2019 Puerto Rico Health & Insurance Conference

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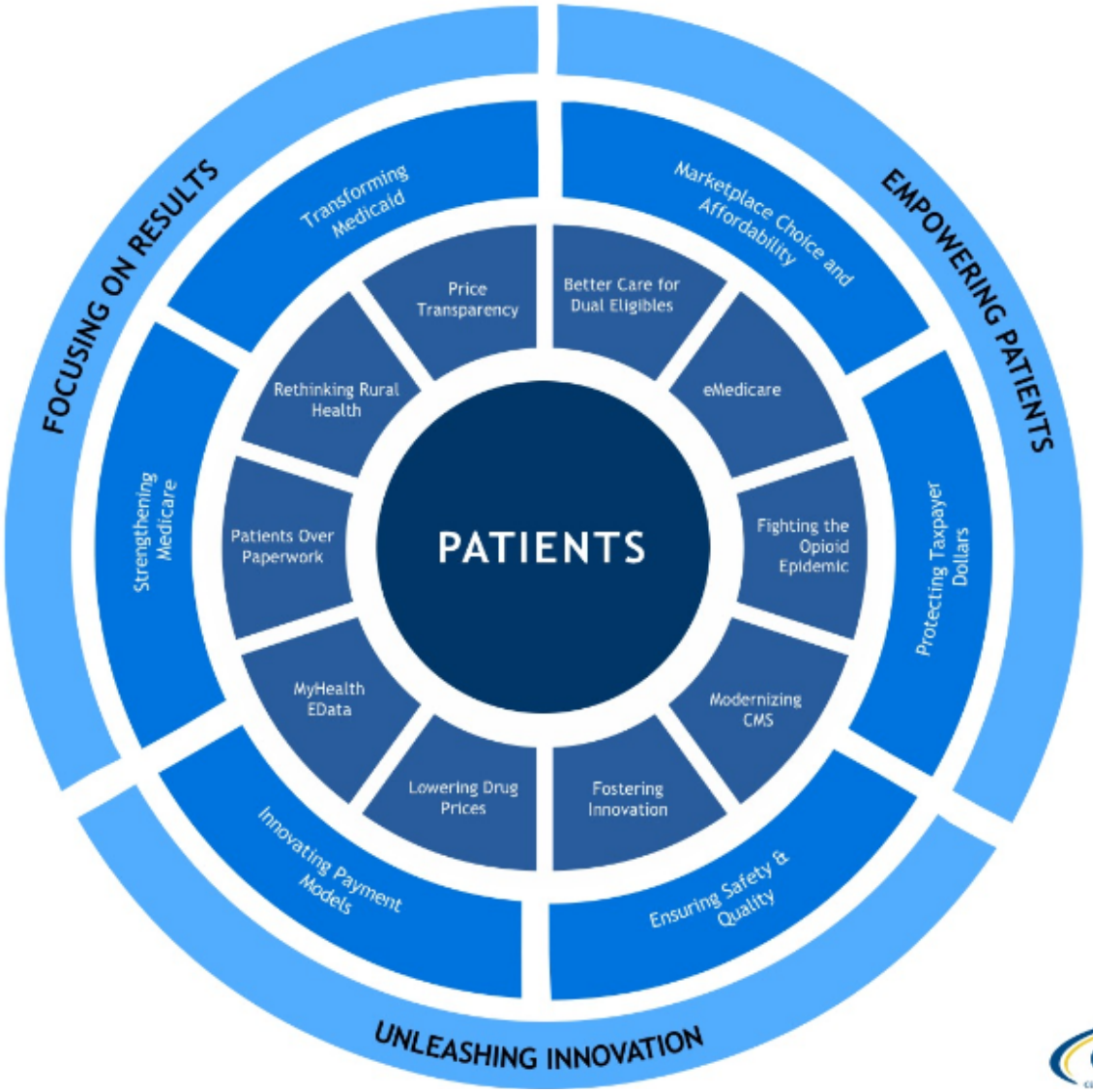
Consortium for Medicare Health Plans Operations

Puerto Rico Snapshot

- Medicare beneficiaries - 743,340 (more than 23 states)
- Medicare Advantage enrollment - 578,996
  - 78% penetration)
  - compared to national MA penetration rate of 36%
- Medicaid enrollment - 912,144
- Dual Eligibles (Medicare & Medicaid) - 317,181

16 Agency Initiatives



MyHealthEData

Initiative aimed to empower patients through:

- Ownership and access to their secure health record
- Health records will travel with them seamlessly throughout their lives

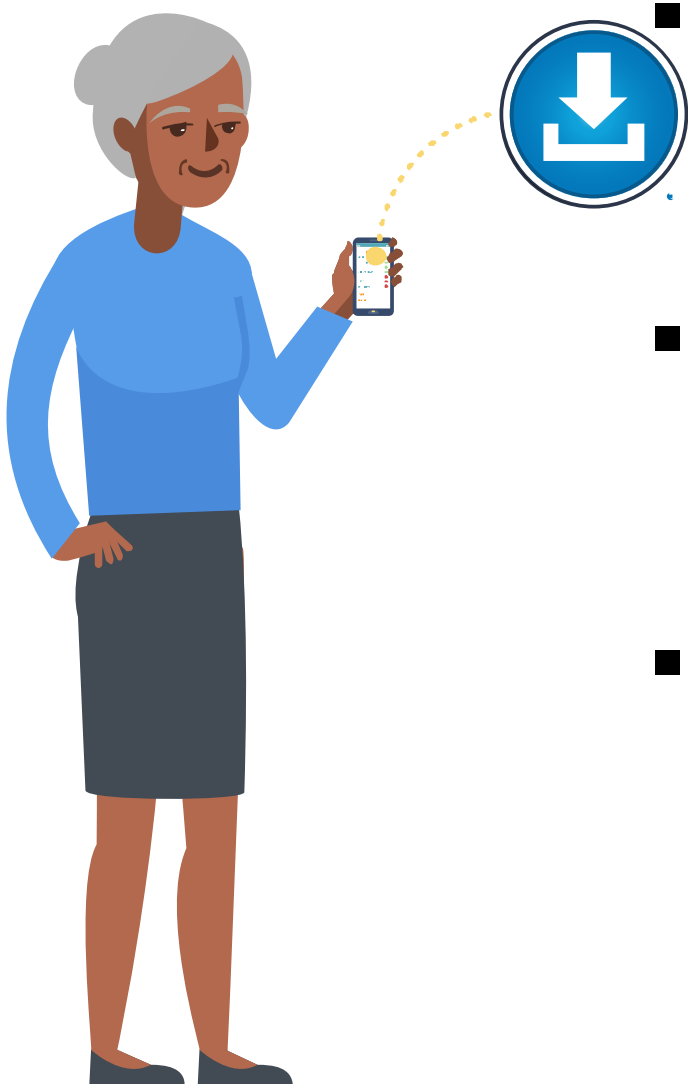
Supported by:

- Interoperability
- CMS final and proposed rules and ONC proposed rule
- Blue Button 2.0
- eMedicare
- Price Transparency

Interoperability-Proposed Rules

- CMS & ONC's complimentary proposed rules; comment periods end on 5/3/19
- If finalized, rules would
  - Require by 2020, all Medicare Advantage plans, Medicaid, CHIP, and health plans sold on a marketplace, to share claims and other health information electronically to members and allow members to take their electronic record with them if they change plans
  - Publicly list providers that are blocking information
  - Require hospitals to send electronic notification to other providers caring for a patient
  - Establish Application Programming Interfaces (APIs)
  - Ensure providers are equipped to share data in real time

Blue Button 2.0



- Over 1,500 third-party app developers are building user-friendly apps
- People with Medicare can download and access their data through MyMedicare.gov
- Choose which apps and who to share their Medicare data with
  - Available apps are listed on Medicare.gov

EMedicare

- "What's Covered" App
- Medicare.gov tools
  - Compare coverage options
  - Estimate Medicare costs
  - Plan Finder
  - Procedure Price Lookup
  - Compare Tools
- Telehealth
- MyMedicare.gov
  - Access to digital version of Medicare card
  - Download Health Record Data and find available Blue Button Apps

eMedicare

Telehealth

New telehealth services:

- Virtual check-ins
- Home health remote patient monitoring
- Clinical assessments for dialysis patients
- Innovation models, such as the Emergency Triage, Treat, and Transport (ET3) model

Patients Over Paperwork

CMS established a process to

- Reduce unnecessary burden
- Increase efficiencies
- Improve the beneficiary experience

PATIENTS OVER PAPERWORK

Patients over Paperwork – Scope

- **Nursing Homes** – Understanding the fee-for-service Medicare skilled nursing facility customer experience and identify burdens the SNF customer faces.
- **Beneficiary** – Understanding the beneficiary burden with transitions of care between all settings.
- **Clinician** – Create concepts to improve the clinician experience within the documentation burden.
- **Hospital** – Understanding the hospital burden relevant to reporting including: quality reporting, conditions of participation, certification and accrediting, billing and cost reporting, and clinician documentation and health records.
- **Hospice** – Understand the unmet needs and intertwined journeys of all stakeholders who interact with or administer the hospice benefit from the first discussion of advanced terminal illness through the provision of bereavement services.
- **Home Health** – Understand the overall experience of home health care delivery from the perspective of home health agencies and beneficiaries.
- **Dialysis Facility** – Understand the range of patient and provider experiences from early care for Chronic Kidney Disease, transition into dialysis, and continuous care including coordination between settings.

CMS Innovation Statute

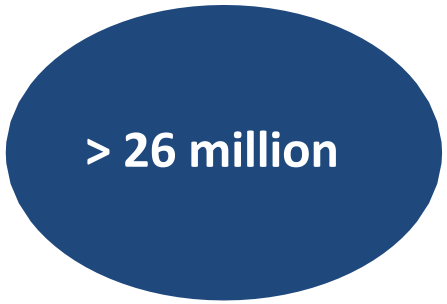
"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles"

Three scenarios for success from Statute:

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

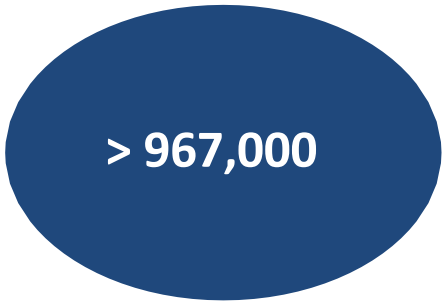
If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

CMS Innovation Center's range of impact



Beneficiaries touched

CMS Innovation Center–models impact over 26M beneficiaries[1,2] **across the U.S.**



Providers participating

Over 967,000 health care providers and provider groups[2] **across the nation** are participating in CMS Innovation Center programs

[1] Includes CMS beneficiaries (i.e., individuals with coverage through Medicare FFS, Medicaid, both Medicare and Medicaid (as Medicare-Medicaid enrollees), CHIP, and Medicare Advantage) and individuals with private insurance, including in multi-payer models

[2] Figures as of September 30, 2018

Source: Innovation Center-Report to Congress, February 2019

Value-Based Insurance Design Model

- January 1, 2017: The VBID model began testing the impact of providing eligible MAOs the flexibility to offer reduced cost sharing or additional supplemental benefits to enrollees with select chronic conditions, as determined by CMS, on health outcomes and expenditures.
- 2018: CMS updated the model test to include Alabama, Michigan, and Texas. VBID also included dementia and rheumatoid arthritis as interventions.
- 2019: CMS allowed organizations in 15 additional states to apply (CA, CO, FL, GA, HI, ME, MN, MT, NJ, NM, NC, ND, SD, VA, and WV); MAOs were allowed to:
  1. Utilize CMS-defined chronic conditions or
  2. Propose a targeting methodology

Value-Based Insurance Design Model in 2020

- Bipartisan Budget Act of 2018 (BBA) allows eligible MAOs in all 50 states and territories to apply for one or more of the health plan innovations being tested in the VBID model
- Coordinated care plans (CCPs) – including HMOs and local PPOs - may apply to VBID currently
- Regional Preferred Provider Organizations (RPPOs) may apply to VBID for 2020
- Dual Eligible Special Needs Plans (D-SNPs) and Institutional Special Needs Plans (I-SNPs) may apply to VBID for 2020

Emergency Triage, Treat and Transport (ET3) Model

EXISTING CHALLENGES

- Medicare primarily pays for emergency ground ambulance services when individuals are transported to a hospital emergency department (ED).
- Therefore, beneficiaries who call 911 with a medical emergency are often transported to a high-acuity care setting, even when a lower-acuity, less costly destination may be more appropriate.

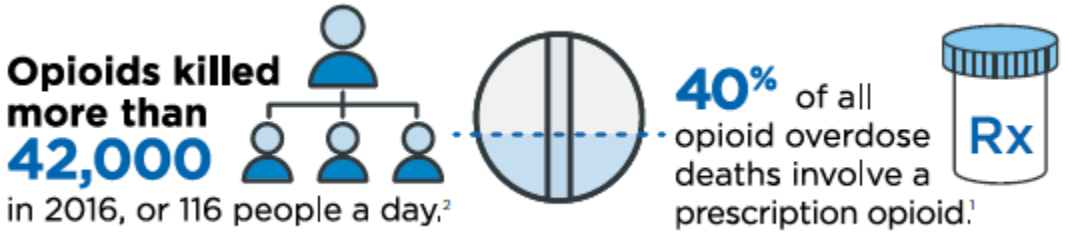
MODEL INTERVENTIONS

- Ambulance transport to alternative destinations
- Treatment in place via a qualified health care practitioner
- Medical triage line
- Performance-based payment adjustment for achievement on key quality measures

MODEL GOALS

- Provide person-centered care
- Increase efficiency in the EMS system
- Encourage appropriate utilization of services to meet health care needs effectively

CMS Roadmap to Address the Opioid Epidemic



KEY AREAS OF CMS FOCUS

As one of the largest payers of healthcare services, CMS has a key role in addressing the opioid epidemic and is focused on three key areas:

PREVENTION

Manage pain using a safe and effective range of treatment options that rely less on prescription opioids

TREATMENT

Expand access to treatment for opioid use disorder

DATA

Use data to target prevention and treatment efforts and to identify fraud and abuse

For more information on the Opioid Epidemic visit HHS.gov/opioids

New Opioid Policy CMS-4182-F

- New policies for opioid prescriptions in the Medicare Part D prescription drug program beginning January 2019
  - CMS-4182F govinfo.gov/content/pkg/FR-2018-04-16/pdf/2018-07179.pdf
- Policies encourage the patient's pharmacy, doctor, and Medicare drug plan to work together with the patient to ensure the safe use of prescription opioids

"At-Risk" Definition and Limitations

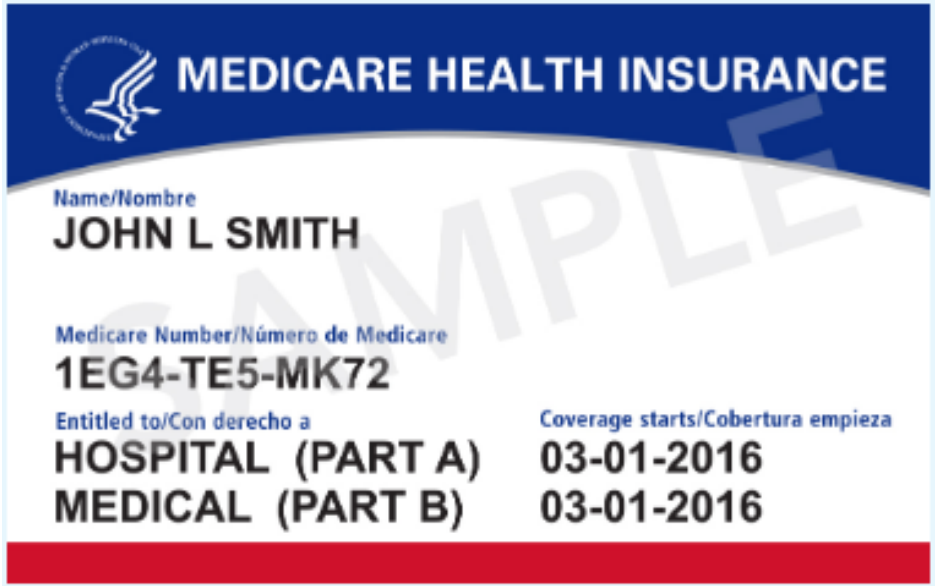
- People who use opioids from multiple prescribers and/or multiple pharmacies
- Plans allowed to limit access to frequently abused drugs (opioids and benzodiazepines)
  - To selected prescriber(s)
  - To selected pharmacy(ies) "lock-in"
  - Use of person-specific point-of-sale (POS) claim edits
- Plans *can't* allow limitations if the person
  - Is engaged in case management with prescribers
  - Can submit prescriber and pharmacy preferences

Drug Management Program (DMP) Notices

- Before a plan places a patient in its DMP, the plan will send the person a letter that
  - Explains the DMP
  - Specific limitation the plan wants to make
  - Why the patient was selected
  - Asks the patient to tell the plan which doctors or pharmacies they prefer to use to get their prescription opioids and/or benzodiazepines
- After the patient has a chance to respond, the plan will send a second letter if it decides to limit the patient's coverage for these drugs

New Medicare Card

- New Medicare Card mailing completed
- Can print copies from MyMedicare.gov
- Can use old card until January 1, 2020



For More Information

- CMS Interoperability Proposed Rule: https://www.federalregister.gov/documents/2019/03/04/2019-02200/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and
- Patients over Paperwork: https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html
- CMS Innovation Center: https://innovation.cms.gov/
- Opioid policies: https://www.cms.gov/Medicare/Prescription-Drug-coverage/PrescriptionDrugCovContra/RxUtilization.html