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CMS Awards $110Mmillion in ACA Funding to Continue Improvements in Patient Safety (Page 2)

The Affordable Care Act is Working!

For the last 50 years, Americans have struggled to navigate a health care system that has failed to put patients first. Millions who were uninsured struggled to pay for even a doctor's visit, while those who had insurance risked losing it when they needed it most. Quality care, especially preventive screenings and checkups that keep people healthy, was a luxury for many. And doctors were encouraged to focus on the *amount* of care they delivered, rather than *effectively* treating patients' big-picture health.

Today, as a nation, we are at the threshold of a truly historic opportunity. The promise of positive transformative change in the U.S. health care system is at hand, thanks to:

- The Affordable Care Act (ACA) working to improve access, affordability and quality in health care;
- Private and public sector alignment around better care, smarter spending, and healthier people;
- New initiatives to advance Precision Medicine;
- Newly unlocked health data to inform providers and empower consumers; and
- An increased interest among Americans in prevention and wellness.

The evidence is clear when it comes to access, affordability, and quality the Affordable Care Act is working.

ACCESS

Strong Enrollment in the Health Insurance Marketplace: On March 31, 2015 about **10.2 million** Americans had paid their premiums and had active coverage through the Health Insurance Marketplace.

Historic Reduction in the Uninsured: We have seen the largest reduction in the uninsured in four decades. Since the passage of the ACA, approximately **16.4 million** uninsured people have gained health coverage. Those gains come primarily from the Marketplace, young adults who can stay on their parents' plans until they turn 26, and Medicaid expansions.

Progress in Fighting Health Inequity: Since 2013, the uninsured rate has declined 9.2 percentage points for African Americans, resulting in **2.3 million** adults gaining coverage. The uninsured rate has also declined 12.3 percentage points for Latinos, resulting in **4.2 million** adults gaining coverage. Since 2013, the uninsured rate among women declined 7.7 percentage points, resulting in **7.7 million** women gaining coverage. An estimated **55 million** women are also benefiting from preventive services coverage with no out-of-pocket costs. Additionally, health insurers can no longer discriminate based on gender, so being a woman is no longer a preexisting condition

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Inside this Issue:

CMS to Address Healthcare Equity in Medicare

CMS's Office of Minority Health (CMS OMH) recently unveiled the first plan to address health equity in Medicare. The CMS Equity Plan for Improving Quality in Medicare (*CMS Equity Plan for Medicare*) is an action-oriented plan that focuses on six priority areas and aims to reduce health disparities in four years. The plan was released at a conference entitled: *Medicare & Medicaid at 50: Their Past, Present, and Future Impact on Health Equity*, which was held in commemoration of the 50th anniversary of Medicare and Medicaid and the 30th anniversary of the 1985 *Report of the Secretary's Task Force on Black and Minority Health*, also known as the *Heckler Report*.

The Equity Plan focuses on Medicare populations that experience disproportionately high burdens of disease, lower quality of care, and barriers accessing care. These include racial and ethnic minorities, sexual and gender minorities, people with disabilities, and those living in rural areas. The priorities and activities described in the plan were developed during a rigorous year-long process in collaboration with NORC at the University of Chicago, which included examining evidence, identifying opportunities, and gathering input from a broad array of stakeholders across the country. Six priority areas and several high-yield activities serve as the plan's foundation. The priorities include:

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

Priority 2: Evaluate Disparities Impacts and Integrate Equity Solutions Across CMS Programs

Two-Midnight Rule Update

On July 1, 2015, CMS released proposed updates to the "Two-Midnight" rule regarding when inpatient admissions are appropriate for payment under Medicare Part A. These changes would continue CMS' long-standing emphasis on the importance of a physician's medical judgment in meeting the needs of Medicare beneficiaries. These updates were included in the calendar year (CY) 2016 Hospital Outpatient Prospective Payment System (OPPS) proposed rule.

We have gathered input from our stakeholders including hospitals, physicians, the Medicare Payment Advisory Commission (MedPAC), beneficiary advocates, the Congress and feedback from the probe and educate process conducted by the Medicare Administrative Contractors (MACs). CMS' contractors have worked with hospitals to clarify the parameters of Medicare's payment policy in regard to inpatient and outpatient patient status. CMS has sought to balance multiple goals, including respecting the judgment of physicians, supporting high quality care, providing clear guidelines for hospitals and doctors, and incentivizing efficient care to protect the Medicare trust funds.

CMS proposed that for stays expected to last less than 2 midnights and the procedure is not on the inpatient only list, an inpatient admission would be payable under Medicare Part A on a case-by-case basis based on the judgment of admitting physician. Documentation must support medical necessity. CMS reiterates the expectation that it would be rare and unusual for a beneficiary to require inpatient hospital admission for a minor surgical procedure or other treatment in the hospital that is expected to keep the patient for only a few hours and does not span at least overnight. We plan to monitor these types of admissions and to prioritize for medical review. For hospital stays that are expected to be 2-midnights or longer, our policy remains unchanged.

CMS announced that, beginning October 1, 2015, Quality Improvement Organizations (QIOs), rather than MACs, will conduct the first line medical reviews of short stay hospital claims. QIO patient status reviews will focus on educating doctors and hospitals on inpatient admission policy.

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Hospital Engagement Networks Will Continue Patient Safety Improvement Efforts in Hospitals

CMS has awarded $110 million in ACA funding to 17 national, regional, or state hospital associations and health system organizations to continue efforts in reducing preventable hospital-acquired conditions and readmissions. Through the Partnership for Patients initiative, the second round of the Hospital Engagement Networks (HEN) will continue to work to improve patient care in the hospital setting.

Since the launch of the Partnership for Patients, the vast majority of U.S. hospitals and many other stakeholders have joined the collaborative effort and delivered results. The Department of Health and Human Services has estimated that 50,000 fewer patients died in hospitals and approximately $12 billion in health care costs were saved because of a reduction in hospital-acquired conditions from 2010 to 2013. Nationally, patient safety is improving, resulting in 1.3 million adverse events and infections avoided in hospitals. This translates to a 17 percent decline in hospital-acquired conditions over the three-year period.

The Partnership for Patients and HENs are one part of an overall framework established by the ACA to deliver better care, spend dollars more wisely, and improve care. Initiatives like the Partnership for Patients, Accountable Care Organizations, Quality Improvement Organizations, and others have helped reduce hospital readmissions in Medicare by nearly 8 percent between January 2012 and December 2013. This translates into 150,000 fewer readmissions.

Round two of the HENs will continue to work to develop learning collaboratives for hospitals and provide a wide array of initiatives and activities to improve patient safety. They will be required to: conduct intensive training programs to teach and support hospitals in making patient care safer; provide technical assistance to hospitals so that hospitals can achieve quality measurement goals; and establish, implement, and improve the system to track and monitor hospital progress in meeting the Partnership for Patients' quality improvement goals.

The activities of the HENs will be closely monitored by CMS to ensure that they are generating results and improving patient safety. The 17 organizations (listed in alphabetical order) receiving contracts in round two of the Hospital Engagement Networks are:

- American Hospital Association;
- Ascension Health;
- Carolinas HealthCare System;
- Dignity Health;
- Healthcare Association of New York State;
- Health Research Education Trust of New Jersey;
- Hospital & Healthsystem Association of Pennsylvania;
- Iowa Healthcare Collaborative;
- LifePoint Health;
- Michigan Health & Hospital Association Health Foundation;

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HENs Continue Patient Safety Improvements (Cont'd)

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- Minnesota Hospital Association;
- Ohio Children's Hospital Solutions for Patient Safety;
- Ohio Hospital Association;
- Premier, Inc.;
- Tennessee Hospital Association;
- VHA-UHC Alliance NewCo Inc.; and
- Washington State Hospital Association.

The AAC takes important steps toward a more accessible, affordable, and higher-quality health care system. Today's announcement is part of a broader effort to transform our health care system into one that works better for the American people. The Administration has a vision of a system that delivers better care, spends our dollars in a smarter way, and puts patients in the center of their care to keep them healthy.

The HEN fact sheet media release is available for viewing.

Please visit, partnershipforpatients.cms.gov for more information on the Partnership for patients

Information Disclaimer:

The information provided in this newsletter is intended only to be general summary information to the Region VIII provider community. It is not intended to take the place of either the written law or regulations.

Links to Other Resources:

Our newsletter may link to other federal agencies. You are subject to those sites' privacy policies. Reference in this newsletter to any specific commercial products, process, service, manufacturer, or company does not constitute its endorsement or recommendation by the U.S. government, HHS, or CMS. HHS or CMS are not responsible for the contents of any "off-site" resource identified.

Medicare Open Enrollment Period Begins Oct 15th

Your patients' health needs change from year to year and their health plans may change benefits and costs each year too. That's why it's important for all Medicare beneficiaries to evaluate their coverage choices each fall. Encourage your patients to compare their current plan to new options so that they can see if they can lower their costs or find a plan that better suits their needs. Open Enrollment is the one time of year when ALL Medicare beneficiaries can see what new benefits options Medicare has to offer and make changes to their coverage.

Whether your patients have Original Medicare or a Medicare Advantage plan, they'll continue to enjoy many of the same benefits and choices they have now, including:

- Certain preventive benefits – including certain cancer screenings – are available at no cost to you when provided by qualified and participating health professionals. The annual wellness visit lets you sit down with your doctor to discuss your health care needs and the best ways to stay healthy.

- Medicare will notify you about plan performance and the ability to use its online Plan Finder to compare and enroll in quality plans.

- In 2016, if people in the "donut hole" in Medicare's prescription drug benefit, they will save 55 percent on covered brand-name drugs and see increased savings on generic drugs while in the donut hole.

It's worth it for your patients to take the time to review and compare their coverage options, and they don't have to do it alone. Medicare is available to help. Your patients can:

- Visit Medicare.gov/find-a-plan to compare current coverage with all of the options that are available in their area, and enroll in a new plan if they decide to make a change.

- Call 1-800-MEDICARE (1-800-633-4227) 24-hours a day/7 days a week to find out more about their coverage options. TTY users should call 1-877-486-2048.

- Review the *Medicare & You 2016* handbook. It is mailed to people with Medicare in September and is also available online at Medicare.gov.

- Get one-on-one help from their State Health Insurance Assistance Program (SHIP). They can visit Medicare.gov/contacts or call 1-800-MEDICARE to get the phone number.

- If they have limited income and resources, they may be able to get Extra Help paying for their prescription drug coverage costs. For more information, they can visit - socialsecurity.gov/i1020 or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

ICD-10 Information

Get ICD-10 Answers in One Place: The ICD-10-CM/PCS Frequently Asked Questions web page has answers to your questions about:

- Claims processing and billing
- Coding
- General Equivalence Mappings (GEMs)
- Home Health
- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)

Visit the *ICD-10 Medicare Fee-For-Service Provider Resources* web page for a complete list of Medicare Learning Network educational materials.

ICD-10 Resources: CMS has released a concise guide to ICD-10 resources. The guide focuses on quick references and key steps you can take to get ready for the October 1 transition. Resources include:

- New Clinical Concepts Guides for specialties
- The Road to 10
- Brief animated videos
- Infographics
- A Quick Start Guide featuring 5 basic steps

Visit CMS's ICD-10 website for complete details.

The Affordable Care Act is Working (cont'd)

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Medicaid Expansion. Over 12.3 million additional individuals are enrolled in Medicaid and CHIP as of April 2015, compared to before October 2013. To date, 28 states plus DC have expanded Medicaid under the ACA. This is one of the areas where we know more can be done. We want to work with all the states that have yet to expand, to get as many people covered as possible.

Reducing Uncompensated Care in Hospitals. As a result of Marketplace coverage and Medicaid expansion, hospital uncompensated care costs were reduced by an estimated $7.4 billion in 2014, compared to what they would have been in the absence of the coverage expansion. Medicaid expansion states account for $5 billion, or 68 percent, of that reduction. If all States fully expanded Medicaid, uncompensated care costs would be about $8.9 billion lower in 2016 than they would be if no additional states expanded Medicaid.

From Coverage to Care. Now that millions of Americans have health coverage, we are working to educate consumers about their coverage and to reduce barriers so that they can get the care they need to live longer and healthier lives.

AFFORDABILITY

Health Care Coverage is now Affordable for Millions of Americans. Of the about 10.2 million consumers who had paid their premium and had active Marketplace coverage on March 31, 2015, nearly 8.7 million (85 percent) nationwide and 6.4 million in the 34 states with Federally-facilitated Marketplaces received an average premium tax credit of $272 per month. And in 2015, nearly 80 percent of Marketplace shoppers using HealthCare.gov could purchase coverage for $100 or less after tax credits.

Choice, Competition and Premiums. Insurers have decided that the Marketplace is a good place to do business and as a result, consumers have more choices. Twenty-five percent more issuers joined the Marketplace for the 2015 Open Enrollment, and consumers could choose from an average of 40 health plans, up from 30 in 2014. Studies show more issuers are associated with more affordable premiums.

Health Care Cost Growth Has Slowed Sharply. Since the ACA became law, the price of health care has risen at the slowest rate in 50 years. Medicare has paid out nearly $316 billion less through 2013 than it would have had previous trends continued. The average premium for employer-based family coverage rose just 3 percent in nominal terms in 2014.

QUALITY

Improved Patient Safety. Since 2011, patient harms like hospital-acquired conditions, pressure ulcers, central line associated infections, falls and traumas have fallen by 17 percent, saving an estimated 50,000 lives and $12 billion dollars.

Fewer Avoidable Hospital Readmissions. The Medicare all-cause 30-day readmission rate fell to approximately 17.5 percent in 2013, translating to an estimated 150,000 fewer hospital readmissions among Medicare beneficiaries between January 2012 and December 2013.

Alternative Care Models are Driving Value. Accountable Care Organizations (ACOs) are groups of providers and insurers who work together to put patients in the center of their care and create better health outcomes. Today, more than one in every 14 Americans gets their health care from one of more than 700 ACOs established by Medicare and other payers. ACOs have generated a combined $417 million in savings for Medicare. In addition, the Pioneer ACO model has been certified as the first patient care model to meet the stringent criteria for expansion to a larger population of Medicare beneficiaries.

Higher Quality Coverage. After years of dropped coverage, flimsy plans and barriers to care, everyone's coverage has improved because consumers have new protections, including those who get health insurance through their employers. They can't be turned away because of pre-existing conditions; they can't be dropped just because they get sick and insurance has to cover care that Americans count on like trips to the emergency room, prescriptions and preventive services.

We are transforming the way Americans get health care and they have sent a clear message that the ACA's benefits are needed, wanted, and liked.

CMS Addresses Healthcare Equity in Medicare (cont'd)

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Priority 3: Develop and Disseminate Promising Approaches to Reduce Health Disparities

Priority 4: Increase the Ability of the Health Care Workforce to Meet the Needs of Vulnerable Populations

Priority 5: Improve Communication and Language Access for Individuals with Limited English Proficiency and Persons with Disabilities

Priority 6: Increase Physical Accessibility of Health Care Facilities

The CMS Equity Plan for Medicare will help to ensure that as we work towards better care, smarter spending, and healthier people we also continue to work to achieve health equity in Medicare," said Cara James, director of the CMS Office of Minority Health. The foundation for addressing each of the plan's priorities includes the following interconnected principles that guide CMS' efforts to achieve health equity: 1.) Increasing understanding and awareness of disparities; 2.) Developing and disseminating solutions; and 3.) Taking sustainable action and evaluating progress.

Visit CMS's Office of Minority Health website to learn more about the six priorities and achieving health equity in Medicare.

Two-Midnight Rule Update (cont'd)

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Recovery Auditor patient status reviews will be conducted by Recovery Auditors for those hospitals that consistently have high denial rates based on QIO patient status review outcomes. We accepted written comments on the OPPS proposed rule through August 31, 2015, and CMS plans to issue the OPPS final rule on or around November 1, 2015.