CMS Update

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California Hospital Association
Transforming to Value-Based Care: Strategies for Hospital Success

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CMS Financial Report 2018

The Nation’s Health Care Dollar

- Medicare
- Medicaid
- Private Insurance
- Other

The Nation’s Health Care Dollar 2006

- Medicare: 19.84%
- Medicaid: 15.84%
- Other: 4.54%
- Private Insurance: 34.96%

CMS Financial Report 2018

2018 Annual Conference
Federal Outlays

FY 2018 Outlays = $995B

<table>
<thead>
<tr>
<th>Program</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Medicare</td>
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<tr>
<td>Medicare Part A/B</td>
<td>57.5%</td>
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<tr>
<td>Medicare Part C/D</td>
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<tr>
<td>Medicaid</td>
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<tr>
<td>CHIP</td>
<td>1.2%</td>
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<td>State grants/demos/Innovation Center/other</td>
<td>0.9%</td>
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</table>

Medicare Enrollment Dashboard

Program Challenges

The aging of the population and rising health care costs are contributing to the growth in Medicare spending over time.

Characteristics of the Medicare Population
Medicare FFS Beneficiaries and Medicare Spending by # Chronic Conditions, 2015

Status Quo is Unsustainable

2018 Medicare Trustees Report Table I.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 (billion)</th>
<th>Total Expenditures (billion)</th>
<th>Change in Fund</th>
<th>Ratio of assets to expenditure</th>
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<tbody>
<tr>
<td>2017</td>
<td>$239.4</td>
<td>$286.5</td>
<td>-$47.1</td>
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<tr>
<td>2018</td>
<td>305.5</td>
<td>311.7</td>
<td>-6.2</td>
<td>85</td>
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<td>2019</td>
<td>340.8</td>
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<td>2020</td>
<td>363.4</td>
<td>348.5</td>
<td>-14.9</td>
<td>86</td>
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<tr>
<td>2021</td>
<td>392.7</td>
<td>370.7</td>
<td>-22.0</td>
<td>84</td>
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<tr>
<td>2022</td>
<td>408.8</td>
<td>408.8</td>
<td>0</td>
<td>84</td>
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<tr>
<td>2023</td>
<td>423.5</td>
<td>428.8</td>
<td>-5.3</td>
<td>83</td>
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<tr>
<td>2024</td>
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<tr>
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<tr>
<td>2027</td>
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<td>428.8</td>
<td>-24.9</td>
<td>79</td>
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</table>

Note: Table does not necessarily equal the sum 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.
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

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**eMedicare: Access to accurate, valuable information**

Create a modern, personalized and seamless customer experience

Mobile-friendly services
   - New applications
   - More control over Medicare information

“...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...”
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**MyHealthEData Initiative: Patient Controls Access to Data**

“...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 manage the costability of our healthcare system...”
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Transparency: You have the Right to Know

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 provider 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/3p0
Meaningful Measures: Objectives

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
Guiding principles:
- Accountability and Competition
- Quality
- Beneficiary Engagement
- Program Integrity

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.

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.
**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.

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

**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.

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**Program Flexibilities**

**Expanded SNF 3-Day Rule Waiver Eligibility**
- An additional 34 days per year for patients who receive care in a skilled nursing facility
- Patients must be admitted due to a medically necessary condition

**Expanded Use of Telehealth Services**
- Implementation for visits 1, 2, and 3
- Virtual visits for new or established patients

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**Timeline for CMS Value-Based Programs**

- 2008: Initial Implementation
- 2010: Initial Rollout
- 2015: Broad Expansion
- 2017: Full Scale Deployment
- 2019: Full Scale Expansion
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

- Support providers and states to improve the delivery of care
- Improve quality of life and patient/family satisfaction
- Enhance care for high-need beneficiaries

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:
- Provide services for up to 35 days
- Improve quality of life and patient/family satisfaction
- Inform and promote payment systems for Medicare and Medicaid programs

Model characteristics:
- Hospices receive $400 per month
- 1-year model, phased in over 2 years
- 2-year model, phased in over 2 years
- Hospice services randomly assigned to 1 or 2

Services

- Nursing
- Social work
- Hospice aide
- Recreational services
- Volunteer services
- Spiritual 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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<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Payment Adjustment Reporting Period</td>
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<td>Payment adjustment Reporting Period</td>
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<tr>
<td>Relative</td>
<td>2.0%</td>
<td>1.5%</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.

![Diagram showing Medicare growth below GDP growth and national health expenditure growth since 2010.](source)

Thank You

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