity to participate in the Shared Savings Program. The existing organization, however, must be recognized under applicable State or tribal law, be capable of receiving and distributing shared savings and repaying shared losses, and meet the other ACO functions identified in the statute.

[The Medicare Shared Savings Program Final Rule](#) is available for download. Please visit our [MSSP](#) website for information about applying to participate in the Medicare Shared Savings Program.

## The Affordable Care Act: A Menu of Options for Improving Care (Continued)

**[Advance Payment Accountable Care Organization Model:](#)** The Advanced Payment model will provide additional support to physician-owned and rural providers participating in the Medicare Shared Savings Program who also would benefit from additional start-up resources to build the necessary infrastructure, such as new staff or information technology systems. The advance payments would be recovered from shared savings achieved by the Accountable Care Organization.

**[Pioneer Accountable Care Organization Model:](#)** The Pioneer model is an initiative complementary to the Medicare Shared Savings Program designed for organizations with experience providing integrated care across settings. The Pioneer Model tests a rapid transition to a population-based model of care and engages other payers in moving toward outcomes-based contracts. The initial

group of Pioneer sites, slated to be announced later this year, will be positioned to rapidly demonstrate what can be achieved when we provide highly coordinated care to Medicare fee-for-service beneficiaries.

**[Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees:](#)** A longstanding barrier to coordinating care for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. This initiative will test two models; a capitated model and a managed fee-for-service model for states to better align the financing of the Medicare and Medicaid programs and integrate primary, acute, behavioral health, long-term services and supports for Medicare-Medicaid enrollees. For those states that are interested in testing these two models, CMS is offering streamlined approaches and technical assistance to support necessary planning activities.

### 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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