

Outline

- Brief history of Medicare...what it is, E&E, characteristics of people covered, coverage, costs, duals, access, spending trends, financing, etc.
- Current and future direction as a result of the ACA & MACRA – delivery & payment systems reforms – outcome based payments/quality, program integrity, prevention & wellness
- Q&A

What CMS Does

- Oversees and administers Medicare and Federally-facilitated Health Insurance Marketplace
- Works with states to administer
 - Medicaid
 - Children's Health Insurance Program (CHIP)
 - State Partnership Marketplaces
- Maintains and monitors quality standards
- Fights fraud and abuse
- Explores quality-improving and cost-saving advances by funding or leading studies, demonstrations, and pilots



CMS by the Numbers



- Medicare enrollees
 - 19.1 million in 1966
 - 57 million – Dec 2015
- Medicaid enrollees
 - 10 million in 1967
 - 71.1 million – Dec 2015
- CHIP enrollment
 - 6.0 million – Dec 2015
- Marketplace coverage
 - Approx. 12.7 million people signed up for or renewed their coverage during the 2016 OEP
- 1 out of 2 people in the U.S. are impacted by CMS programs

Financing of CMS Programs & Operations

FUNDS FLOW FROM

THROUGH

TO FINANCE

Payroll Taxes

Medicare Premiums

Investment Interest

Federal Taxes

Medicare
Trust Funds

Medicare Benefits

Quality Improvement Organizations

Medicare Integrity Program

Program Management

Federal Taxes

General Fund
Appropriation

Medicaid

Children's Health Insurance Program (CHIP)

Medicaid Integrity Program

Program Management

Offsetting Collections

CMS User Fees

Recovery Audit Contracts

Reimbursables

Medicare- The Beginning

- **Medicare and Medicaid enacted in 1965**
- **Implemented in 1966**
 - Over 19 million enrolled by July 1 of that year
- **Medicare is a health insurance program for:**
 - People age 65 and older
 - Certain people under age 65 with disabilities
 - People of all ages with End-stage Renal Disease (ESRD)



President Johnson signs Medicare into law. President and Mrs. Truman receive the first Medicare cards.

Parts of Medicare



Part A Hospital Insurance

Hospital
SNF
HHA
Hospice



Part B Medical Insurance

Physician/
practitioner/
supplier services
Outpatient
Dx Tests, etc.



Part C Medicare Advantage Plans (like HMOs/PPOs)

Includes Part A,
Part B, and
sometimes Part
D coverage



Part D Medicare Prescription Drug Coverage

Medicare Coverage



In general, Medicare-covered services are those services considered medically reasonable and necessary to the overall diagnosis or treatment of the beneficiary's condition or to improve the functioning of a malformed body member. Services or supplies are considered medically necessary if they meet the standards of good medical practice and are:

- Proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
- Furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition; and
- Not mainly for the convenience of the beneficiary, provider, or supplier.
- Services must also meet specific medical necessity criteria defined by National Coverage Determinations and Local Coverage Determinations. For every service billed, you must indicate the specific sign, symptom, or beneficiary complaint necessitating the service. Although furnishing a service or test may be considered good medical practice, Medicare generally prohibits payment for services without beneficiary symptoms or complaints or specific documentation.

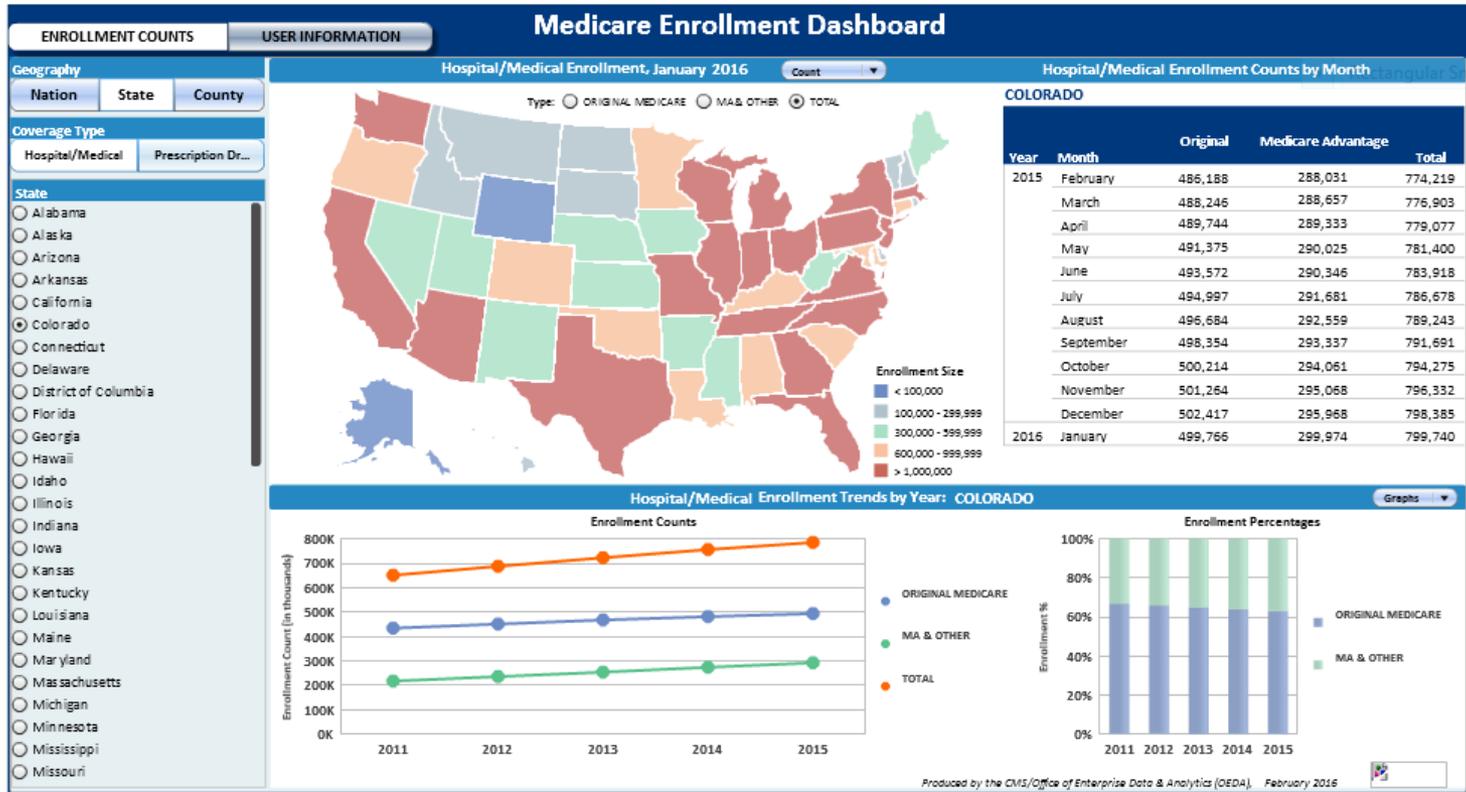
Part B-Covered Preventive Services

- “Welcome to Medicare” preventive visit
- Annual “Wellness” visit
- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Behavioral therapy for cardiovascular disease
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screening
- Mammograms (screening)
- Obesity screening and counseling
- Pap test, pelvic exam, and clinical breast exam
- Pneumococcal pneumonia shot
- Prostate cancer screening
- Sexually transmitted infection screening (STIs) and high-intensity behavioral counseling to prevent STIs
- Smoking cessation

NOT Covered by Part A and Part B

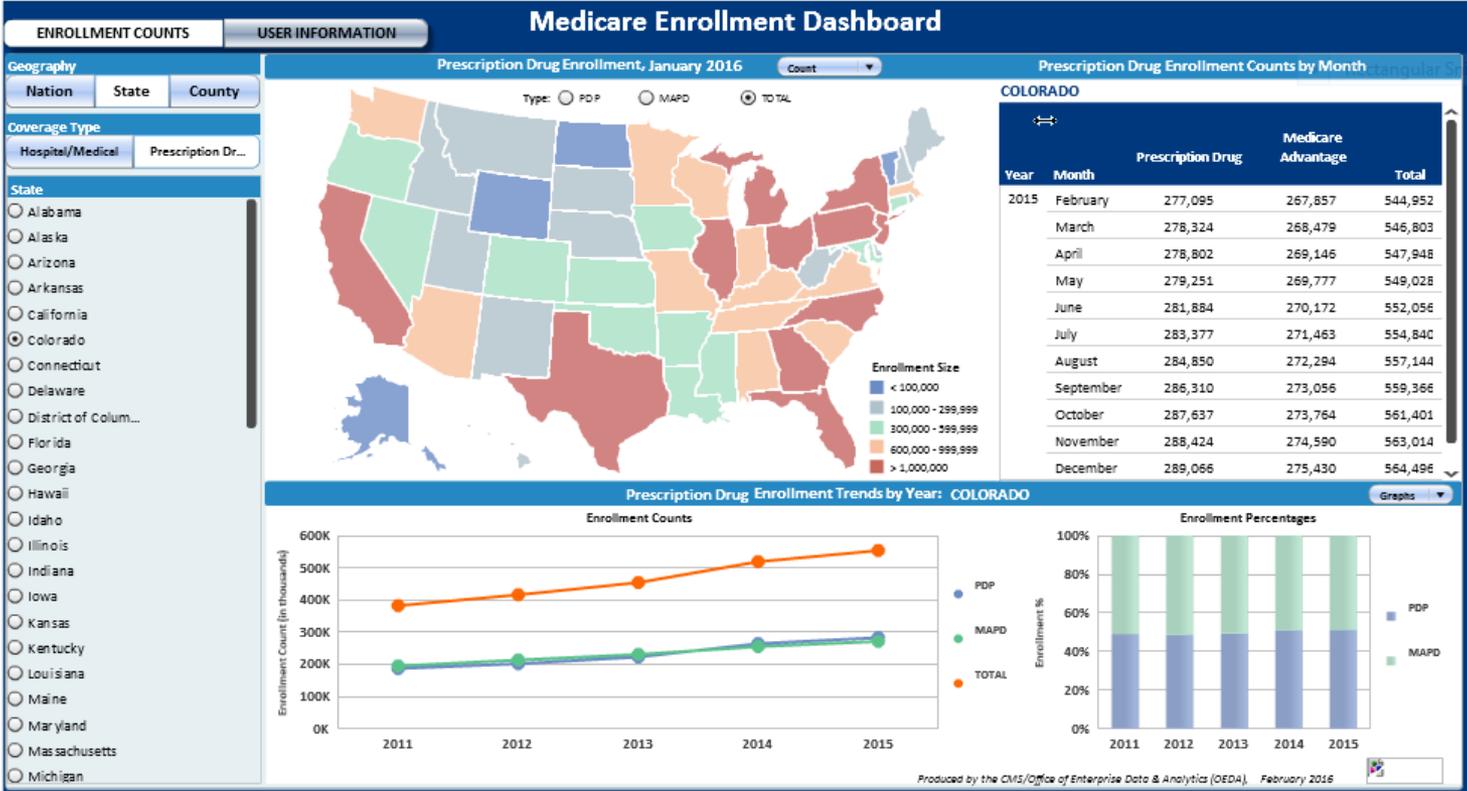
- Long-term care/Custodial Care
- Routine dental care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting hearing aids
- Care outside of the U.S.
- Other – check on www.medicare.gov

Colorado Medicare Enrollment /Trends



<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html>

Colorado Medicare Enrollment – Part D

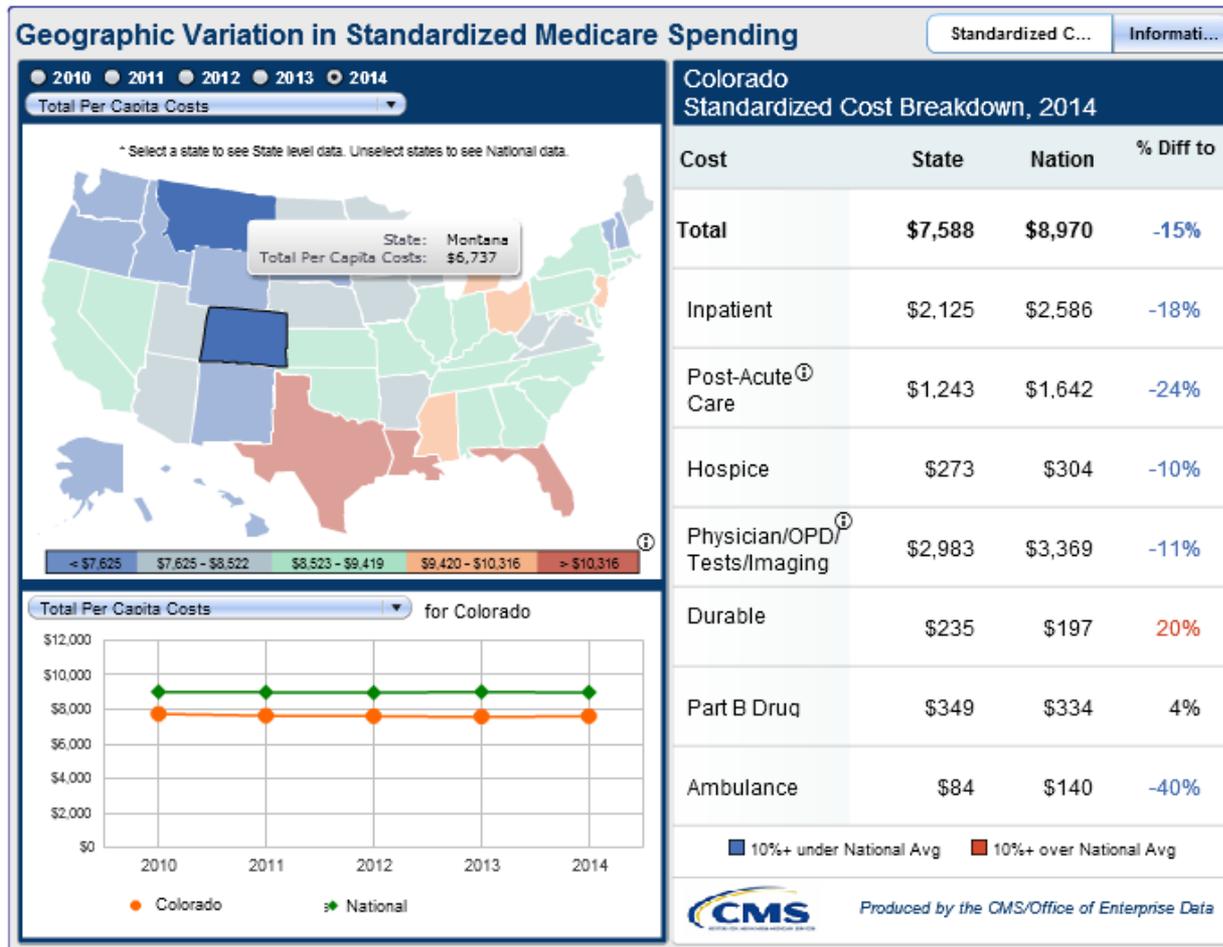


<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html>

Medicare's Financial Status

- Medicare is the largest health care insurance program—and the second-largest social insurance program—in the United States. Medicare is also complex, and it faces a number of financial challenges in both the short term and the long term. These challenges include the following:
 - The solvency of the HI trust fund
 - The long-range health of the HI trust fund
 - The rapid growth projected for SMI (Pt B & D) costs as a percent of Gross Domestic Product.
 - The likelihood that the lower payment rate updates to most categories of Medicare providers for 2011 and later, as mandated by the Affordable Care Act, will not be viable in the long range.
 - The likelihood that the specified rate updates under the new Part B physician payment update system will not keep up with underlying physician costs over the long range, possibly leading to decreased access to, or quality of, physician services for beneficiaries or to the overriding of the specified updates (as repeatedly occurred when the SGR system was in place), which would in turn lead to higher costs.

Medicare Spending – Colorado



https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/GeoVar-State/GeoVar_State.html

Highlights of Affordable Care Act



- Closes prescription drug coverage “Donut Hole”
- Reduces subsidies to insurance companies
- Strengthens the financial health of Medicare
 - Invests in fighting waste, fraud, and abuse
 - Will extend the financial health of Medicare by 9 years
- Changes annual enrollment period
- Improves preventive services coverage by eliminating
 - Deductibles
 - Copayments
 - Other cost-sharing

Medicare-Medicaid Coordination Office



Section 2602 of the Affordable Care Act

- **Purpose:** Improve quality, reduce costs and improve the beneficiary experience.
- –Ensure Medicare-Medicaid enrollees have full **access** to the services to which they are entitled.
- –Improve the **coordination** between the federal government and states.
- –Identify and test **innovative** care coordination and integration models.
- –Eliminate financial **misalignments** that lead to poor quality and cost shifting.

Medicare-Medicaid Coordination Office (cont.)



- In 2011, CMS announced new models to integrate the service delivery and financing of both Medicare and Medicaid through a Federal-State demonstration to better serve the population.

- **Goal:** Increase access to quality, seamlessly integrated programs for Medicare-Medicaid enrollees.

- **Demonstration Models:**
 - **Capitated Model:** Three-way contract among State, CMS and health plan to provide comprehensive, coordinated care in a more cost-effective way.
 - **Managed FFS Model:** Agreement between State and CMS under which states would be eligible to benefit from savings resulting from initiatives to reduce costs in both Medicaid and Medicare.
 - **2/28/14** - Colorado demonstration approved (ACC:MPP)

Medicare-Medicaid Coordination Office (cont.)



- Person-centered care planning
- Choice of plans and providers
- Continuity of care provisions
- Care coordination and assistance with care transitions
- Enrollment assistance and options counseling
- One identification card for all benefits and services
- Single statement of all rights and responsibilities
- Integrated grievances and appeals process
- Maximum travel and distance times
- Limitations on wait and appointment times

Medicare-Medicaid Enrollees



- Referred to as “dual eligibles”
 - Over 10 million nationally
- Medicaid may partially or fully cover
 - Part A and/or Part B premiums and other Medicare cost-sharing
 - All Medicaid state plan benefits, including long-term services and supports
- Medicaid benefits for Medicare cost-sharing are generally provided under the Medicare Savings Programs

Medicare Savings Programs



- Help from Medicaid paying Medicare costs
 - For people with limited income and resources
- Often higher income and resources than full Medicaid
- Programs include
 - Qualified Medicare Beneficiary (QMB)
 - Specified Low-income Medicare Beneficiary (SLMB)
 - Qualifying Individual (QI)
 - Qualified Disabled & Working Individuals (QDWI)

Dual Eligible Special Needs Plan (D-SNP)



- Effective January 1, 2014
 - DSNPs that qualify under the Benefits Flexibility Initiative
 - May offer additional supplemental benefits to better integrate care and keep beneficiaries in their homes
 - Non-skilled in-home support services
 - In-home food delivery
 - Supports for caregivers
 - Adult day care services
 - Home assessments and modifications
 - New benefits must be provided at no cost
 - Qualification process includes review of state contract for integration and quality indicators

Dual Eligible Special Needs Plan (D-SNP) (cont.)



- All D-SNPs MUST have contracts with state Medicaid agencies in the states in which they operate
 - This is an annual requirement
- State contracts had to be uploaded into the Health Plan Management System (HPMS) by July 1, 2013, to cover contract year 2014
 - If not, plan(s) will be terminated for 2014
- Affected beneficiaries
 - Will be disenrolled to Original Medicare and auto-enrolled in benchmark PDP
 - Have ongoing SEP to choose another plan

The CMS Innovation Center was created by the Affordable Care Act to develop, test, and implement new payment and delivery models

“The purpose of the [Center] is to test innovative payment and service delivery models to **reduce program expenditures...while preserving or enhancing the quality of care** furnished to individuals under such titles”

Section 3021 of
Affordable Care Act

Three scenarios for success

1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking



The Innovation Center portfolio aligns with delivery system reform focus areas

Focus Areas CMS Innovation Center Portfolio*

<p>Pay Providers</p>	<p><u>Test and expand alternative payment models</u></p> <ul style="list-style-type: none"> ▪ Accountable Care <ul style="list-style-type: none"> – Pioneer ACO Model – Medicare Shared Savings Program (housed in Center for Medicare) – Advance Payment ACO Model – Comprehensive ERSD Care Initiative – Next Generation ACO ▪ Primary Care Transformation <ul style="list-style-type: none"> – Comprehensive Primary Care Initiative (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 ▪ Bundled payment models <ul style="list-style-type: none"> – Bundled Payment for Care Improvement Models 1-4 – Oncology Care Model – Comprehensive Care for Joint Replacement ▪ Initiatives Focused on the Medicaid <ul style="list-style-type: none"> – Medicaid Incentives for Prevention of Chronic Diseases – Strong Start Initiative – Medicaid Innovation Accelerator Program ▪ Dual Eligible (Medicare-Medicaid Enrollees) <ul style="list-style-type: none"> – Financial Alignment Initiative – Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents ▪ Medicare Advantage (Part C) and Part D <ul style="list-style-type: none"> – Medicare Advantage Value-Based Insurance Design model – Part D Enhanced Medication Therapy Management
<p>Deliver Care</p>	<p><u>Support providers and states to improve the delivery of care</u></p> <ul style="list-style-type: none"> ▪ Learning and Diffusion <ul style="list-style-type: none"> – Partnership for Patients – Transforming Clinical Practice – Community-Based Care Transitions ▪ Health Care Innovation Awards ▪ Accountable Health Communities ▪ State Innovation Models Initiative <ul style="list-style-type: none"> – SIM Round 1 – SIM Round 2 – Maryland All-Payer Model ▪ Million Hearts Cardiovascular Risk Reduction Model
<p>Distribute Information</p>	<p><u>Increase information available for effective informed decision-making by consumers and providers</u></p> <ul style="list-style-type: none"> ▪ Health Care Payment Learning and Action Network ▪ Information to providers in CMMI models ▪ Shared decision-making required by many models

* Many CMMI programs test innovations across multiple focus areas

Affordable Care Act and Fraud



- ACA provides new tools
 - Shifting beyond pay & chase
 - Rigorous screening process – provider enrollment
 - Expanded authority to suspend payments and reimbursements when fraud is suspected
 - Use of technology & data
 - Predictive modeling has prevented or identified 820 million in fraudulent payments over last 3 years
 - 25 billion returned to Medicare Trust Fund over last 5 years
 - We must strike the right balance

What is “MACRA”?

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015.

What does Title I of MACRA do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over volume
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible alternative payment models (APMs)**

Medicare Provisions

- Prohibition of Inclusion of Social Security Numbers on Medicare Cards
- Income-related Premium Adjustment for Parts B and D
- Medigap (Medicare Supplement Insurance) Policy Changes

MACRA Goals



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.

Questions?

