

STRENGTHENING MEDICARE

Strengthening Medicare

- ✓ We responded to the President's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors by giving patients more choices on where to obtain care, improve access and convenience, and lower out-of-pocket expenses by expanding the number of procedures payable when furnished in either the ambulatory surgery centers or outpatient hospital departments.
 - We've added 20 new procedures that can be provided in the hospital outpatient setting
- ✓ Through strengthening negotiation and maximizing competition, we contributed to lowering the average MA premiums and increasing plan choices for beneficiaries in 2019 and 2020.
 - We've helped lower Medicare Advantage premiums by 23 percent and added 1,200 plan options since 2018.
- ✓ Starting in 2021, we will pay clinicians across all specialties for the time they spend treating the growing number of patients with greater needs and multiple medical conditions, through increasing the value of evaluation and management (E/M) codes for office/outpatient visits and providing enhanced payments for certain types of visits.

eMedicare

eMedicare

- ✓ For the first time in a decade, we launched a modernized and redesigned Medicare Plan Finder, which provides users with a mobile friendly and easy-to-read design.
- ✓ We launched our first app, "What's Covered," that delivers accurate cost and coverage information on mobile devices so users can quickly see whether Medicare covers an item or service.

my health data

MyHealthEData

- ✓ Through Blue Button 2.0 beneficiaries can securely connect their data to apps and other tools developed by innovative companies. The apps can help them organize and share their claims data, find health plans, make care appointments, and check symptoms. To date, 54 applications are in production and over 2400 developers from 1456 organizations are working on development of applications.
- ✓ The "Data At the Point of Care" API Pilot is making a patient's Medicare A, B, and/or D claims data available to the clinician directly in their workflow to support treatments decisions.
- ✓ We announced the top 25 innovators of the Artificial Intelligence Health Outcomes Challenge.

By launching this Challenge, we are providing an opportunity for innovators to demonstrate how artificial intelligence tools, such as deep learning and neural networks, can be used to predict unplanned hospital and skilled nursing facility admissions and adverse events.

Transforming **MEDICAID**

Transforming Medicaid

- ✓ We are building on past CMS efforts to ensure sound fiscal stewardship and oversight of the Medicaid program by proposing a comprehensive update to Medicaid's Fiscal Accountability Regulations. This proposal clamps down on fraud and abuse by reducing the potential for improper payments so that federal Medicaid dollars are being spent on Medicaid beneficiaries, not state projects or to supplement the state's share of Medicaid financing.
- ✓ We are ensuring the integrity of the Medicaid and the Children's Health Insurance Program (CHIP) eligibility and enrollment process by aiming to improve the accuracy and consistency of eligibility determinations across states through rulemaking.
- ✓ For the first time, released a robust repository of research-ready Transformed Medicaid Statistical Information System T-MSIS data files. Now, researchers and others can now answer questions about Medicaid and CHIP enrollment, services and payment.
- ✓ We released an updated Medicaid and CHIP Scorecard – an innovative public-facing federal dashboard that includes additional data points, measures, and enhanced functionality.
- ✓ We produced the first ever Substance Use Data Book, with information about diagnosis and treatment. These and other efforts helped to ensure that states have the flexibility to best serve their residents.

FIGHTING THE **OPIOID CRISIS**

Fighting the Opioid Crisis

- ✓ We introduced new Medicare Part D opioid safety policies to reduce prescription opioid misuse while preserving medically necessary access to these medications. The new opioid policies include improved safety alerts at the pharmacy for Part D beneficiaries who are filling their initial opioid prescription or who are receiving high doses of prescription opioids.
- ✓ Through the Integrated Care for Kids (InCK) and the Maternal Opioids Misuse (MoM) payment models, we are focusing on coordinating and increasing access to treatment for vulnerable populations: children and pregnant women.
- ✓ We are working to increase the capacity of Medicaid providers to deliver treatment and recovery services in 15 states through \$47.5 million in planning grants.
- ✓ CMS approved 27 state Medicaid 1115 demonstrations to improve access to SUD treatment, which includes opioid use disorder treatment, including new flexibility to cover inpatient and residential treatment.
- ✓ CMS is continuing to combat the opioid epidemic by expanding Medicare coverage to opioid treatment programs (OTPs) that deliver Medication-Assisted Treatment (MAT) to people suffering from Opioid Use Disorder (OUD) beginning on January 1, 2020. OTPs are programs or providers

that provide a range of services to people with opioid use disorder, including medication-assisted treatment and counseling.

RETHINKING Rural Health ▲

Rethinking Rural Health

- ✓ CMS now pays for virtual check-ins that allows a patient to check in with their clinician by phone or other telecommunication system and send videos or images their clinician. This helps the clinician decide whether the patient needs to make a trip to be seen in-person.
- ✓ CMS made changes to the hospital wage index in inpatient and outpatient settings that address Medicare payment disparities that account for differences in local labor cost. This change ensures that people living in rural areas have access to high quality, affordable healthcare.
- ✓ CMS sought to improve access to maternal healthcare for those living in rural communities. In June 2019, CMS and partners hosted an interactive “Conversation on Maternal Healthcare in Rural Communities: Charting a Path to Improved Access, Quality, and Outcomes” which included participation of nearly 1,000 individuals. In addition, CMS released an issue brief to advance understanding of issues facing mothers in rural communities. The brief, *Improving Access to Maternal Health Care in Rural Communities*, provided background information on focused on access to care for women in rural communities before, during, and after pregnancy.
- ✓ CMS finalized a change to the generally applicable minimum required level of supervision for hospital outpatient therapeutic services furnished by all hospitals and Critical Access Hospitals (CAHs) from direct supervision to general supervision. General supervision means that the procedure is furnished under the physician’s overall direction and control, but that the physician’s presence is not required during the performance of the procedure. This should provide more flexibility to rural hospitals, particularly CAHs, in providing care for their patients.

MARKETPLACE CHOICE *and* AFFORDABILITY

Marketplace Choice & Affordability

- ✓ In coordination with the Departments of Labor and Treasury, issued a rule that allows employers to offer Health Reimbursement Arrangements (HRAs) beginning January 2020, giving millions of American workers more options for health insurance coverage.
- ✓ For the second year in a row, average benchmark premiums declined – this year by 4 percent – while the number of issuers participating in the marketplace increased by 20, giving consumers more coverage choices.
- ✓ Since 2017, CMS and the Department of the Treasury approved twelve Section 1332 waivers authorizing state reinsurance programs to lower premiums, ranging from an estimated 6% reduction in Rhode Island to a 30% reduction in Maryland.
- ✓ We developed a new enhanced direct enrollment pathway for consumers to enroll in health insurance coverage through the federally facilitated exchange.

Protecting Taxpayer Dollars

- ✓ As a result of the President's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors we are implementing program integrity changes to eliminate waste fraud, and abuse through prior authorization for five groups of procedures that can be considered cosmetic.
- ✓ The 2019 Medicare-FFS estimated improper payment rate decreased from 8.12 percent in 2018 to 7.25 percent in 2019. This is the third consecutive year the rate has been below the 10 percent threshold for compliance established in the Improper Payments Elimination and Recovery Act of 2010.
- ✓ To prevent questionable providers and suppliers from entering the Medicare program, and enhance our ability to promptly identify and act on instances of improper behavior we finalized the Program Integrity Enhancements to the Provider Enrollment Process Final Rule.
- ✓ Through two Requests for Information (RFIs) we are seeking input from various stakeholders including the clinical community and healthcare information technology industry on ways we can transform program integrity as health care modernizes, placing emphasis on reducing provider burden and using advanced technology.
- ✓ We prevented between \$5 and \$23 billion in fraud through the Medicare Card Address Validation Project.



Ensuring Safety & Quality

- ✓ The 5-Part Nursing Home Strategy is improving care delivered in 15,000 nursing homes nationwide, and streamlining expectations for the 70,000 inspections performed each year.
- ✓ We released the first Qualified Health Plan star ratings, which help consumers to make informed healthcare decisions, facilitate oversight of health plans, and provide actionable information to health plans to improve the quality of services they provide.
- ✓ We eliminated 79 measures across quality payment programs in the hospital setting, inpatient psychiatric facilities, ambulatory surgery, cancer hospitals, and hospital outpatient departments through the Meaningful Measures initiative. This resulted in projected savings of \$128 million and an anticipated reduction of 3.3 million burden hours.
- ✓ Through the Omnibus Burden Reduction Rule, we implemented changes to save providers an estimated 4.4 million hours of time previously spent on paperwork with an overall projected savings to providers of \$800 million annually.

INNOVATIVE *Payment Models*

Innovative Payment Models

- ✓ Realigned incentives to develop over a dozen new innovative payment models that allow reimbursement to be tied to value, rather than merely volume of services.
- ✓ An Executive order from the President made way for the Kidney Care Choice Model and the proposed ESRD Treatment Choices Model. These add financial incentives for providers to manage care for Medicare beneficiaries to delay the onset of dialysis and incentivize kidney transplantation.
- ✓ We revamped the Medicare Shared Savings programs under Pathways to Success to put ACOs on a quicker path to taking on real risk. By January 2020, almost 34% of ACOs will be on the path to take on risk -- well more than expected in the first year.
- ✓ We awarded the first incentive bonuses to almost 90% of Qualifying APM Participant (QP) clinicians participating in Advanced Alternative Payment Models under the Medicare Access and CHIP Reauthorization Act (MACRA) and the Quality Payment Program.

PATIENTS **OVER PAPERWORK**

Patients Over Paperwork

- ✓ As a result of the President's Executive Order that direct federal agencies to "cut the red tape" to reduce burdensome regulation CMS is eliminating overly-burdensome and unnecessary regulations and sub-regulatory guidance to allow clinicians and providers to focus on their primary mission – improving their patients' health. We yielded saving to the medical community at an estimated 6.6 billion dollars—with a reduction of 42 million burden hours through 2021 giving that time back to clinicians and providers to spend with their patients and not on needless paperwork.
- ✓ The Omnibus Burden Reduction rule removes Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other healthcare providers to reduce inefficiencies and moves the nation closer to a healthcare system that delivers value, high quality care and better outcomes for patients at the lowest possible cost.
- ✓ We simplified ways for clinicians to participate in the pay-for-performance program; Merit-Based Incentive Payment System (MIPS) called the MIPS Value Pathways (MVPs).
- ✓ We proposed to modernize and clarify the regulations that interpret the Medicare physician self-referral law, also called the "Stark Law". We are reducing unnecessary regulatory burden on physicians and other healthcare providers while reinforcing the Stark Law's goal of protecting patients from unnecessary services and being steered to less convenient, lower quality, or more expensive services because of a physician's financial self-interest. This proposed rule opens additional avenues for physicians and other healthcare providers to coordinate the care of the patients they serve – allowing providers across different healthcare settings to work together to ensure patients receive the highest quality of care.

PRICE TRANSPARENCY

Price Transparency

- ✓ For the first time, we're requiring the display of the Five-Star Quality Rating System nationwide for Marketplace health plans, to offer consumers more information to help them compare plans.
- ✓ We responded to the President's Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First by finalizing policies that make hospital prices more transparent, and proposed additional policies that would expand transparency to ALL healthcare prices, so patients are more informed about costs.

Better Care for Dual Eligibles

Better Care for Dual Eligibles

- ✓ We provided more opportunities for states to test approaches to serving dually eligible individuals that work best for their state.
- ✓ We modernized the Programs of All-Inclusive Care for the Elderly with a fully integrated model of managed care service delivery for the frail elderly, most of whom are dually-eligible beneficiaries
- ✓ We improved quality of care for dually-enrolled beneficiaries in Medicare and Medicaid who participate in Dual Eligible Special Needs Plans (D-SNPs) through the 2020 Medicare Advantage rule which requires plans to more seamlessly integrate benefits across the two programs to promote coordination, and it unifies the appeals processes across Medicare and Medicaid to make it easier for enrollees in these plans to navigate their coverage.

Fostering INNOVATION

Fostering Innovation

- ✓ We responded to the President's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors by streamlining the innovative medical products process by providing alternatives for new technology add-on payment (NTAP) pathway in which Breakthrough Devices are no longer required to demonstrate evidence of "substantial clinical improvement" to qualify for new technology add-on payments. This will provide additional Medicare payment for these technologies while real-world evidence is emerging, giving Medicare beneficiaries timely access to the latest innovations in treatment.
- ✓ We increased the NTAP to 65% for all medical products to remove disincentives for the most promising new technologies

- ✓ We are now covering the FDA-approved Chimeric Antigen Receptor T-cell, or “CAR T-cell” therapy cancer treatment that uses a patient’s own genetically modified immune cells to fight disease to treat some people with specific types of cancer.
- ✓ We also took rapid action to combat antimicrobial resistance and secure access to life-saving new antibiotic drugs for American seniors, by removing several financial disincentives and setting policies to reduce inappropriate use.



Lowering Drug Prices

- ✓ For the third year in a row, the average basic premium for Medicare Part D prescription drug plans, which cover prescription drugs that beneficiaries pick up at a pharmacy, is projected to decline. Over the past three years, average Part D basic premiums have decreased by 13.5 percent, from \$34.70 in 2017 to a projected \$30 in 2020, saving beneficiaries about \$1.9 billion in premium costs over that time.
- ✓ We finalized a new requirement that Part D plan sponsors make available at least one real-time benefit tool that provides prescribers with patient-specific information on formulary and benefit information.



Modernizing CMS

- ✓ We implemented an Agency reorganization that better aligns our work with our strategic initiatives, and removes structural barriers to fully integrate staff into “One CMS.”
- ✓ Upgraded a new set of organizational capabilities to improve upon advanced analytics, program and performance improvement management, strategic planning, and strategic procurement and vendor management.
- ✓ CMS launched Medicare Payment System modernization and implemented new pricing modules in the cloud and Application Programming Interfaces as a first step in re-engineering its claims processing systems using agile and user-centered methods.