2017 Annual Conference

CMS at Work

Putting Patients First

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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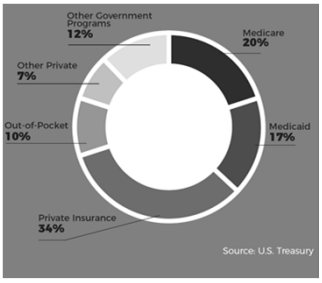
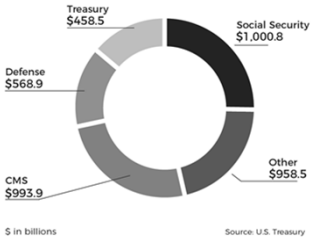
The Nation's Health Care Dollar FY 2017



CMS Financial Report 2017

2017 Federal Outlays

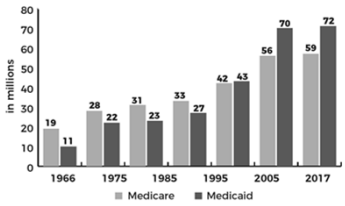


$ in billions

Source: U.S. Treasury

CMS Financial Report 2017

2017 Program Enrollment



CMS Financial Report **2017**

CMS Financial Report 2017

HI Trust Fund Ratio

TRUST FUND RATIO

Beginning of Fiscal Year [3]

	2013	2014	2015	2016	2017
HI	86%	77%	73%	67%	66%

[3] Assets at the beginning of the year to expenditures during the year

Long-Term Financing

The short-range outlook for the HI trust fund has improved compared to what was projected last year. After 2021, the trust fund ratio starts to decline quickly until the fund is depleted in 2029, one year later than projected last year. The percentage of expenditures covered by tax revenues is projected to decrease from 88 percent in 2029 to 81 percent in 2041 and then to increase to about 88 percent by the end of the projection period.

CMS Financial Report 2017

Medicare Overall

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges…

…if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then these further policy reforms will have to address much larger financial challenges than those assumed under current law.

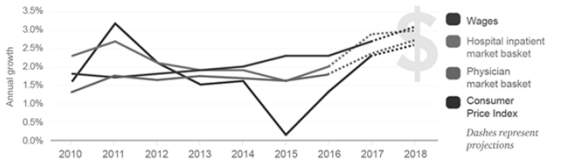
In their 2017 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges." They also stated: "Consideration of such reforms should not be delayed."

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2017_CMS_Financial_Report.pdf

https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html

Figure 7: The price of providing hospital and physician services has increased as the rate of general inflation growth has increased

Growth in wages and healthcare "market baskets"



Source: PwC Health Research Institute analysis of CMS Market Basket, CMS National Health Expenditure Accounts, CBO Economic and Budget Outlook, and Bureau of Labor and Statistics data.[87]

CMS Strategic Goals

1. **Empower patients and doctors to make decisions about their health care.**
   - Reduce burdensome regulations so that doctors and providers can focus on providing high quality healthcare to their patients.
   - Put policies in place that build a patient centered system of care that increases competition, quality and access.
   - Empower patients to take ownership of their health and ensure that patients have the flexibility and information to make choices as they seek care.
2. **Usher in a new era of state flexibility and local leadership.**
   - Provide states and local communities flexibility so they can design innovative programs that best meet their citizens' unique needs.
   - Hold states accountable for achieving outcomes and results.
3. **Support innovative approaches to improve quality, accessibility, and affordability.**
   - Use data driven insights to ensure cost effective care that also leads to improvements inpatient outcomes.
   - Leverage technology to prevent and identify waste, fraud and abuse so that taxpayer dollars can focus on providing high quality care to beneficiaries.
4. **Improve the CMS customer experience.**
   - Provide patients and providers with the tools and information they need to make decisions that work best for them.
   - Empower states with their efforts to drive innovation to improve quality and health outcomes.

CMS Strategic Goals

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1. Empower patients and doctors to make decisions about their health care.

- CMS created the new Hospice Compare website to help consumers find and compare hospice providers based on whether the provider assesses the patient's goals of treatment preferences and other quality indicators.

2. Usher in a new era of state flexibility and local leadership.

- CMS wants to support states in their efforts to create innovative Medicaid programs for the people they serve, because states know what is best for their residents.

3. Support innovative approaches to improve quality, accessibility, and affordability.

- The Medicare Diabetes Prevention Program (MDPP) expanded model is a structured intervention with the goal of preventing progression to type 2 diabetes in individuals with an indication of pre-diabetes. Expanded model services are furnished in community and health care settings by coaches and will be covered as additional Medicare preventive services, effective April 1, 2018.

4. Improve the CMS customer experience.

- CMS is transforming access to Medicare telehealth services by paying for more services and making it easier for providers to bill. Improving access to telehealth reflects CMS's work to modernize Medicare payments to promote patient-centered innovations.

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Patients Over Paperwork

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- evaluate and streamline regulations
- reduce unnecessary burden
- increase efficiencies
- improve the beneficiary experience
- remove regulatory obstacles
- allow providers to spend time with patients

"When burdensome regulations no longer advance the goal of patients first, we must improve or eliminate them."
--CMS Administrator Seema Verma, October 30, 2017

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Meaningful Measures

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- streamline quality measures
  - focus on providing high-quality care and improving patient outcomes
- reduce regulatory burden
- promote innovation through greater flexibility and patient engagement
- implement MACRA while minimizing provider burden and cost

"We need to move from fee-for-service to a system that pays for value and quality – but how we define value and quality today is a problem."
--CMS Administrator Seema Verma, October 30, 2017

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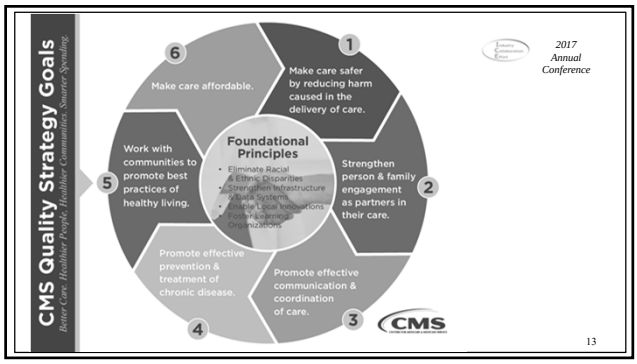
CMS Quality Strategy Goals
Better Care. Healthier People. Healthier Communities. Smarter Spending.
1
Make care safer by reducing harm caused in the delivery of care.
2
Strengthen person & family engagement as partners in their care.
3
Promote effective communication & coordination of care.
4
Promote effective prevention & treatment of chronic disease.
5
Work with communities to promote best practices of healthy living.
6
Make care affordable.
Foundational Principles
Eliminate Racial & Ethnic Disparities
Strengthen Infrastructure & Work Systems
Enable Local Innovations
Foster Learning & Dissemination
CMS
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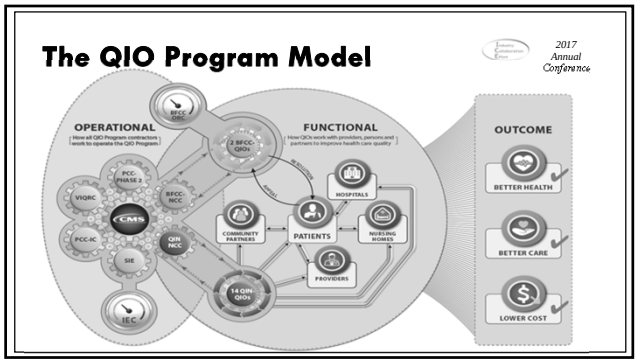
The QIO Program Model
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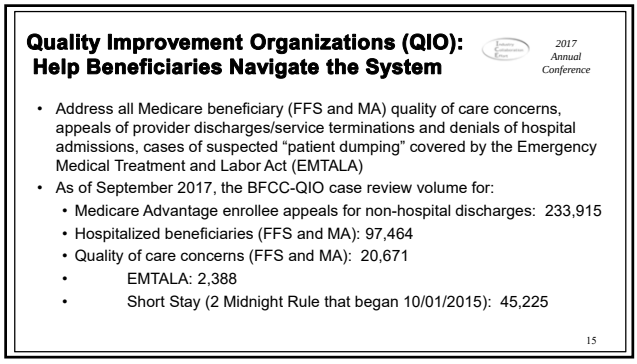
OPERATIONAL
FUNCTIONAL
OUTCOME
BFCC-QIOs
2 BFCC-QIOs
PCC PHASE 2
VIQRC
BFCC-RCC
CMS
PCC-IC
QIN-NCC
SIE
IEC
14 QIN-QIOs
HOSPITALS
COMMUNITY PARTNERS
PATIENTS
NURSING HOMES
PROVIDERS
BETTER HEALTH
BETTER CARE
LOWER COST


Quality Improvement Organizations (QIO): Help Beneficiaries Navigate the System
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• Address all Medicare beneficiary (FFS and MA) quality of care concerns, appeals of provider discharges/service terminations and denials of hospital admissions, cases of suspected "patient dumping" covered by the Emergency Medical Treatment and Labor Act (EMTALA)
• As of September 2017, the BFCC-QIO case review volume for:
• Medicare Advantage enrollee appeals for non-hospital discharges: 233,915
• Hospitalized beneficiaries (FFS and MA): 97,464
• Quality of care concerns (FFS and MA): 20,671
• EMTALA: 2,388
• Short Stay (2 Midnight Rule that began 10/01/2015): 45,225
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CMS Innovation Center Portfolio

Pay Providers	**Test and expand alternative payment models** • **Accountable Care** – ACO Investment Model – Pioneer ACO Model – Medicare Shared Savings Program (housed in Center for Medicare) – Comprehensive ESRD Care Initiative – Next Generation ACO • **Primary Care Transformation** – Comprehensive Primary Care Initiative (CPC) & CPC+ – Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration – Independence at Home Demonstration – Graduate Nurse Education Demonstration – Home Health Value Based Purchasing – Medicare Care Choices – Frontier Community Health Integration Project – Medicare Diabetes Prevention Program	• **Bundled payment models** – Bundled Payment for Care Improvement Models 1-4 – Oncology Care Model – Comprehensive Care for Joint Replacement • **Initiatives Focused on the Medicaid** – Medicaid Incentives for Prevention of Chronic Diseases – Strong Start Initiative – Medicaid Innovation Accelerator Program • **Dual Eligible (Medicare-Medicaid Enrollees)** – Financial Alignment Initiative – Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Medicare-Medicaid ACO Model • **Medicare Advantage (Part C) and Part D** – Medicare Advantage Value-Based Insurance Design Model – Part D Enhanced Medication Therapy Management
Deliver Care	**Support providers and states to improve the delivery of care** • **Learning and Diffusion** – Partnership For Patients – Transforming Clinical Practice • **Health Care Innovation Awards** • **Accountable Health Communities**	• **State Innovation Models Initiative** – SIM Round 1 & SIM Round 2 – Maryland All-Payer Model – Pennsylvania Rural Health Model – Vermont All-Payer ACO Model • **Million Hearts Cardiovascular Risk Reduction Model**
Distribute Information	**Increase information available for effective informed decision-making by consumers and providers** • **Information to providers in CMMI models**	• **Shared decision-making required by many models**

* Many CMMI programs test innovations across multiple focus areas

Innovation Center RFI - New Direction

The RFI seeks broad input related to a new direction for the CMS Innovation Center that will promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, and improve outcomes.

The administration plans to launch models in several focus areas:

- Expanded Opportunities for Participation in Advanced APMs
- Consumer-Directed Care & Market-Based Innovation Models
- Physician Specialty Models
  - Physician-Focused Payment Model Technical Advisory Committee (PTAC) Recommended Models
- Prescription Drug Models
- Medicare Advantage (MA) Innovation Models
- State-Based and Local Innovation, including Medicaid-focused Models
- Mental and Behavioral Health Models
- Program Integrity

Guiding Principles

- Choice and competition in the marketplace
- Provider choice and incentives
- Patient-centered care
- Benefit design and price transparency
- Transparent model design and evaluation
- Small scale testing

Comment period ended November 20, 2017

Accountable Health Communities

Key Innovations

- Systematic screening of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs
- Tests the effectiveness of referrals and community services navigation on total cost of care using a rigorous mixed method evaluative approach
- Partner alignment at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs

Model Tracks

Assistance Track

- 12 Bridge Organizations provide community service navigation services to *assist* high-risk beneficiaries with accessing services to address health-related social needs

Alignment Track

- 20 Bridge Organizations encourage partner *alignment* to ensure that community services are available and responsive to the needs of beneficiaries

Comprehensive Primary Care Plus (CPC+)

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CMS's largest-ever initiative to transform how primary care is delivered and paid for in America

GOALS

1. Strengthen primary care through multi-payer payment reform and care delivery transformation.
2. Support clinicians to provide comprehensive care that meets the needs of all patients.
3. Improve quality, access, and efficiency of care.

PARTICIPANTS AND PARTNERS

- Advanced primary care practices in two rounds:
  - Round 1: 2,893 practices in 14 regions
  - Round 2: Up to 1,000 practices in 4 regions
- Two tracks to accommodate diversity of practices
- 62 public and private payers in CPC+ regions
- Health IT vendors partner with CMS and Track 2 practices
- 5 year model: 2017-2021; 2018-2022

CARE TRANSFORMATION FUNCTIONS

- Access and continuity
- Care management
- Comprehensiveness and coordination
- Patient and caregiver engagement
- Planned care and population health

PAYMENT REDESIGN COMPONENTS

- PBPM risk-adjusted care management fees
- Performance-based incentive payments for quality, experience, and utilization measures that drive total cost of care
- For Track 2, hybrid of reduced fee-for-service payments and up-front "Comprehensive Primary Care Payment" to offer flexibility in delivering care outside traditional office visits

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Learning and Action Network

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Department of Health and Human Services (HHS) is working

- in concert with partners in the private, public, and non-profit sectors
- to help achieve better care, smarter spending, and healthier people
- to transform the nation's health system to emphasize quality over volume.

HHS launched the LAN

- to increase the adoption of value-based payments and alternative payment models.

"The LAN offers a unique and important opportunity for payors, providers, and other stakeholders to work with CMS - in partnership – to develop innovative approaches to improving our health care system."
--CMS Administrator Seema Verma, October 30, 2017

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Physician Compare

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Helps people with Medicare make informed decisions

Incentivizes clinicians to maximize performance

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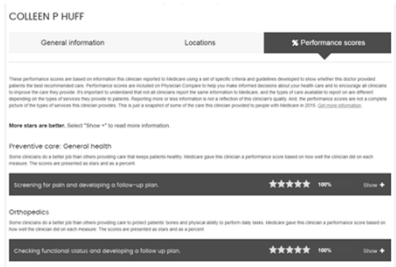
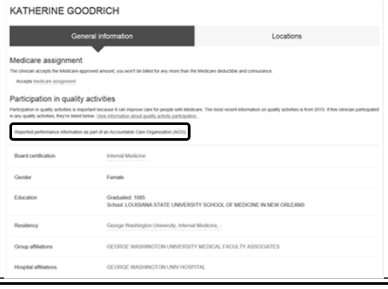
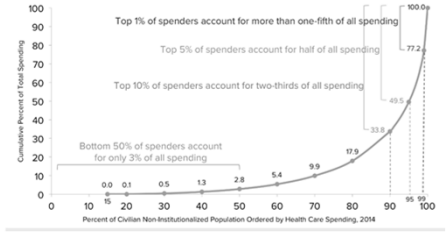
Performance Scores



Physician Compare Example

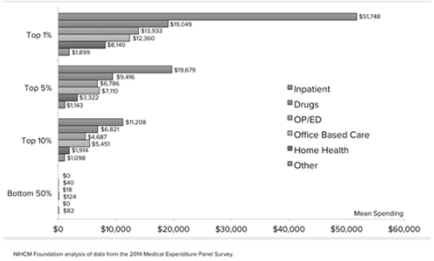


Health Care Spending Is Highly Concentrated Among a Small Portion of the US Non-Institutionalized Population

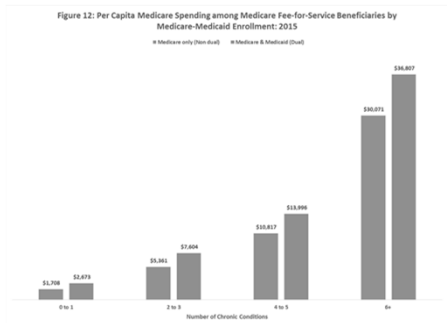


NIHCM Foundation analysis of data from the 2014 Medical Expenditure Panel Survey.

https://www.nihcm.org/images/health-care-concentration-071717-slide1.png



https://www.nihcm.org/images/health-care-concentration-071717-slide3.png



Source: CMS Chronic Conditions Chartbook: 2015

CMS Initiatives

- "Connected Care": Chronic Care Management (CCM) Initiative
- New Medicare Card

What is Chronic Care Management (CCM)?

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Chronic Care Management (CCM) services by a physician or non-physician practitioner (Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist and/or Certified Nurse Midwife) and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until death, and that place the patient at significant risk of death, acute exacerbation / decompensation, or functional decline

- Timed services – threshold amount of clinical staff time performing qualifying activities is require per month
- CCM is a critical component of care that contributes to better health and care for individuals
- CCM offers more centralized management of patient needs and extensive care coordination among practitioners and providers

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What's New for 2017?

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Significant changes starting in 2017 based on feedback from stakeholders.

- Additional separate payment amount through three new billing codes
  - **G0506** (Add-On Code to CCM Initiating Visit, $64)
  - **CPT 99487** (Complex CCM, $94)
  - **CPT 99489** (Complex CCM Add-On, $47)
- **CPT 99490** still effective for Non-Complex CCM ($43)

Visit the *Connected Care* Resource Hub at: **go.cms.gov/CCM**

For questions about the *Connected Care* campaign and its resources, contact, **CCM@cms.hhs.gov**

For all CCM codes – Simplified and reduced billing and documentation rules, especially around patient consent and use of electronic technology.

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New Card! New Number!

Mailing in 2018

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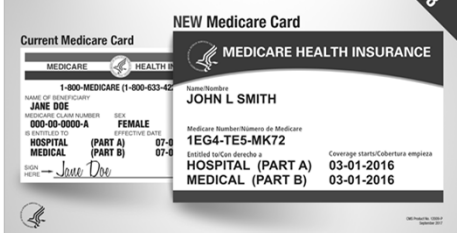

https://www.cms.gov/medicare/new-medicare-card/nmc-home.html

Operations: Transition Period

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- The transition period will run from **April 1, 2018 through December 31, 2019**
- CMS will complete its system and process updates to be ready to accept and return the new Medicare Number on April 1, 2018
- All stakeholders who submit or receive transactions containing the HICN must modify their processes and systems to be ready to submit or exchange the new Medicare Number by April 1, 2018. Stakeholders may submit **either** the new Number or HICN **during the transition period**
- CMS will accept, use for processing, and return to stakeholders **either** the new Medicare Number or HICN, whichever is submitted on the claim, **during the transition period**

Thank You

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