Size and Scope of CMS Responsibilities

- CMS is the **largest purchaser of health care in the world**.
- Combined, Medicare and Medicaid pay approximately **one-third of national health expenditures (approx. $900B)**
- CMS covers 100 million people through Medicare, Medicaid, the Children’s Health Insurance Program; or **roughly 1 in every 3 Americans**.
- The Medicare program alone pays out over $1.5 billion in benefit payments per day.
- Through various contractors, CMS processes over 1.2 billion fee-for-service claims and answers about 75 million inquiries annually.
Implications of Multiple Chronic Conditions
A population view of Medicare

### Spending

Figure 13: Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2015

- 0 to 1 condition: 15%
- 2 to 3 conditions: 21%
- 4 to 5 conditions: 29%
- 6+ conditions: 34%

### Readmissions

Figure 14: Distribution of Medicare Fee-for-Service Beneficiaries and 30-Day Medicare Hospital Readmissions by Number of Chronic Conditions: 2015

- 0 to 1 condition: 15%
- 2 to 3 conditions: 21%
- 4 to 5 conditions: 29%
- 6+ conditions: 34%

Percent of Beneficiaries Percent of Total Medicare Spending

Percent of Beneficiaries Percent of 30-Day Medicare Hospital Readmissions
A health care system that results in better accessibility, quality, affordability, empowerment, and innovation

CMS has started a national conversation about improving the health care delivery system, how Medicare can contribute to making the delivery system less bureaucratic and complex, and how we can reduce burden for clinicians, providers and beneficiaries in a way that increases quality of care and decreases costs – making the health care system more effective, simple, and accessible, while maintaining program integrity and preventing fraud.
We are working with the private sector towards patient-centered care and market-driven reform that: empowers beneficiaries as consumers, provides price transparency, increases choices and competition to drive quality, and improves outcomes.
Patients over Paperwork

Key Burden Reduction Milestones to Date

• Simplified Documentation and Coding
  - Allowing initial prescriptions of immunosuppressive drugs to be shipped to an alternate address other than the beneficiary’s home to ensure timely access to these drugs when the beneficiary does not return home immediately after discharge
  - Changes to home health recertification and eliminated the need for a physician to include a separate statement about how much longer home health services are needed

• Improved Quality and Operational Efficiency
  - Patient Driven Payment Model (SNF payments)
  - New 5-part plan for SNF quality

• Changing CMS Culture
  - Human-centered design
  - Visits to healthcare facilities
Patients over Paperwork
Meaningful Measures

Promote Effective Communication & Coordination of Care
Meaningful Measure Areas:
• Medication Management
• Admissions and Readmissions to Hospitals
• Transfer of Health Information and Interoperability

Promote Effective Prevention & Treatment of Chronic Disease
Meaningful Measure Areas:
• Preventive Care
  • Management of Chronic Conditions
  • Prevention, Treatment, and Management of Mental Health
  • Prevention and Treatment of Opioid and Substance Use Disorders
  • Risk Adjusted Mortality

Strengthen Person & Family Engagement as Partners in their Care
Meaningful Measure Areas:
• Care is Personalized and Aligned with Patient’s Goals
• End of Life Care according to Preferences
• Patient’s Experience of Care
• Patient Functional Status

Work with Communities to Promote Best Practices of Healthy Living
Meaningful Measure Areas:
• Equity of Care
• Community Engagement

Make Care Safer by Reducing Harm Caused in the Delivery of Care
Meaningful Measure Areas:
• Healthcare-Associated Infections
• Preventable Healthcare Harm

Improve Access for Rural Communities

Support Innovative Approaches

Empower Patients and Doctors

Support State Flexibility and Local Leadership

Safeguard Public Health

Track to Measurable Outcomes and Impact

Eliminate Disparities

Reduce burden

Achieve Cost Savings
• **June 6th**: CMS issued a Request for Information (RFI) seeking new ideas from the public on how to continue the progress of the Patients over Paperwork initiative

• Seeking innovative ideas that broaden perspectives on potential solutions to relieve burden and ways to improve:
  - Reporting and documentation requirements
  - Coding and documentation requirements for Medicare or Medicaid payment
  - Prior authorization procedures
  - Policies and requirements for rural providers, clinicians, and beneficiaries
  - Policies and requirements for dually enrolled (i.e., Medicare and Medicaid) beneficiaries
  - Beneficiary enrollment and eligibility determination
  - CMS processes for issuing regulations and policies


• **Comments due August 12, 2019**
CMS Rural Health Council

• Created in 2016, consisting of experts from across the Agency

• Mission:
  - “Sustain a proactive and strategic focus on health and health care issues across rural America by shaping CMS regulations and policies and making long-term recommendations that positively impact rural health consumers, providers and markets.”

• Focus on three Strategic areas:
  1. Ensuring access to high-quality health care to all Americans in rural settings
  2. Addressing the unique economics of providing health care in rural America
  3. Bringing the rural health care focus to CMS’ health care delivery and payment reform initiatives

Listening session themes:

<table>
<thead>
<tr>
<th>Improving Reimbursement</th>
<th>Adapting &amp; Improving Quality Measures and Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Access to Services and Providers</td>
<td>Improving Service Delivery And Payment Models</td>
</tr>
<tr>
<td>Engaging Consumers</td>
<td>Recruiting, Training, and Retaining the Workforce</td>
</tr>
<tr>
<td>Leveraging Partnerships/Resources</td>
<td>Improving Affordability and Accessibility of Insurance Options</td>
</tr>
</tbody>
</table>
# CMS Rural Health Strategy

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Key Supporting Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Apply a Rural Lens to CMS Programs and Policies</td>
<td>• Utilize “Optimizing CMS Policies and Programs for Health Equity Checklist”</td>
</tr>
<tr>
<td></td>
<td>• Integrate rural health lens to quality improvement and innovation activities</td>
</tr>
<tr>
<td>2. Improve Access to Care Through Provider Engagement and Support</td>
<td>• Increase number of trained professionals in rural areas</td>
</tr>
<tr>
<td></td>
<td>• Meaningful measures focusing on value</td>
</tr>
<tr>
<td></td>
<td>• Provide technical assistance</td>
</tr>
<tr>
<td></td>
<td>• Focus on transportation services</td>
</tr>
<tr>
<td>3. Advance Telehealth and Telemedicine</td>
<td>• Modernize and expand telehealth through Innovation models</td>
</tr>
<tr>
<td>4. Empower Patients in Rural Communities to Make Decisions About Their Health Care</td>
<td>• Develop and disseminate easy-to-understand materials to rural patients</td>
</tr>
<tr>
<td></td>
<td>• Engage rural patients through targeted outreach</td>
</tr>
<tr>
<td>5. Leverage Partnerships to Achieve the Goals of the CMS Rural Health Strategy</td>
<td>• Partner with ONC to promote interoperability</td>
</tr>
<tr>
<td></td>
<td>• Partner with Federal Office of Rural Health Policy to understand impact of CMS programs in rural communities</td>
</tr>
<tr>
<td></td>
<td>• Increase participation of health plans in rural areas</td>
</tr>
<tr>
<td></td>
<td>• Partner with CDC and other federal agencies to focus on maternal health, behavioral health and substance use disorders</td>
</tr>
</tbody>
</table>
What is Value-Based Purchasing?
Definition, Purpose, and Legislative Timeline

CMS defines value-based purchasing as paying for health care services in a manner that directly links performance on cost, quality and resource use metrics to health service payments.

“We must shift away from a fee-for-service system that reimburses only on volume and move toward a system that holds providers accountable for outcomes and allows them to innovate. Providers need the freedom to design and offer new approaches to delivering care.”
-CMS Administrator Seema Verma, September 19, 2017
Value-Based Purchasing at CMS

CMS VBP Program Impacts

- 2.1 million fewer incidents of harm and $28 billion saved (Hospital-Acquired Condition Reduction Program)
- 9.7 million beneficiaries served by 428 shared savings ACOs, with a net spending reduction of nearly $1 billion (Medicare Shared Savings Program)
- 66% of Medicaid managed care organization (MCO) contracts include quality initiatives. Twelve states require VBP in MCOs (Medicaid Managed Care)
- $319 million net savings to Medicare total cost of care through avoidance of preventable readmissions and ER visits (Maryland all-Payer Model)
- 150,000 fewer all-cause readmissions with 17.2% relative reduction in readmissions between 2007 and 2015 (Hospital Readmissions Reduction Program)
Value-Based Purchasing at CMS
Moving from Volume to Value

Healthcare Payment Learning and Action Network (LAN):

- Convened by HHS
- Aligns public & private stakeholders toward a payment system that pays for high-quality care and improved health
- Developed four Alternative Payment Model (APM) categories to help guide and track progress

Source: LAN APM Framework Refresh, HCPLan.org
### MIPS Year 3 (2019) Final

#### Opt-in Policy

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule</th>
<th>MIPS</th>
<th>Participation in Qualifying APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+0.5% each year</td>
<td>Max Adjustment (+/-)</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2017</td>
<td>+0.5% each year</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>+0.5% each year</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>+0.5% each year</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>+0.25% or 0.75%</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>+0.25% or 0.75%</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>+0.25% or 0.75%</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td>+0.25% or 0.75%</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td>+0.25% or 0.75%</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>+0.25% or 0.75%</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2026 &amp; on</td>
<td>+0.25% or 0.75%</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

**BBA of 2018 reduced the update for 2019 to +0.25%**
CMS released the 2017 Quality Payment Program (QPP) Experience Report with Appendix, which provides a comprehensive overview of the clinician reporting experience during the first year of the Quality Payment Program.

Data within the report show significant participation and performance in both MIPS and Advanced APM tracks for 2017.

The report analyzes several major aspects of the program, including:
  - Participation
  - Reporting Options
  - Performance Categories
  - Final Score and Payment Adjustments
**2017 QPP Experience Report**

Participation Results

**Key Insights**

- A total of **1,057,824** clinicians were eligible for MIPS in 2017

- **1,006,319** or **95 percent** of MIPS eligible clinicians participated in 2017 and avoided a negative payment adjustment

**TABLE 1**

<table>
<thead>
<tr>
<th>Overall Participation Rate of MIPS Eligible Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total MIPS Eligible Clinicians in 2017</td>
</tr>
<tr>
<td>Number of MIPS Eligible Clinicians that Participated in 2017</td>
</tr>
<tr>
<td>Participation Rate</td>
</tr>
</tbody>
</table>

**NOTE**

Table 1 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. Additionally, “participated” is defined as the total number of MIPS eligible clinicians who received at least 3 points (which was the MIPS performance threshold in 2017) and avoided a negative payment adjustment.
### Key Insights

- Group reporting was the preferred option for participating in the Quality Payment Program
- Significant participation in MIPS through APMs

#### TABLE 2 Overall Participation Count by Reporting Entity

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total MIPS Eligible Clinicians in 2017</td>
<td>1,057,824</td>
</tr>
<tr>
<td>Individual Participation</td>
<td>122,897</td>
</tr>
<tr>
<td>Group Participation</td>
<td>542,202</td>
</tr>
<tr>
<td>MIPS APM Participation</td>
<td>341,220</td>
</tr>
</tbody>
</table>

**NOTE** Table 2 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. Participants are counted once based on the submission method used for the clinician’s final score.
2017 QPP Experience Report
Participation Results

**Key Insights**

- MIPS eligible clinicians in rural practices had a participation rate of **94 percent**, which was virtually equal to the overall average.

- Illustrates that no matter the location, clinicians want to meaningfully engage and participate in the program.

### TABLE 4

<table>
<thead>
<tr>
<th>Small or Rural</th>
<th>Total MIPS Eligible Clinicians</th>
<th>MIPS Eligible Clinicians that Participated</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>229,106</td>
<td>186,428</td>
<td>81%</td>
</tr>
<tr>
<td>Rural</td>
<td>164,598</td>
<td>155,309</td>
<td>94%</td>
</tr>
</tbody>
</table>

**NOTE**
Table 4 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. Small practices are defined as having 15 or fewer clinicians (NPIs billing under the same TIN). A rural practice is one where the TIN has at least one practice site in a zip code designated as a rural area.
### Key Insights

More than **99,000** eligible clinicians became Qualifying APM Participants in 2017, with an additional **52** reaching Partial QP status.

#### TABLE 6

<table>
<thead>
<tr>
<th>Advanced APM Qualifying APM Participant (QP) Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of Qualifying APM Participants (QPs)</td>
</tr>
<tr>
<td>Total number of Partial QPs</td>
</tr>
</tbody>
</table>

**NOTE**

The total number of Partial QPs includes clinicians who both elected to participate in MIPS and those who remained excluded for the performance year.
Key Insights
MIPS eligible clinicians in small and rural practices also opted to submit more than the minimum amount of required data in 2017

![Image of a table showing the overall reporting timeframe for MIPS eligible clinicians in small and rural practices. The table includes columns for Quality#, Quality%, ACI#, ACI%, IA#, and IA% for different reporting periods.](image-url)
Key Insights

• 93 percent received a positive payment adjustment or better; another 2 percent earned a neutral payment adjustment
• Only 5 percent of MIPS eligible clinicians received a negative payment adjustment for their 2017 performance
Key Insights
The mean final score was highest for MIPS eligible clinicians who participated in MIPS through an APM (87.64), followed by those reporting as a part of a group (76.20)

TABLE 19: Mean and Median Scores by Participation Method

<table>
<thead>
<tr>
<th>Participation Method</th>
<th>Mean Final Score</th>
<th>Median Final Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>55.08</td>
<td>60.00</td>
</tr>
<tr>
<td>Groups</td>
<td>76.20</td>
<td>91.04</td>
</tr>
<tr>
<td>MIPS APM</td>
<td>87.64</td>
<td>91.76</td>
</tr>
<tr>
<td>National Total</td>
<td>74.01</td>
<td>88.97</td>
</tr>
</tbody>
</table>

Note: Table 19 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. The National Total row is the overall mean and median when considering all individual, group, and MIPS APM submissions.
Proposed FY 2020 IPPS and LTCH PPS Address Rural Health & Medical Innovation

- Proposed FY 2020 IPPS and LTCH PPS Address Rural Health & Medical Innovation
- IRF: FY 2020 Proposed Payment and Policy Changes
- IPF: FY 2020 Proposed Payment and Quality Reporting Updates
- SNF: FY 2020 Proposed Payment and Policy Changes
- Hospice: FY 2020 Proposed Payment Rate Update

Star Ratings

• 2/28/19 CMS posted potential changes to the Hospital Star Ratings for public comment.

• Changes under consideration, intended to respond to stakeholder feedback, seek to enhance the Star Ratings methodology by making hospital comparisons more precise and consistent, and by allowing more direct, “like-to-like” comparisons.

• One potential change, recommended by some hospitals, would place hospitals with similar characteristics into “peer groups” allowing, for example, small hospitals to be compared to other small hospitals instead of all hospitals. CMS developed these potential changes with feedback from hospitals and other stakeholders through a series of listening sessions and by considering input from a technical expert panel.

• Hospital Compare is the go-to resource for anyone deciding where to schedule a surgery or other inpatient or outpatient service. Users can compare hospitals based on patient experience, the timeliness and effectiveness of care, complication rates, and other factors.
Opioids- Open Letter

• Instructions went to MACs to send to clinicians at end of February
• 4-page letter highlighting CMS’ effort in combatting the opioid crisis
• Mentions roadmap: 3 prongs: prevention, treatment and using data to target prevention and treatment activities
• Guidance for co-prescribing naloxone
• New Medicare Part D opioid policies Safe and effective pain management treatments
Opioids- Mapping Tool

• Feb 22...CMS released expanded version of the opioid prescribing mapping tool
• Shows CMS’ commitment to opioid data transparency, and using data to target efforts, part of three-prong approach
• First time: includes data for opioid prescribing in Medicaid, and can make geographic comparisons of Part D plans prescribing rates
• With last year’s data, CMS sent targeted letters to 24,000 physicians who had higher prescribing rates
Opioids- Mapping Tool

https://go.cms.gov/opioidheatmap
New Medicare Part D Prescription Opioid Policies for 2019: Background

- CMS finalized new policies for Medicare drug plans to follow starting on January 1, 2019.

- These policies involve further partnership with providers and prescription drug plans.

- Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population.
Opioid Safety Alerts

- CMS expects Medicare Part D drug plans to implement the following safety alerts (pharmacy claim edits) for pharmacists to review when an opioid prescription is filled at the pharmacy:
  
  - Seven-day supply limit for initial opioid fills for opioid naïve patients (hard edit),
  - Care coordination edit at 90 morphine milligram equivalents (MME) (soft edit with pharmacist-prescriber consultation),
  - Concurrent opioid and benzodiazepine use (soft edit),
  - Duplicative long-acting (LA) opioid therapy (soft edit), and
  - Optional safety alert at 200 MME or more (hard edit).
Drug Management Programs

• Medicare Part D plans may implement a drug management program that limits access to certain controlled substances that have been determined to be “frequently abused drugs” (FADs) for patients who are considered to be at-risk for prescription drug abuse.

• For 2019, CMS has identified opioids and benzodiazepines as FADs.

• Potential at-risk patients are identified by their opioid use which involve multiple doctors and pharmacies.

• The goal of drug management programs is better care coordination for safer use.
CMS Approach

**Coverage**
CMS coverage policies now ensure some form of medication-assisted treatment across all CMS programs—Medicare, Medicaid, and Exchanges.

**Awareness**
CMS sent 24,000 letters in 2017 and 2018 to Medicare physicians to highlight that they were prescribing higher levels of opioids than their peers to incentivize safe prescribing practices.

**Data**
CMS released data in 2017 and 2018 to show where Medicare opioid prescribing is high to help identify areas for additional interventions.

**Tracking**
Due to safe prescribing policies, the number of Medicare beneficiaries receiving higher than recommended doses from multiple doctors declined by 40% in 2017.

**Best Practices**
CMS activated over 4,000 hospitals, 120,000 clinicians, and 5,000 outpatient settings through national quality improvement networks to rapidly generate results in reducing opioid-related events.

**Access**
As of June 2018, CMS approved 12 state Medicaid 1115 Demonstrations to improve access to opioid use disorder treatment, including new flexibility to cover inpatient and residential treatment while ensuring quality of care.
The MOM model is a patient-centered, service-delivery model, which aims to improve the quality of care and reduce costs for pregnant and postpartum Medicaid beneficiaries with OUD and their infants through state-driven care transformation.

**Goals:**

1. **Improve** quality of care and reduce costs
2. **Expand** access to treatment, service-delivery capacity, and infrastructure
3. **Create** sustainable coverage and payment strategies

Anticipated Notice of Funding Opportunity Release: Early 2019
Anticipated Application Period: Spring 2019
**Integrated Care for Kids (InCK) Model**

- Child-centered *local service delivery* and *state payment model* aimed at reducing expenditures and improving the quality of care for children covered by Medicaid and the Children’s Health Insurance Program (CHIP) through prevention, early identification, and treatment of priority health concerns like behavioral health challenges and physical health needs.

- Offers states and local providers support to address these priorities through a framework of child-centered care integration across behavioral, physical, and other child providers.

- Goals of the InCK Model:
  1. Improve child health,
  2. Reduce avoidable inpatient stays and out of home placement, and
  3. Create sustainable alternative payment models (APMs).

- Key participants of the InCK Model will be the state Medicaid agency and a local entity called a “Lead Organization”
Patrick M. Hamilton, MPA
Health Insurance Specialist
Centers for Medicare & Medicaid Services
Philadelphia Regional Office
(215) 861-4097
Patrick.Hamilton@cms.hhs.gov