2019 Annual Conference

Industry Collaboration Effort

INNOVATIVE APPROACHES TO
ENHANCING QUALITY, ACCESSIBILITY, AND AFFORDABILITY

Gregory R. Dill, PharmD, MPH
CAPT, US Public Health Service
Acting Consortium Administrator
Consortium for Financial Management & Fee-for-Service Operations
Centers for Medicare & Medicaid Services
December 10, 2019

1

DISCLAIMER

2019 Annual Conference

Industry Collaboration Effort

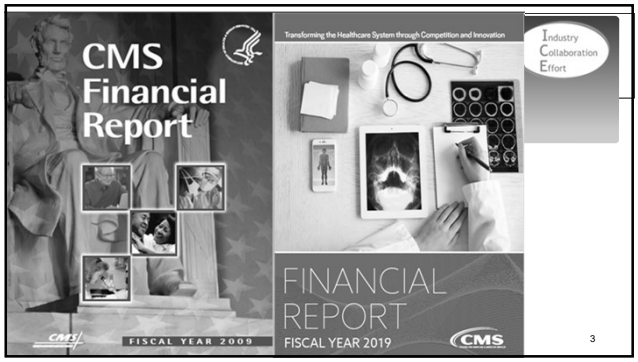
This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

2

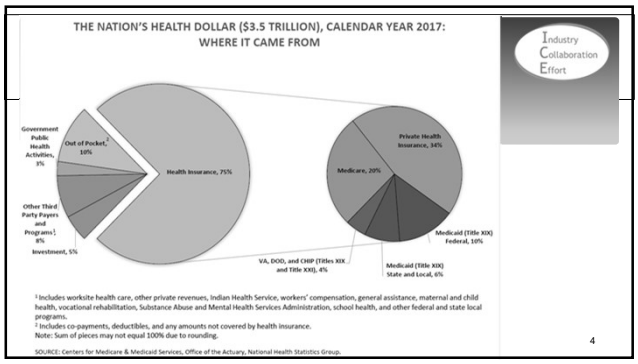
2



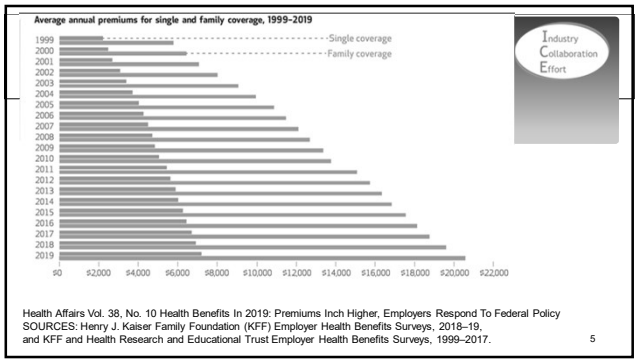
Industry Collaboration Effort

3

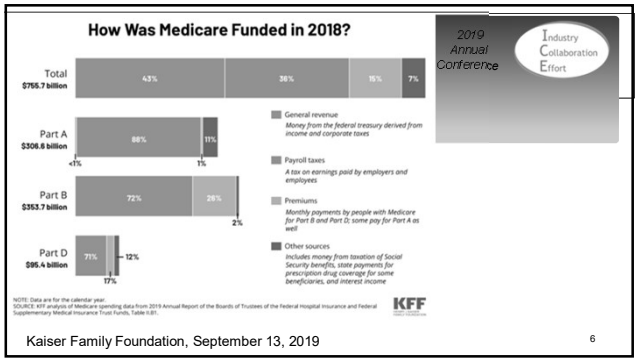
3


THE NATION'S HEALTH DOLLAR ($3.5 TRILLION), CALENDAR YEAR 2017:
WHERE IT CAME FROM
Industry Collaboration Effort
Government Public Health Activities, 3%
Out of Pocket[2], 10%
Health Insurance, 75%
Other Third Party Payers and Programs[1], 8%
Investment, 5%
Private Health Insurance, 34%
Medicare, 20%
Medicaid (Title XIX) Federal, 10%
VA, DOD, and CHIP (Titles XIX and Title XXI), 4%
Medicaid (Title XIX) State and Local, 6%
[1] Includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, school health, and other federal and state local programs.
[2] Includes co-payments, deductibles, and any amounts not covered by health insurance.
Note: Sum of pieces may not equal 100% due to rounding.
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.
4

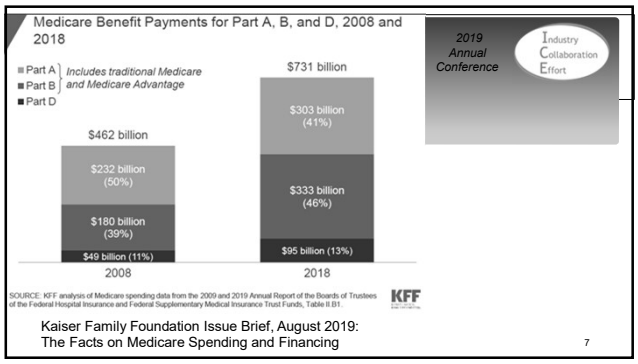
4


Average annual premiums for single and family coverage, 1999–2019
Industry Collaboration Effort
Single coverage
Family coverage
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
$0
$2,000
$4,000
$6,000
$8,000
$10,000
$12,000
$14,000
$16,000
$18,000
$20,000
$22,000
Health Affairs Vol. 38, No. 10 Health Benefits In 2019: Premiums Inch Higher, Employers Respond To Federal Policy
SOURCES: Henry J. Kaiser Family Foundation (KFF) Employer Health Benefits Surveys, 2018–19,
and KFF and Health Research and Educational Trust Employer Health Benefits Surveys, 1999–2017.
5

5


How Was Medicare Funded in 2018?
2019 Annual Conference
Industry Collaboration Effort
Total $755.7 billion
43%
36%
15%
7%
Part A $306.8 billion
88%
11%
<1%
1%
Part B $353.7 billion
72%
26%
2%
Part D $95.4 billion
71%
12%
17%
General revenue
Money from the federal treasury derived from income and corporate taxes
Payroll taxes
A tax on earnings paid by employers and employees
Premiums
Monthly payments by people with Medicare for Part B and Part D; some pay for Part A as well
Other sources
Includes money from taxation of Social Security benefits, state payments for prescription drug coverage for some beneficiaries, and interest income
NOTE: Data are for the calendar year.
SOURCE: KFF analysis of Medicare spending data from 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table II.B1.
KFF
Kaiser Family Foundation, September 13, 2019
6

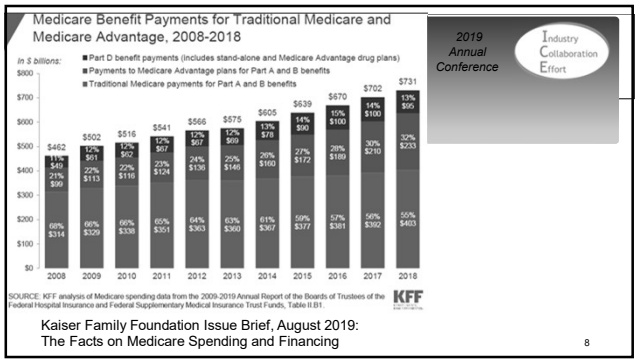
6



Kaiser Family Foundation Issue Brief, August 2019:
The Facts on Medicare Spending and Financing

7

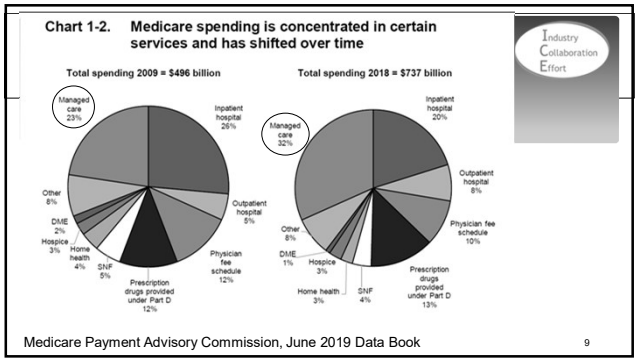
7



Kaiser Family Foundation Issue Brief, August 2019:
The Facts on Medicare Spending and Financing

8

8



Medicare Payment Advisory Commission, June 2019 Data Book

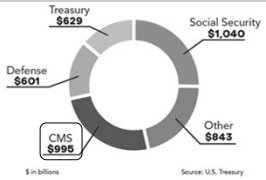
9

9

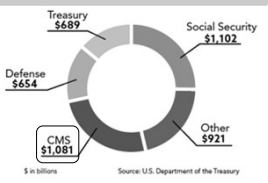
Federal Outlays

2019 Annual Conference

Industry Collaboration Effort



CMS Financial Report 2018



CMS Financial Report 2019

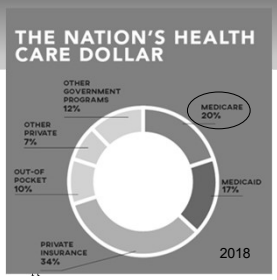
10

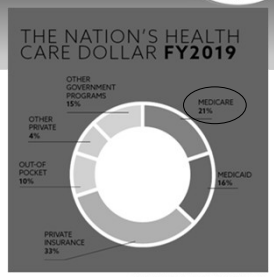
10

CMS Financial Report 2019

2019 Annual Conference

Industry Collaboration Effort





11

11

Table V.B3.—Medicare Enrollment

[In thousands]

Calendar year	HI Part A	SMI Part B	SMI Part D	Part C	Total[1]
Historical data:					
1970	20,104	19,496	—	—	20,398
1975	24,481	23,744	—	—	24,864
1980	28,002	27,278	—	—	28,433
1985	30,621	29,869	—	1,271	31,081
1990	33,747	32,567	—	2,017	34,251
1995	37,175	35,641	—	3,467	37,594
2000	39,257	37,335	—	6,856	39,688
2005	42,233	39,752	1,841	5,794	42,606
2010	47,365	43,882	34,772	11,693	47,720
2011	48,549	44,917	35,720	12,383	48,896
2012	50,540	46,477	37,448	13,588	50,874
2013	52,169	47,952	39,103	14,843	52,504
2014	53,777	49,413	40,499	16,244	54,115
2015	55,246	50,756	41,804	17,493	55,589
2016	56,729	52,094	43,217	18,392	57,073
2017	58,173	53,369	44,480	19,815	58,517
2018	59,577	54,575	45,759	21,331	59,920
Intermediate estimates:					
▲2019	61,006	55,878	47,176	22,750	61,349
2020	62,687	57,358	48,662	23,896	63,030
2021	64,471	58,918	50,195	24,751	64,814
2022	66,260	60,502	51,723	25,687	66,605
2023	68,021	62,074	53,266	26,573	68,366
2024	69,740	63,595	54,740	27,447	70,087
2025	71,481	65,137	56,189	28,305	71,828
2026	73,185	66,662	57,567	29,141	73,533
2027	74,823	68,116	58,895	29,932	75,172
2028	76,384	69,507	60,164	30,680	76,734
2030	79,188	72,052	62,367	32,014	79,538
2035	83,912	76,256	66,006	34,000	84,259
2040	86,245	78,364	67,830	34,893	86,586

2019 Annual Conference

Industry Collaboration Effort

2019 Medicare Trustees Report

12

12

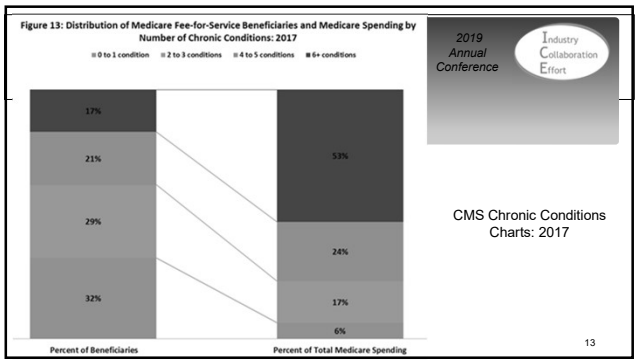
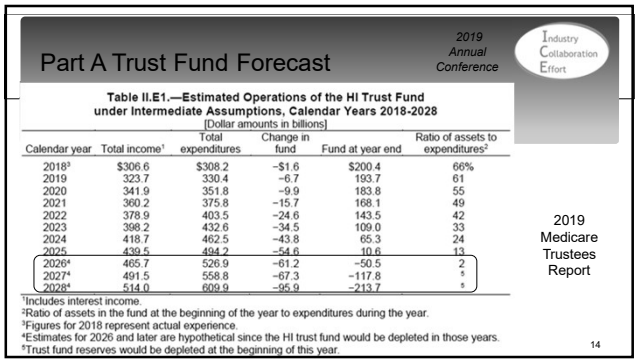
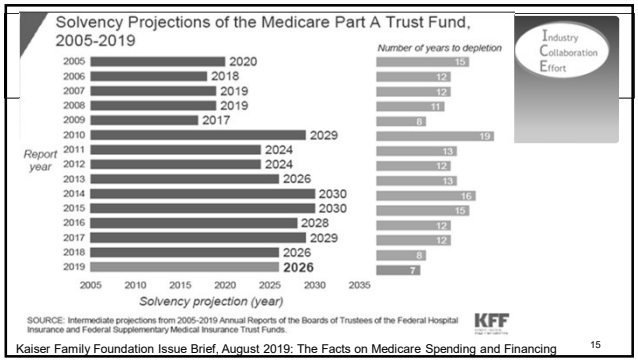


Figure 13: Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2017
0 to 1 condition
2 to 3 conditions
4 to 5 conditions
6+ conditions
17%
21%
29%
32%
53%
24%
17%
6%
Percent of Beneficiaries
Percent of Total Medicare Spending
2019 Annual Conference
Industry Collaboration Effort
CMS Chronic Conditions Charts: 2017
13

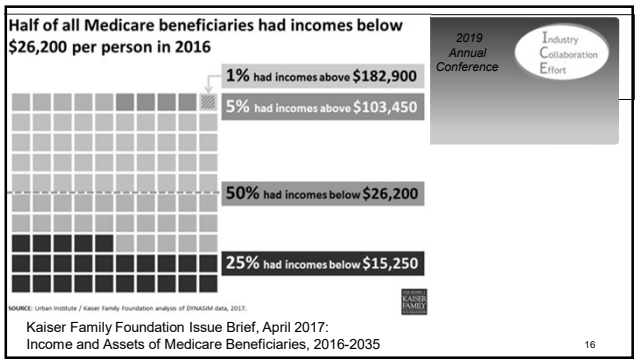
13


Part A Trust Fund Forecast
2019 Annual Conference
Industry Collaboration Effort
Table II.E1.—Estimated Operations of the HI Trust Fund under Intermediate Assumptions, Calendar Years 2018-2028
[Dollar amounts in billions]
Calendar year | Total income[1] | Total expenditures | Change in fund | Fund at year end | Ratio of assets to expenditures[2]
2018[3] | $306.6 | $308.2 | −$1.6 | $200.4 | 66%
2019 | 323.7 | 330.4 | −6.7 | 193.7 | 61
2020 | 341.9 | 351.8 | −9.9 | 183.8 | 55
2021 | 360.2 | 375.8 | −15.7 | 168.1 | 49
2022 | 378.9 | 403.5 | −24.6 | 143.5 | 42
2023 | 398.2 | 432.6 | −34.5 | 109.0 | 33
2024 | 418.7 | 462.5 | −43.8 | 65.3 | 24
2025 | 439.5 | 494.2 | −54.6 | 10.6 | 13
2026[4] | 465.7 | 526.9 | −61.2 | −50.5 | 2
2027[4] | 491.5 | 558.8 | −67.3 | −117.8 | [5]
2028[4] | 514.0 | 609.9 | −95.9 | −213.7 | [5]
[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 2018 represent actual experience.
[4]Estimates for 2026 and later 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.
2019 Medicare Trustees Report
14

14


Solvency Projections of the Medicare Part A Trust Fund, 2005-2019
Industry Collaboration Effort
Number of years to depletion
Report year
2005 2020 15
2006 2018 12
2007 2019 12
2008 2019 11
2009 2017 8
2010 2029 19
2011 2024 13
2012 2024 12
2013 2026 13
2014 2030 16
2015 2030 15
2016 2028 12
2017 2029 12
2018 2026 8
2019 2026 7
2005 2010 2015 2020 2025 2030 2035
Solvency projection (year)
SOURCE: Intermediate projections from 2005-2019 Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.
KFF
Kaiser Family Foundation Issue Brief, August 2019: The Facts on Medicare Spending and Financing
15

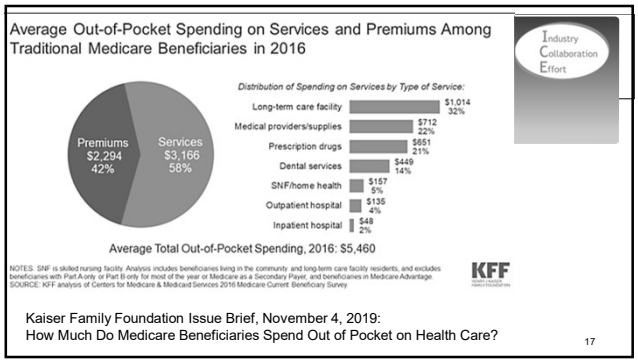
15



Kaiser Family Foundation Issue Brief, April 2017:
Income and Assets of Medicare Beneficiaries, 2016-2035

16

16



Kaiser Family Foundation Issue Brief, November 4, 2019:
How Much Do Medicare Beneficiaries Spend Out of Pocket on Health Care?

17

17

Executive Order: Protecting and Improving Medicare for Our Nation's Seniors

2019 Annual Conference

Industry Collaboration Effort

"President Trump's Executive Order delivers on the clear promise he's made to Americans about their healthcare: protect what works in our system and fix what's broken. America's seniors are overwhelmingly satisfied with the care they receive through traditional Medicare and Medicare Advantage, and the President is continuing to take action to strengthen and improve these programs."

– HHS Secretary Alex Azar on October 3, 2019

18

18

Creating a Healthcare System That Puts Patients at the Center: Better Health for All Americans

2019 Annual Conference

Industry Collaboration Effort

- expanding options and providing savings for seniors on Medicare Advantage;
- eliminating unnecessary burdens on providers;
- focusing Medicare payments on time spent with patients rather than on procedures performed;
- accelerating access to the latest medical technologies;
- cutting waste, fraud, and abuse; and
- expanding freedom and control for seniors on Medicare

19

19

CMS Strategic Goals

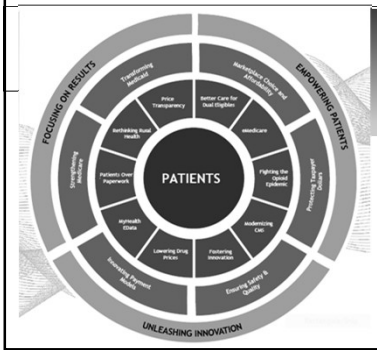
2019 Annual Conference

Industry Collaboration Effort

- Empowering Patients
- Focusing on Results
- Unleashing Innovation

20

20



Achieving the Goals

2019 Annual Conference

Industry Collaboration Effort

21

21

CMS support of health care will result in patient-centered, market-driven reforms that drive quality and improve outcomes

Industry Collaboration Effort

Historical state → Evolving future state

Public and Private sectors

Key characteristics
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Key characteristics
- Patient-centered
- Incentives for outcomes
- Sustainable
- Market-driven
- Coordinated care

22

22

Medicare Shared Savings Program

2019 Annual Conference

Industry Collaboration Effort

- The Medicare Shared Savings Program (Shared Savings Program) was established in 2012 to move CMS' payment systems towards paying for value and outcomes.
- Voluntary national program that encourages groups of doctors, hospitals, and other health care providers to come together as an "Accountable Care Organization" (ACO) that is held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population.
  - ACOs that successfully meet quality and savings requirements share a percentage of the achieved savings with Medicare. ACOs under two-sided models are accountable for sharing in losses.
- In 2018, CMS issued the Pathways to Success Final Rules to encourage ACOs to transition to two-sided models
  - 29% of Shared Savings Program ACOs now under two-sided risk
  - 89 two sided ACOs approved to use the SNF 3 Day Rule Waiver

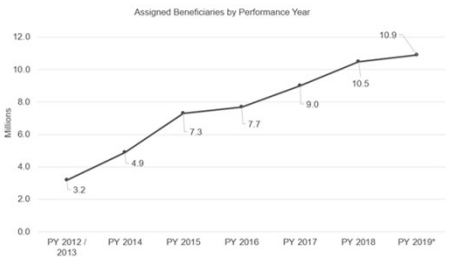
23

23

ACO Assigned Beneficiaries

2019 Annual Conference

Industry Collaboration Effort



24

24

Performance Year Results

2019 Annual Conference

Industry Collaboration Effort

25

25

MACRA Goals

2019 Annual Conference

Industry Collaboration Effort

Through MACRA, HHS aims to:

- Offer **multiple pathways** with varying levels of risk and reward for providers to tie more of their payments to value.
- Over time, **expand the opportunities** for a broad range of providers to participate in APMs.
- **Minimize additional reporting burdens** for APM participants.
- **Promote understanding** of each physician's or practitioner's status with respect to MIPS and/or APMs.
- Support **multi-payer initiatives** and the development of APMs in Medicaid, Medicare Advantage, and other payer arrangements.

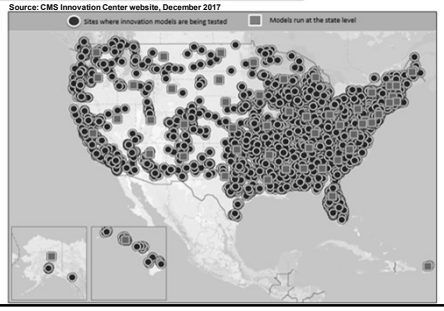
26

26

CMS has engaged the health care delivery system and invested in innovation across the country

Industry Collaboration Effort

Source: CMS Innovation Center website, December 2017



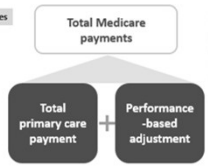
27

27

Primary Care First

Foster Independence, Reward Outcomes

Primary Care First includes two payment model options for practices ready to accept increased financial risk in exchange for flexibility and potential rewards based on performance, including support for practices serving high-needs populations



Industry Collaboration Effort

Goals:

1. **Reduce Medicare spending** by preventing avoidable inpatient hospital admissions
2. **Improve quality of care and access to care** for all beneficiaries, particularly those with complex chronic conditions and serious illness

October 29, 2019: Payer Statement of Interest Form posted

October 24, 2019: Online application portal live through January 22, 2020

28

28

Direct Contracting

Direct Contracting offers new forms of capitated population-based payments (PBPs), enhanced payment options, and flexibilities to increase the tools available for providers to meet beneficiaries' medical and non-medical needs.

Option	Risk Arrangement
Professional PBP	50% Savings/Losses
Global PBP	100% Savings/Losses
Geographic PBP (proposed)	100% Savings/Losses

Industry Collaboration Effort

Goals:

1. **Transform risk-sharing arrangements** in Fee-for-Service Medicare
2. **Empower beneficiaries** to personally engage in their own care delivery
3. **Reduce provider burden** to meet health care needs effectively

Request for Applications for Professional and Global PBP anticipated Fall 2019

29

29

Emergency Triage, Treat, and Transport (ET3) Model

Appropriate care, at the right time, in the right place

The **ET3 Model** provides greater flexibility to ambulance care teams responding to 911 calls, aimed at **reducing expenditures** while **preserving or enhancing quality of care** for beneficiaries


Treatment On Scene


Alternate Location


Hospital

Industry Collaboration Effort

Goals:

1. **Provide person-centered care** and give beneficiaries greater control of their care
2. **Encourage appropriate utilization of services** to meet health care needs effectively
3. **Increase efficiency in the EMS system** to more readily respond to high-acuity cases

Notice of Funding Opportunity anticipated late 2019

30

30

Medicare Advantage Value Based Insurance Design Model offers more flexibility to Medicare Advantage Plans

Industry Collaboration Effort

Allows MA plans to structure enrollee cost-sharing and other health plan design elements to encourage enrollees to use clinical services that have the greatest potential to positively impact on enrollee health

- Began on January 1, 2017 and will run for 5 years

Plans in 25 states will be eligible to participate

- Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee
- **Starting in 2018:** Alabama, Michigan and Texas
- **Starting in 2019:** California, Colorado, Florida, Georgia, Hawaii, Maine, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia, and West Virginia.

31

31

2020 VBID Model Components

VBID	Rewards and Incentives	Telehealth Networks
Test the impact of targeted reduced cost-sharing or additional supplemental benefits based on enrollees': a. Chronic Condition(s) b. Socioeconomic Status c. Both (a) and (b)	Test how rewards and incentives programs that more closely reflect the expected benefit of the health related service or activity, within an annual limit, may impact enrollee decision making about their health in more meaningful ways	Test how telehealth can augment and complement current MA networks. For rural areas with fewer providers, telehealth should serve to expand access to care and increase beneficiary choice of MAOs

Wellness and Health Care Planning
(Required for VBID Model participation)

32

VBID: CY 2021 Hospice Benefit in Medicare Advantage

2019 Annual Conference

Industry Collaboration Effort

- Beginning in CY 2021, the VBID model will allow participating MAOs to include Medicare's hospice benefit as part of its plan benefit design and test the impact on cost and quality
- This change is designed to increase access to hospice services and facilitate better coordination between patients' hospice providers and their other clinicians
- CMS will gather additional input from MAOs, providers, beneficiaries, hospice organizations, and other stakeholders as part of a seamless implementation
- CMS will release additional information and guidance on this component in the coming months through the VBID model website

33

33

Part D Payment Modernization Model: Goals

2019 Annual Conference

Industry Collaboration Effort

- Create new incentives for plans, patients, and providers to choose drugs with lower list prices to better manage catastrophic coverage phase federal reinsurance subsidy spending
- Ensure Medicare beneficiaries are able to maintain affordable access to the prescription drugs that they need

34

34

Part D Payment Modernization Model: Rewards & Incentives

2019 Annual Conference

Industry Collaboration Effort

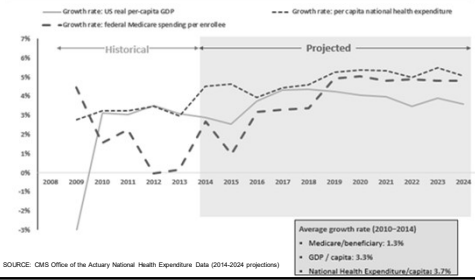
- CMS is permitting model participants to propose Part D Rewards and Incentives (RI) programs that, in connection with medication use, focus on promoting improved health, medication adherence, and the efficient use of health care resources
- The goals include rewarding and incentivizing enrollees':
  - Participation in a disease state management program
  - Engaging in medication therapy management with pharmacists or providers
  - Receipt of preventive health services, such as vaccines
  - Active engagement with their plans in understanding their medications, including clinically-equivalent alternatives that may be more cost-accessible

35

35

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

Industry Collaboration Effort



SOURCE: CMS Office of the Actuary National Health Expenditure Data (2014-2024 projections)

36

36

Thank You

2019 Annual Conference

Industry Collaboration Effort

Gregory R. Dill, PharmD, MPH
CAPT, US Public Health Service
gregory.dill@cms.hhs.gov

37

37