Disclaimer

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

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Federal Outlays

FY 2018 Outlays = $995B
[HHS FY 2018 Budget in Brief - CMS – Overview]

<table>
<thead>
<tr>
<th>Program</th>
<th>Percentage</th>
<th>Medicare (Part A/B)</th>
<th>Medicare (Part C/D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>58.0%</td>
<td>57.5%</td>
<td>42.5%</td>
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<tr>
<td>Medicaid</td>
<td>39.9%</td>
<td></td>
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<tr>
<td>CHIP</td>
<td>1.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State grants /demos/ Innovation Center/other</td>
<td>0.9%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The aging of the population and rising health care costs are contributing to the growth in Medicare spending over time.

U.S. population ages 65 and older, 2010-2050

<table>
<thead>
<tr>
<th>Year</th>
<th>Income below $26,200</th>
<th>Savings below $74,450</th>
<th>Functional Impairment (1+ ADL Limitations)</th>
<th>Cognitive/Mental Impairment</th>
<th>5+ Chronic Conditions</th>
<th>Fair/Poor Health</th>
<th>Under Age 65 with Permanent Disabilities</th>
<th>Age 85+</th>
<th>Long-term Care Facility Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1.9</td>
<td>2.8</td>
<td>2.8</td>
<td>2.8</td>
<td>2.8</td>
<td>2.8</td>
<td>2.8</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>2020</td>
<td>16.6</td>
<td>18.1</td>
<td>18.1</td>
<td>18.1</td>
<td>18.1</td>
<td>18.1</td>
<td>18.1</td>
<td>18.1</td>
<td>18.1</td>
</tr>
<tr>
<td>2030</td>
<td>33.2</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
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<tr>
<td>2040</td>
<td>34.0</td>
<td>18.1</td>
<td>18.1</td>
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<td>18.1</td>
<td>18.1</td>
<td>18.1</td>
<td>18.1</td>
</tr>
<tr>
<td>2050</td>
<td>32.7</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
<td>20.1</td>
</tr>
</tbody>
</table>


NOTE: ADL is activity of daily living.


2018 Annual Conference
### Table II.E1.—Estimated Operations of the HI Trust Fund under Intermediate Assumptions, Calendar Years 2017-2027

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>Total income(^1)</th>
<th>Total expenditures</th>
<th>Change in fund</th>
<th>Fund at year end</th>
<th>Ratio of assets to expenditures(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017(^3)</td>
<td>$299.4</td>
<td>$296.5</td>
<td>$2.8</td>
<td>$202.0</td>
<td>67%</td>
</tr>
<tr>
<td>2018</td>
<td>305.5</td>
<td>310.7</td>
<td>-5.2</td>
<td>196.8</td>
<td>65</td>
</tr>
<tr>
<td>2019</td>
<td>325.0</td>
<td>328.2</td>
<td>-3.1</td>
<td>193.6</td>
<td>60</td>
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<tr>
<td>2020</td>
<td>343.4</td>
<td>348.5</td>
<td>-5.1</td>
<td>188.5</td>
<td>56</td>
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<tr>
<td>2021</td>
<td>362.7</td>
<td>372.7</td>
<td>-10.1</td>
<td>178.4</td>
<td>51</td>
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<tr>
<td>2022</td>
<td>382.3</td>
<td>400.7</td>
<td>-18.4</td>
<td>160.0</td>
<td>45</td>
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<tr>
<td>2023</td>
<td>402.3</td>
<td>429.8</td>
<td>-27.5</td>
<td>132.6</td>
<td>37</td>
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<tr>
<td>2024</td>
<td>423.5</td>
<td>459.5</td>
<td>-36.1</td>
<td>96.5</td>
<td>29</td>
</tr>
<tr>
<td>2025</td>
<td>444.8</td>
<td>490.8</td>
<td>-46.0</td>
<td>50.5</td>
<td>20</td>
</tr>
<tr>
<td>2026(^4)</td>
<td>470.8</td>
<td>522.7</td>
<td>-51.9</td>
<td><strong>-1.4</strong></td>
<td><strong>10</strong></td>
</tr>
<tr>
<td>2027(^4)</td>
<td>497.5</td>
<td>554.8</td>
<td>-57.3</td>
<td>-58.7</td>
<td>(^5)</td>
</tr>
</tbody>
</table>

\(^1\)Includes interest income.
\(^2\)Ratio of assets in the fund at the beginning of the year to expenditures during the year.
\(^3\)Figures for 2017 represent actual experience.
\(^4\)Estimates for 2026 and 2027 are hypothetical since the HI trust fund would be depleted in those years.
\(^5\)Trust fund reserves would be depleted at the beginning of this year.

Note: Totals do not necessarily equal the sums of rounded components.
HHS Priorities: Secretary Azar has identified four priorities for HHS to focus the Department’s work to improve the health and well-being of the American people.

- **The Opioids Crisis**
  HHS is committed to ending the crisis of opioid addiction and overdose in America.

- **Health Insurance Reform**
  HHS is working to improve the availability and affordability of health insurance.

- **Drug Pricing**
  HHS is determined to lower the costs of prescription drugs for all Americans without discouraging innovation.

- **Value-Based Care**
  HHS is working to transform our system to one that pays for value.
CMS Strategic Goals

• Empower patients and doctors to make decisions about their health care.
• Usher in a new era of state flexibility and local leadership.
• Support innovative approaches to improve quality, accessibility, and affordability.
• Improve the CMS customer experience.
Moving Away from Delivering Volume of Services to Delivering Value for Patients

Four pillars

• empowering patients
• increasing competition
• realigning incentives
• reducing barriers to value-driven care
"We can’t achieve value-based care until we put the patient in the driver’s seat of our healthcare system...that requires empowering patients with the data they need to make informed decisions as healthcare consumers (quality data, cost data, patient’s own data).”

-- CMS Administrator Seema Verma, May 9, 2018, Medicare Advantage and Prescription Drug Plan Spring Conference
MyHealthEData Initiative: Patient Controls Access to Data

“While we’re on track for healthcare costs to represent one out of every five dollars of American GDP by 2026, it’s technology that will help ensure the sustainability of our healthcare system.”

-- CMS Administrator Seema Verma, November 15, 2018, Alliance for Connected Care Telehealth Policy Forum for Health Systems
Medicare coverage explained
Hospitals to make available a list of their current standard charges in a machine-readable format, making it easier for patients to know the cost of services before they commit to them, and allowing them to shop for the best value.  

https://www.medicare.gov/procedure-price-lookup/

“Working with their clinicians, Procedure Price Lookup will help patients with Medicare consider potential cost differences when choosing among safe and clinically appropriate settings to get the care that best meets their needs.” -- CMS Administrator Seema Verma, November 27, 2018
What CMS is Doing to Minimize Burden

1. Simplifying Paperwork
2. Making Required Paperwork Easier to Find
3. Improving the Audit Process
4. Making EHRs Interoperable
5. Improving Communications

https://go.cms.gov/cpi
Meaningful Measures focus everyone’s efforts on the same quality areas and lend specificity, which can help identify measures that:

- Address high-impact measure areas that safeguard public health
- Are patient-centered and meaningful to patients, clinicians and providers
- Are outcome-based where possible
- Fulfill requirements in programs’ statutes
- Minimize level of burden for providers
- Identify significant opportunity for improvement
- Address measure needs for population based payment through alternative payment models
- Align across programs and/or with other payers
Timeline for CMS Value-Based Programs

**LEGISLATION**
- ACA: Affordable Care Act
- MIPPA: Medicare Improvements for Patients & Providers Act
- PAMA: Protecting Access to Medicare Act

**PROGRAM**
- APMs: Alternative Payment Models
- ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
- HACRP: Hospital-Acquired Condition Reduction Program
- HRRP: Hospital Readmissions Reduction Program
- HVBP: Hospital Value-Based Purchasing Program
- MIPS: Merit-Based Incentive Payment System
- VM: Value Modifier or Physician Value-Based Modifier (PVBM)
- SNF-VBP: Skilled Nursing Facility Value-Based Purchasing Program
Timeline for CMS Value-Based Programs

**LEGISLATION PASSED**
- MIPPA: Medicare Improvements for Patients and Providers Act
- ACA: Affordable Care Act
- MACRA: Medicare Access and CHIP Reauthorization Act of 2015

**PROGRAM IMPLEMENTED**
- ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
- HVBP: Hospital Value-Based Purchasing Program
- HRRP: Hospital Readmissions Reduction Program
- PAMA: Physician Payments Improvement Act
- MACRA: Medicare Access and CHIP Reauthorization Act
- ACO: Accountable Care Organizations
- APMS: Alternative Payment Models
- SNF-VBP: Skilled Nursing Facility Value-Based Purchasing Program
- VM: Value Modifier or Physician Value-Based Modifier (PVBM)
- MIPS: Merit-Based Incentive Payment System
### Medicare Shared Savings Program
**Fast Facts – January 2018**

#### Historical Participation and Performance

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>ACOs</th>
<th>Assigned Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>561</td>
<td>10.5 million</td>
</tr>
<tr>
<td>2017</td>
<td>480</td>
<td>9.0 million</td>
</tr>
<tr>
<td>2016</td>
<td>433</td>
<td>7.7 million</td>
</tr>
<tr>
<td>2015</td>
<td>404</td>
<td>7.3 million</td>
</tr>
<tr>
<td>2014</td>
<td>338</td>
<td>4.9 million</td>
</tr>
<tr>
<td>2012/2013</td>
<td>220</td>
<td>3.2 million</td>
</tr>
</tbody>
</table>

#### Performance Year Results

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Total Earned Performance Payments</th>
<th>Average Overall Quality Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>$700,607,912</td>
<td>94.65%</td>
</tr>
<tr>
<td>2015</td>
<td>$645,543,866</td>
<td>91.44%</td>
</tr>
<tr>
<td>2014</td>
<td>$341,246,303</td>
<td>83.08%</td>
</tr>
<tr>
<td>2012/2013</td>
<td>$315,908,772</td>
<td>95.00%</td>
</tr>
</tbody>
</table>

#### 2018 Accountable Care Organization Information

<table>
<thead>
<tr>
<th>ACO Characteristics</th>
<th>ACOs</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Risk Based:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Track 1</td>
<td>460</td>
<td>82%</td>
</tr>
<tr>
<td>Risk Based:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Track 1+ Model</td>
<td>55</td>
<td>10%</td>
</tr>
<tr>
<td>SNF 3-Day Rule Waiver</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Track 2</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td>Track 3</td>
<td>38</td>
<td>7%</td>
</tr>
<tr>
<td>SNF 3-Day Rule Waiver</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>
Guiding principles:

• Accountability and Competition
• Quality
• Beneficiary Engagement
• Program Integrity

• Encourages ACOs to transition to two-sided models (where they may share in savings and are accountable for repaying shared losses) and to strengthen program integrity.

• Ensures rigorous benchmarking.
• Provides new tools to support coordination of care across settings and strengthen beneficiary engagement.

Currently over 10.4 million beneficiaries in FFS Medicare (of the 38 million total FFS beneficiaries) receive care from providers participating in a Medicare ACO.
Participation Options

BASIC Track
Includes a “glide path” for eligible ACOs consisting of five levels (called Levels A through E) that begin under a one-sided model and incrementally phase-in higher levels of risk and reward. The highest level, Level E, qualifies as an Advanced Alternative Payment Model (APM) under the Quality Payment Program.

ENHANCED Track
Based on the program’s Track 3; provides greater risk in exchange for greater potential reward. This track is also an Advanced APM under the Quality Payment Program.

Eligible ACOs enter into for an agreement period of not less than 5 years, for agreement periods beginning on July 1, 2019
**Program Flexibilities**

### Expanded SNF 3-Day Rule Waiver Eligibility

- Amended the existing SNF 3-Day Rule Waiver to allow Critical Access Hospitals and other small, rural hospitals operating under a swing bed agreement to be eligible to partner with eligible ACOs as SNF affiliates for purposes of the SNF 3-Day Rule Waiver.

<table>
<thead>
<tr>
<th>Track 1 (One-sided model; Discontinued for Future Agreement Periods)</th>
<th>Track 2 (Two-sided model; Discontinued for Future Agreement Periods)</th>
<th>Track 1+ Model (Two-sided model; Discontinued for Future Agreement Periods)</th>
<th>BASIC track (New track)</th>
<th>ENHANCED track (Track 3 financial model)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A (unavailable under current policy)</td>
<td>N/A (unavailable under current policy)</td>
<td>Current policy (prospective assignment)</td>
<td>For performance years beginning on July 1, 2019, and subsequent years, eligible for performance years under a two-sided model (prospective or preliminary prospective assignment)</td>
<td>For performance years beginning on July 1, 2019, and subsequent years (prospective or preliminary prospective assignment)</td>
</tr>
</tbody>
</table>

### Expanded Use of Telehealth Services

- Beginning on January 1, 2020, eligible physicians and practitioners in ACOs under performance-based risk and prospective assignment may receive payment for telehealth services furnished to prospectively assigned beneficiaries even if the otherwise applicable geographic limitations are not met, including when the beneficiary's home is the originating site.

  - **Note:** the beneficiary's home may only be used as the originating site if the service is appropriate to provide in the home setting; a service that is typically furnished in an inpatient setting will not be covered where the beneficiary's home is the originating site.

<table>
<thead>
<tr>
<th>Track 1 (One-sided model; Discontinued for Future Agreement Periods)</th>
<th>Track 2 (Two-sided model; Discontinued for Future Agreement Periods)</th>
<th>Track 1+ Model (Two-sided model; Discontinued for Future Agreement Periods)</th>
<th>BASIC track (New track)</th>
<th>ENHANCED track (Track 3 financial model)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A (because this is a one-sided model)</td>
<td>N/A (because this track uses preliminary prospective assignment)</td>
<td>For performance year 2020 and onward (prospective assignment)</td>
<td>For Performance Year 2020 and onward, applicable for performance years under a two-sided model (ACO selects prospective assignment)</td>
<td>For Performance Year 2020 and onward (ACO selects prospective assignment)</td>
</tr>
</tbody>
</table>
Timeline for CMS Value-Based Programs

**LEGISLATION PASSED**
- **2008**: MIPPA
- **2010**: ACA
- **2012**: ESRD-QIP, HRRP
- **2014**: PAMA
- **2015**: MACRA
- **2018**: APMs
- **2019**: MIPS

**PROGRAM IMPLEMENTED**
- **2008**: MIPPA
- **2010**: ACA
- **2012**: ESRD-QIP, HRRP, HVBP
- **2014**: PAMA, HAC
- **2015**: VM
- **2018**: SNF-VBP
- **2019**: APMs

**LEGISLATION**
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- **SNF-VBP**: Skilled Nursing Facility Value-Based Purchasing Program
Quality Payment Program for 2019 Participation

There are two ways to take part in the Quality Payment Program:

- **MIPS**
  - Merit-based Incentive Payment System
  - If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

- **Advanced APMs**
  - Advanced Alternative Payment Models
  - If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.
Eligible Participants

- Physicians (which includes doctor of medicine, doctor of osteopathy, doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, doctor of optometry and chiropractors)
- Physician Assistants (PAs)
- Nurse Practitioners (NPs)
- Clinical Nurse Specialists (CNSs)
- Certified Registered Nurse Anesthetists (CRNAs)
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists
- Audiologists
- Clinical Psychologists
- Registered Dietitians or Nutritional Professionals

*You can also participate as a group if the group includes at least one of the clinician types listed above.*

1 With respect to certain specified treatment, a doctor of chiropractic must be legally authorized to practice by a State in which he/she performs this function.
Performance Categories

Performance in MIPS is measured through the data clinicians report in four areas: Quality, Cost, Improvement Activities, and Promoting Interoperability. The performance categories have different “weights” and are added together to give you a MIPS final score. [Explore the measures](#) for each category on the Quality Payment Program website.

![Performance Categories Diagram]

- **Quality**: 45% of MIPS Final Score
- **Promoting Interoperability**: 25% of MIPS Final Score
- **Cost**: 15% of MIPS Final Score
- **Improvement Activities**: 15% of MIPS Final Score

\[ \text{Quality} + \text{Promoting Interoperability} + \text{Cost} + \text{Improvement Activities} = 100\% \text{ of MIPS Final Score} \]

You can participate in MIPS as an individual, group, or virtual group. Learn more by visiting the Quality Payment Program [website](#).
Advanced APMs: Current List for 2019

- Bundled Payments for Care Improvement (BPCI) Advanced Model*
- Comprehensive Care for Joint Replacement Model
- Comprehensive ESRD Care Model (LDO Arrangement)
- Comprehensive ESRD Care Model (non-LDO Two-sided Risk Arrangement)
- Comprehensive Primary Care Plus (CPC+) Model
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Maryland Total Cost of Care Model (Care Redesign Program)
- Maryland Total Cost of Care Model (Maryland Primary Care Program)
- Next Generation ACO Model
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
- Oncology Care Model (OCM) – Two-Sided Risk Arrangement
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

*BPCI Advanced began in October 2018, and participants will have an opportunity to achieve QP status, or be scored under the APM scoring standard for MIPS, starting in performance year 2019.
New BPCI Advanced

- Voluntary Model
- A single retrospective bundled payment and one risk track, with a 90-day Clinical Episode duration
- 29 Inpatient Clinical Episodes
- 3 Outpatient Clinical Episodes
- Qualifies as an Advanced APM
- Payment is tied to performance on quality measures
- Preliminary Target Prices provided in advance of the first Performance Period of each Model Year
BPCI Advanced: Objectives

1. Care Redesign
2. Data Analysis and Feedback
3. Financial Accountability
4. Health Care Provider Engagement
5. Patient and Caregiver Engagement
Services Included in Clinical Episode

- IP or OP hospital services that comprise the Anchor Stay or Anchor Procedure (respectively)
- Physicians’ services
- Other hospital OP services
- IP hospital readmission services
- Long-term care hospital (LTCH) services
- Hospice services
- Inpatient rehabilitation facility (IRF) services
- Skilled nursing facility (SNF) services
- Home health agency (HHA) services
- Clinical laboratory services
- Durable medical equipment (DME)
- Part B drugs
# CMS Innovation Center Portfolio: Aligns with Broader Agency Goals

## Pay Providers

<table>
<thead>
<tr>
<th>Test alternative payment models</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountable Care</strong></td>
<td></td>
</tr>
<tr>
<td>– ACO Investment Model</td>
<td></td>
</tr>
<tr>
<td>– Pioneer ACO Model</td>
<td></td>
</tr>
<tr>
<td>– Medicare Shared Savings Program (housed in Center for Medicare)</td>
<td></td>
</tr>
<tr>
<td>– Comprehensive ESRD Care Initiative</td>
<td></td>
</tr>
<tr>
<td>– Next Generation ACO</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Transformation</strong></td>
<td></td>
</tr>
<tr>
<td>– Comprehensive Primary Care Initiative (CPC) &amp; CPC+ Demonstration</td>
<td></td>
</tr>
<tr>
<td>– Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration</td>
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<tr>
<td>– Independence at Home Demonstration</td>
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<td>– Graduate Nurse Education Demonstration</td>
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<tr>
<td>– Home Health Value Based Purchasing</td>
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<td>– Medicare Care Choices</td>
<td></td>
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<tr>
<td>– Frontier Community Health Integration Project</td>
<td></td>
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<tr>
<td>– Medicare Diabetes Prevention Program Expanded Model</td>
<td></td>
</tr>
<tr>
<td><strong>Bundled payment models</strong></td>
<td></td>
</tr>
<tr>
<td>– Bundled Payment for Care Improvement Models 1-4</td>
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</tr>
<tr>
<td>– BPCI Advanced</td>
<td></td>
</tr>
<tr>
<td>– Oncology Care Model</td>
<td></td>
</tr>
<tr>
<td>– Comprehensive Care for Joint Replacement</td>
<td></td>
</tr>
</tbody>
</table>

## Deliver Care

<table>
<thead>
<tr>
<th>Support providers and states to improve the delivery of care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learning and Diffusion</strong></td>
<td></td>
</tr>
<tr>
<td>– Partnership for Patients</td>
<td></td>
</tr>
<tr>
<td>– Transforming Clinical Practice</td>
<td></td>
</tr>
<tr>
<td><strong>Health Care Innovation Awards</strong></td>
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<tr>
<td><strong>Integrated Care for Kids (InCK) Model</strong></td>
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<tr>
<td><strong>Accountable Health Communities</strong></td>
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<tr>
<td><strong>State Innovation Models Initiative</strong></td>
<td></td>
</tr>
<tr>
<td>– SIM Round 1 &amp; SIM Round 2</td>
<td></td>
</tr>
<tr>
<td>– Maryland All-Payer Model</td>
<td></td>
</tr>
<tr>
<td>– Pennsylvania Rural Health Model</td>
<td></td>
</tr>
<tr>
<td>– Vermont All-Payer ACO Model</td>
<td></td>
</tr>
<tr>
<td><strong>Million Hearts Cardiovascular Risk Reduction Model</strong></td>
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## Distribute Information

<table>
<thead>
<tr>
<th>Increase information available for effective informed decision-making by consumers and providers</th>
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<tbody>
<tr>
<td><strong>Information to providers in CMMI models</strong></td>
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<td><strong>Shared decision-making required by many models</strong></td>
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Medicare Care Choices Model (MCCM) provides new options for hospice patients

MCCM allows Medicare beneficiaries who qualify for hospice to receive **supportive care services while receiving care for their terminal condition**. Evidence from private market that concurrent care can improve outcomes, patient and family experience, and lower costs.

MCCM is designed to:

- Increase access to supportive care services provided by hospice;
- Improve quality of life and patient/family satisfaction;
- Inform new payment systems for the Medicare and Medicaid programs.

Model characteristics:

- Hospices receive $400 PBPM for providing services for 15 days or more per month
- 5 year model, phased in over 2 years with **130+ participating hospices** randomly assigned to phase 1 or 2

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**Services**

The following services are available 24 hours a day, 7 days a week:

- Nursing
- Social work
- Hospice aide
- Hospice homemaker
- Volunteer services
- Chaplain services
- Bereavement services
- Nutritional support
- Respite care
Promoting Interoperability (formerly Meaningful Use)

Change in direction:
OLD - support the adoption of health IT
NEW - promote interoperability and patient access to data

**FY 2019 EHR Eligible Hospital payment adjustment:** Eligible hospitals that are not meaningful EHR users will be subject to a payment adjustment beginning on October 1, 2018. This payment adjustment is applied as a reduction to the applicable percentage increase to the Inpatient Prospective Payment System (IPPS) payment rate.

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<tr>
<td>% Decrease</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
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*The FY2019 payment adjustments are based on the 2017 reporting period.*
Medicare growth has fallen below GDP growth and national health expenditure growth since 2010 due, in part, to CMS policy changes and new models of care.
Thank You

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