CMS Hot Topics and Priorities for 2017 and Beyond

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2017 National Training Program

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Module 4

Current Topics

Lessons

1. Legislation Updates
2. CMS Goals and Initiatives
3. Medicare Updates
4. Medicaid/Children’s Health Insurance Program Updates
5. Marketplace Updates

Lesson 1—Legislation Updates

- 21st Century Cures Act
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

21st Century Cures Act

- Improving Medicare local coverage determinations (LCD)
  - Medicare Administrative Contractors to post details of LCDs 45 days before effective date
- Medicare Pharmaceutical and Technology Ombudsman
  - To respond to manufacturer complaints, grievances, and requests about coverage, coding, or payment
- Medicare site-of-service price transparency
  - Hospital outpatient departments and ambulatory care centers must post the estimated payment amount for a service and the beneficiary liability

21st Century Cures Act—Continued

- Delay in authority to terminate contracts for Medicare Advantage (MA) Plans failing to achieve minimum quality ratings through Plan Year 2018
- Updating the "Welcome to Medicare" package
- Preserving Medicare beneficiary choice under MA beginning in 2019
  - First 3 months each year, those who are MA eligible can change coverage
- Allowing people with End-Stage Renal Disease to choose an MA Plan beginning in 2021
  - Organ procurement will be covered by Original Medicare

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- MACRA made 3 important changes to how Medicare pays those who give care to people with Medicare
  - Called the Quality Payment Program (QPP)
    1. Ends the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers' services by tying quality to payment
    2. Makes a new framework for rewarding health care providers for giving better care, not just more care
    3. Combines our existing quality reporting programs into one new system

Lesson 2—CMS Goals and Initiatives

- Program Initiatives
- CMS Quality Strategy
  - Person and Family Engagement Strategy
- Innovation Center Models

CMS Programs Initiatives and Goals

- The **Medicare Shared Savings Program** promotes the goal of reducing growth in expenditures for Medicare
- The **Hospital Value-Based Purchasing Program** adjusts hospital payments based on performance
- The new **Merit-based Incentive Payment System** (MIPs) and the transition of clinicians to Alternative Payment Models

CMS Quality Strategy–4 Main Goals

1. **Better Care and Lower Cost**:
   Beneficiaries receive high quality, coordinated, effective, efficient care, and as a result, health care costs are reduced
2. **Prevention and Population Health**:
   All Americans are healthier and their care is less costly because of improved health status resulting from use of preventive benefits and necessary health services
3. **Expanded Healthcare Coverage:**
   All Americans have access to affordable health insurance options that protect them from financial hardship and ensure quality health care coverage
4. **Enterprise Excellence:**
   CMS' high quality, diverse workforce develops, supports and utilizes innovative strategies, tools and processes, and collaborates effectively with its partners and agents to reach its goals

Person and Family Engagement Strategy

- Serves as a guide for the implementation of principles and strategies throughout CMS programs
- Expand the awareness and practice of person and family engagement by providing the following goals:

  Goal 1: Actively encourage person and family engagement

  Goal 2: Promote tools and strategies that reflect person and/or family values and preferences and self-managing their care

  Goal 3: Create an environment where persons and their families work in partnership with their health care providers

  Goal 4: Develop meaningful measures and tools aimed at improving the experience and outcomes of care

Innovation Center Models and Initiatives

- Over 30 new payment models have been launched over the past 6 years
- Investments in Electronic Health Records and a data and analytics infrastructure are sparking a new set of innovative companies
- Portfolio of models has attracted participation from a broad array of health care providers, states, payers, and other partners
- An estimated 18 million individuals, including CMS beneficiaries and individuals with private insurance included in multi-payer model
- Medicare exceeded, earlier than predicted, the goal to tie more than 30% of fee-for-service payments through alternative payment models
  - Medicare is on pace to reach 50% by the end of 2018

Advancing Care Coordination through Episode Payment Models (Bundled Payment Models)

- **Improve cardiac care:** 3 new payment models will support clinicians in providing care to eligible patients
- **Improve orthopedic care:** A new payment model will support clinicians in providing care to patients who receive surgery after a hip fracture
- **Provides an Accountable Care Organization (ACO) opportunity for small practices:** Encourage more practices, especially small practices, to advance to performance-based risk

Improving Patient Outcomes through Cardiac and Orthopedic Care Coordination Models

- The models will be referred to as:
  - The Acute Myocardial Infarction (AMI) Model
    - In 98 Metropolitan Statistical Areas (MSAs)
  - The Coronary Artery Bypass Graft (CABG) Model
    - In 67 MSAs
  - The Surgical Hip and Femur Fracture Treatment (SHFFT) Model
    - In 67 MSAs
  - The Cardiac Rehabilitation (CR) Incentive Payment Model
    - In 67 MSAs
- Beneficiaries retain their freedom to choose services and providers
- Visit innovation.cms.gov/initiatives/epm to locate models by area

Accountable Health Communities Model Assistance and Alignment

- Tracks will implement and test separate service delivery approaches:
  - **Assistance Track:** Provides community service navigation services to assist high-risk beneficiaries with accessing services to address identified health-related social needs
  - **Alignment Track:** Encourage partner alignment to ensure that community services are available and responsive to the needs of beneficiaries
- Started May 1, 2017, with a 5-year performance period
- Visit innovation.cms.gov/initiatives/ahcm to view a list of the Assistance and Alignment Tracks bridge organizations

Lesson 3—Medicare Updates

- Program Enrollment
- Medicare Access and CHIP Reauthorization Act Medicare Provisions (MACRA)
- Durable Medical Equipment Prosthetic, Orthotic, and Supplies (DMEPOS) Competitive Bidding Round 2019
- Medicare Outpatient Observation Notice (MOON)
- Medicare Advantage (Part C)
- Medicare Prescription Drug Coverage (Part D)

Medicare Program Enrollment

2017 Average Medicare Monthly Projected Enrollment in Millions

Part A and/or Part B	**57.7**
Aged	48.7
Disabled	9.0
Original Medicare Enrollment	37.7
Medicare Advantage and Other Health Plan Enrollment, including employer waiver plans	19.9
MA Enrollment	18.3
Part D (Medicare Advantage with Rx Coverage and Prescription Drug Plans)	42.3

Medicare Access and CHIP Reauthorization Act Medicare Provisions (MACRA)—Updates

- Savings to Medicare and Medicaid Programs
- Income-related Premium Adjustment for Part B and Part D
- Continuing Automatic Extension of Providers Opt-Out Election
- Medicare Supplement Insurance (Medigap) Policy Changes

MACRA

MACRA Savings to Medicare and Medicaid Programs

- Significant provisions of MACRA include
  - Higher income thresholds starting in 2018 for determining Part B and Part D premium subsidies
  - Beginning in 2020, more people will pay higher Part B and Part D premiums due to a change in the indexing of income thresholds

MACRA

Income-related Premium Adjustment for Part B and Part D

Modified Adjusted Gross Income Threshold for Years Prior to 2018	Modified Adjusted Gross Income Threshold for Years Beginning in 2018	Applicable Percentage
More than $85,000 but not more than $107,000	More than $85,000 but not more than $107,000	35%
More than $107,000 but not more than $160,000	More than $107,000 but not more than $133,500	50%
More than $160,000 but not more than $214,000	More than $133,500 but not more than $160,000	65%
More than $214,000	More than $160,000	80%

Beginning in 2020, the income thresholds would be adjusted each year by increasing the previous year's income threshold amounts by the consumer price index for urban consumers.

MACRA

Social Security Number Removal Initiative (SSNRI)

- Prohibits Social Security numbers on Medicare cards
  - Starting in 2019
- The Medicare Beneficiary Identifiers (MBIs) will be:
  - Clearly different than the HICN and RRB number
  - 11-characters in length
  - Made up only of numbers and uppercase letters (no special characters)
- Beginning in April 2018, CMS will start sending the new Medicare cards with the MBI to all people with Medicare
  - 60 million active and 90 million deceased/archived
- Transition period will begin no earlier than April 1, 2018 and run through December 31, 2019
- A new unique MBI will be generated for Medicare beneficiaries whose identities have been compromised

MACRA

Medicare Supplement Insurance (Medigap) Policy Changes—Update

- Limitation on certain Medigap policies for people newly eligible for Medicare
  - On or after January 1, 2020
  - Medigap policies sold to people newly eligible for Medicare **will no longer provide coverage for the Part B deductible**
- Newly eligible means an individual who, before January 1, 2020, is neither 65, nor has Part A
- Plans C and F will become Plans D and G respectively for policies sold to those newly eligible
  - High deductible Plan F may be grandfathered
  - Policies bought before January 1, 2020, won’t be affected

MACRA

Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Round 2019

- Consolidate all rounds and areas included in DMEPOS Competitive Bidding Program into a single round of competition
- Contracts will be effective January 1, 2019 through December 31, 2021
- Will include 141 competitive bidding areas (CBAs) and have a total of 11 product categories
- Adds insulin pumps and supplies as a product category to be bid in the national CBA

Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act

- Medicare Outpatient Observation Notice (MOON) Update
  - Hospitals must issue the MOON to people with Medicare in Original Medicare and Medicare Advantage Plans
  - Hospitals began using the MOON by March 8, 2017
    - Available in
      - Both English and Spanish
      - PDF and Word formats

Medicare Advantage Plans and Medicare Prescription Drug Program Updates

- 2018 requirements
  - Medicare Advantage Plans (Part C)
  - Medicare Prescription Drug Plans (Part D)

Medicare Advantage (Part C) Provider and Supplier Enrollment

- Health care providers must be enrolled in Medicare to contract with a Medicare Advantage organization
  - Creates consistency with CMS's current health care provider and supplier enrollment
  - Helps to protect Medicare beneficiaries and the Medicare Trust Funds
  - Ensures that only qualified providers and suppliers treat Medicare beneficiaries

Medicare Advantage (MA) Service Category Cost-Sharing Requirements

- CMS will not permit cost sharing for the first 20 days of the Skilled Nursing Facility (SNF) benefit for CY 2018
- The per-day cost sharing for days 21 through 100 must not be greater than the Original Medicare SNF amount
- Cost sharing for the overall SNF benefit must be no higher than the actuarially equivalent cost sharing in Original Medicare
- MA Plans may not charge higher cost sharing than Medicare for chemotherapy administration, skilled nursing care, and renal dialysis

Final CY 2018 Call Letter

CY 2018 Voluntary and Mandatory Medicare Out-of-Pocket (MOOP) Limit Range Amounts by Plan Type

Plan Type	Voluntary	Mandatory
HMO	$0 - $3,400	$3,401 - $6,700
HMO POS	$0 - $3,400 In-network	$3,401 - $6,700 In-network
Local PPO	$0 - $3,400 In-network and $0 - $5,100 Combined	$3,401 - $6,700 In-network and $3,401 - $10,000 Combined
Regional PPO	$0 - $3,400 In-network and $0 - $5,100 Combined	$3,401 - $6,700 In-network and $3,401 - $10,000 Combined
PFFS (full network)	$0 - $3,400 Combined	$3,401 - $6,700 Combined
PFFS (partial network)	$0 - $3,400 Combined	$3,401 - $6,700 Combined
PFFS (non-network)	$0 – $3,400	$3,401 - $6,700

Seamless Enrollment of Individuals Upon Initial Eligibility for Medicare

- Temporarily suspended acceptance of any new seamless enrollment proposals
- CMS has published data on seamless conversion enrollments
  - Identifies the organizations that have received CMS approval to offer seamless enrollment
  - Specifies the lines of business from which these organizations are permitted to enroll members

Part D—Drug Utilization Updates

- To improve safety and reduce waste
- Allows Part D plans to designate specific drugs for which a member's initial fill could be limited to a 1-month supply
  - After the first 1-month supply, the change to extended days' supply would be continuous for the person with Medicare
- Encourages sponsors to inform people with Medicare directly of additional formulary drugs that become available mid-year

Tiering Exceptions: Policy Clarifications Preferred and Non-Preferred Drugs

- Plan should not restrict their consideration of a tiering exception request based on the tier label; and
- Should not limit their consideration to a single lower tier if there are multiple lower tiers containing alternative drugs

Specialty Tiers Drugs

- Part D sponsor may design its exception process so that very high cost or unique drugs aren't eligible for a tiering exception
- Only Part D drugs with sponsor-negotiated prices that exceed an established dollar-per-month threshold are eligible for specialty tier placement
- CMS will maintain the $670 threshold for CY 2018
- CMS continues to investigate these and other trends to shape future analyses involving the specialty tier

Preventing Opioid Overutilization

- Part D plans to implement controls to prevent opioid overutilization at point-of-sale
- Members who are in need of medication-assisted treatment (MAT) shouldn’t be subject to unnecessary hurdles
- Part D formulary and plan benefit designs that hinder access to MAT, either through overly restrictive utilization management strategies or high cost-sharing, won’t be approved

Improving Drug Utilization Review Controls

- CMS is implementing 2 enhancements to reduce opioid misuse in Medicare Part D
  1. Align with the recently updated CDC guideline for Prescribing Opioids for Chronic Pain
  2. Sponsors to continue implementing soft and/or hard safety edits for opioids
- Edits help identify and prevent opioid misuse in real-time and alert prescribers
- Point of sale edits aren't intended to substitute physician judgment or dictate a prescribing limit

Medicare Part D Overutilization Monitoring System (OMS) Update

- CMS is adding a concurrent benzodiazepine use flag to the OMS reports to Part D on opioid over utilizers who are also receiving benzodiazepines
  - Opioid and benzodiazepines cause extreme sleepiness and exacerbate respiratory depression, the primary factor in fatal opioid overdose
- Part D sponsors will consider benzodiazepine use within their opioid overutilization review process

Additional Delay in Enforcement of the Medicare Part D Prescriber Enrollment Requirement

- Until January 1, 2019
- Prescribers will have sufficient time to complete their enrollment activities
- Provide Part D sponsors and pharmacy benefit managers and Medicare Advantage Organizations offering Medicare Advantage Plans with Prescription Drug (MA-PDs) coverage additional time to finalize the system enhancements needed to comply

Part D Low Enrollment

- CMS has the authority to non-renew Part D plans that do not have a sufficient number of enrollees
- Plans that have fewer than 500 enrollees are urged to voluntarily withdraw
- Stand-alone plans with less than 1,000 enrollees are encouraged to consolidate

Improved Coverage in the Coverage Gap

Year	What You Pay for Covered Brand-Name Drugs in the Coverage Gap	What You Pay for Covered Generic Drugs in the Coverage Gap
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

Lesson 4—Medicaid/Children's Health Insurance Program (CHIP)—Updates

- Medicaid and CHIP Enrollment
- Medicare Access and CHIP Reauthorization Act CHIP provisions
- Mental Health and Substance Use Disorder Parity Rule For Medicaid and CHIP

Medicaid and Children's Health Insurance Program (CHIP) Enrollment

2017 Average Monthly Projected Population in Millions

Medicaid	
Total	72.3
Aged	5.8
Blind/Disabled	10.6
Children	28.2
Adults	15.7
Expansion Adult	12
Children's Health Insurance Program	6.7

***Doesn't add up due to rounding**

Medicare Access and CHIP Reauthorization Act CHIP Provisions—Update

- Preserves and extends CHIP funding through fiscal year 2017
  - Would likely provide enough funds to cover some amount of projected 2018 expenditures
  - CHIP is authorized through September 2019
- Extension of Express Lane Eligibility (ELE)
  - Permits states to rely on findings for things like income, household size, or other factors of eligibility, from another program designated as an Express Lane agency to facilitate enrollment in health coverage. Express Lane agencies may include
    - SNAP, School Lunch, TANF, Head Start, and WIC
- Extension of Outreach and Enrollment Program

MACRA

Lesson 5—Marketplace Updates

- New Special Enrollment Period Verification (SEPV)
- New Health Coverage Enrollment Option for Small Business
- Proxy Direct Enrollment Pathway for 2018 Individual Market Open Enrollment Period

Special Enrollment Period (SEP) Overview

- SEPs provide a way for people who lose health insurance or experience other qualifying events during the year to enroll in or change coverage outside of the annual open enrollment period
- In most cases, consumers have 60 days from the date of the qualifying event to enroll in coverage
- SEP qualifying events fall into 6 categories. To learn more about when consumers may qualify for an SEP, visit Marketplace.cms.gov/outreach-and-education/special-enrollment-periods-available-to-consumers.pdf

Special Enrollment Period Verification (SEPV)

- Beginning in Summer 2017, new applicants (those who aren't already enrolled in Marketplace coverage) who attest to certain types of SEP qualifying events will be subject to the SEPV process or pre-enrollment verification. Eligible consumers must submit documents that confirm their SEP eligibility before they can enroll and start using their Marketplace coverage.
- Phase 1: On **June 23, 2017,** pre-enrollment verification starts for 2 SEP types:
  - Loss of coverage
  - Permanent move
- Phase 2: In **August 2017**, pre-enrollment verification starts for 3 additional SEP types:
  - Marriage
  - Gaining or becoming a dependent through adoption, placement for adoption, placement in foster care, or a child support or other court order
  - Medicaid/CHIP denial
- For more information, visit https://marketplace.cms.gov/technical-assistance-resources/sep-preenrollment-verification-overview.pdf

New Health Coverage Enrollment Option for Small Business—Intention to Propose Rule Making

- Instead of enrolling online at HealthCare.gov, employers would enroll directly with an insurance company offering SHOP plans, or with the assistance of an agent or broker registered with the Federally-facilitated SHOP
- Employers would still obtain a determination of eligibility by going to HealthCare.gov
- Employers that have enrolled in SHOP coverage for plan years that began in 2017 would be able to continue using HealthCare.gov in 2018 for enrollment and premium payment, until their current plan year ends and it's time to renew
- Employers can sign up for SHOP coverage taking effect in 2017 on HealthCare.gov until November 15, 2017
- States operating State-based SHOP Marketplaces would be able to provide for online enrollment, or could opt to direct small employers to insurance companies and SHOP-registered agents and brokers to directly enroll in SHOP plans

Proxy Direct Enrollment Pathway for 2018 Individual Market Open Enrollment Period

- New streamlined and simplified direct enrollment process for consumers signing up for individual market coverage through Exchanges that use HealthCare.gov
- Consumers applying through direct enrollment partners will now be able to complete their application using one website
- Provide for easier access to healthcare comparisons and shopping experiences for coverage offered through HealthCare.gov

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