

CMS Region 7 Updates

02/24/2017

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ACA/Marketplace Updates

CMS Issues Proposed Rule to Increase Patients' Health Insurance Choices for 2018 - Comments are due by 03-07-2017.

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for 2018, which proposes new reforms that are critical to stabilizing the individual and small group health insurance markets to help protect patients. This proposed rule would make changes to special enrollment periods, the annual open enrollment period, guaranteed availability, network adequacy rules, essential community providers, and actuarial value requirements; and announces upcoming changes to the qualified health plan certification timeline.

"Americans participating in the individual health insurance markets deserve as many health insurance options as possible," said Dr. Patrick Conway, Acting Administrator of the Centers for Medicare & Medicaid Services. "This proposal will take steps to stabilize the Marketplace, provide more flexibility to states and insurers, and give patients access to more coverage options. They will help protect Americans enrolled in the individual and small group health insurance markets while future reforms are being debated."

The rule proposes a variety of policy and operational changes to stabilize the Marketplace, including:

- **Special Enrollment Period Pre-Enrollment Verification:** The rule proposes to expand pre-enrollment verification of eligibility to individuals who newly enroll through special enrollment periods in Marketplaces using the HealthCare.gov platform. This proposed change would help make sure that special enrollment periods are available to all who are eligible for them, but will require individuals to submit supporting documentation, a common practice in the employer health insurance market. This will help place downward pressure on premiums, curb abuses, and encourage year-round enrollment.
- **Guaranteed Availability:** The rule proposes to address potential abuses by allowing an issuer to collect premiums for prior unpaid coverage, before enrolling a patient in the next year's plan with the same issuer. This will incentivize patients to avoid coverage lapses.
- **Determining the Level of Coverage:** The rule proposes to make adjustments to the de minimis range used for determining the level of coverage by providing greater flexibility to issuers to provide patients with more coverage options.
- **Network Adequacy:** The proposed rule takes an important step in reaffirming the traditional role of states to serve their populations. In the review of qualified health plans, CMS proposes to defer to the states' reviews in states with the authority and means to assess issuer network adequacy. States are best positioned to ensure their residents have access to high quality care networks.
- **Qualified Health Plan (QHP) Certification Calendar:** In the rule, CMS announces its intention to release a revised proposed timeline for the QHP certification and rate review process for plan year 2018. The revised timeline would provide issuers with additional time to implement proposed changes that are finalized prior to the 2018 coverage year. These changes will give issuers flexibility to incorporate benefit changes and maximize the number of coverage options available to patients.

- **Open Enrollment Period:** The rule also proposes to shorten the upcoming annual open enrollment period for the individual market. For the 2018 coverage year, we propose an open enrollment period of November 1, 2017, to December 15, 2017. This proposed change will align the Marketplaces with the Employer-Sponsored Insurance Market and Medicare, and help lower prices for Americans by reducing adverse selection.

The proposed rule can be found, here:

<https://www.federalregister.gov/documents/2017/02/17/2017-03027/patient-protection-and-affordable-care-act-market-stabilization>

###

Transitional Policy Bulletin

CMS issued a bulletin that extends the transitional policy to policy years beginning on or before October 1, 2018. This bulletin extends the transition to fully ACA-compliant coverage in the individual and small group health insurance markets for one additional year.

For the complete bulletin, visit here: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Extension-Transitional-Policy-CY2018.pdf>

###

CMS Releases New Fact Sheet Regarding Incarcerated and Recently Released Consumers

The Affordable Care Act (ACA) expands access to the Marketplace, Medicaid, and Medicare coverage and services that consumers recently released from incarceration may need. CMS has provided a new [fact sheet](#) for assisters who are helping incarcerated or recently released consumers and their families explore eligibility for coverage. The guidance helps to explain the differences in the rules for Marketplace, Medicaid, and Medicare coverage of incarcerated and recently released consumers and applies to consumers in the Federally-facilitated Marketplaces (FFM), State Partnership Marketplaces (SPMs), or State-based Marketplaces using the federal platform (SBM-FPs) for eligibility and enrollment. The fact sheet also provides information on Marketplace coverage for the household members of incarcerated consumers and on aiding the transition of recently incarcerated consumers.

###

MACRA/Quality Payment Program (QPP) Updates

Attest to 2016 EHR Incentive Program Requirements by March 13 to Avoid a 2018 Payment Adjustment

The Centers for Medicare & Medicaid Services (CMS) has extended the attestation deadline for providers participating in the Medicare EHR Incentive Program to **Monday, March 13, 2017, at 11:59 p.m. PT.**

Providers participating in the Medicare EHR Incentive Program must attest to the [2016 program requirements](#) by March 13, 2017 to avoid a 2018 payment adjustment.

If you are participating in the Medicaid EHR Incentive Program, please refer to your [state's deadlines](#) for attestation information.

If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you MUST demonstrate meaningful use to avoid the Medicare payment adjustment. You may demonstrate meaningful use under either Medicare or Medicaid. If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you MUST demonstrate meaningful use to avoid the Medicare payment adjustment. You may demonstrate meaningful use under either Medicare or Medicaid.

Attestation Resources

- [Registration and Attestation System](#)
- [Eligible Professional \(EP\)](#) and [Eligible Hospital and Critical Access Hospital \(CAH\)](#) Attestation Worksheets
- [EP](#) and [Eligible Hospital and CAH](#) Attestation User Guides
- [EP](#) and [Eligible Hospital and CAH](#) Registration User Guides
- [Attestation Batch Upload Webpage](#)

For More Information

For questions about the Registration and Attestation System, contact the EHR Information Center at 1-888-734-6433 (press option 1). The EHR Information Center is open Monday through Friday from 6:30 a.m. to 5:30 p.m. ET, except Federal holidays.

###

Comprehensive Primary Care Plus (CPC+) Round 2 Payer Solicitation

The Center for Medicare and Medicaid Innovation's (Innovation Center) opened payer solicitations for the second round of the Comprehensive Primary Care Plus (CPC+) model. The CPC+ model brings together Medicare and other payers, including commercial insurance plans and state Medicaid agencies, to provide the necessary financial support for practices to make significant changes in their care delivery. CMS is soliciting proposals, from existing and new payers in the 14 current CPC+ regions and in up to 10 new regions, to partner with CMS for CPC+ Round 2 which is expected to begin in 2018. CMS will enter into a Memorandum of Understanding (MOU) with selected payer partners to document a shared commitment to align on payment, data sharing, and quality metrics throughout the five-year initiative. CMS will not provide any funding to payers for partnering in the CPC+ Model.

Payers may submit a proposal through **April 3, 2017 at 5pm ET**. CMS welcomes proposals from payers in new regions, as well as new payers in any of the existing 14 CPC+ regions.

Additional information on the fact sheet (PDF) can be found here:

<https://innovation.cms.gov/Files/fact-sheet/cpcplus-payer-factsheet.pdf>

FAQs (PDF) can be found here: <https://innovation.cms.gov/Files/x/cpcplus-payersolicitationfaq.pdf>

For questions about the model or the solicitation process,

visit <http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus> or email CPCplus@cms.hhs.gov.

###

CMS awards approximately \$100 million to help small practices succeed in the Quality Payment Program

New helpline launched to provide additional support

The Centers for Medicare & Medicaid Services (CMS) awarded approximately \$20 million to 11 organizations for the first year of a five-year program to provide on-the-ground training and education about the Quality Payment Program for clinicians in individual or small group practices of 15 clinicians or fewer. CMS intends to invest up to an additional \$80 million over the remaining four years.

These local, experienced, community-based organizations will provide hands-on training to help thousands of small practices, especially those that practice in historically under-resourced areas including rural areas, health professional shortage areas, and medically underserved areas. The training and education resources will be available immediately, nationwide, and will be provided at no cost to eligible clinicians and practices.

“Clinicians in small and rural practices are critical to serving the millions of Americans across the nation who rely on Medicare for their health care,” said Dr. Kate Goodrich, CMS Chief Medical Officer and Director of the Center for Clinical Standards and Quality. “Congress, through the bipartisan Medicare Access and CHIP Reauthorization Act, recognized the importance of small practices and rural practices and provided the funding for this assistance, so clinicians in these practices can navigate the new program, while being able to focus on what matters most -- the needs of their patients.”

The selected organizations will provide customized technical assistance to clinicians and practices to help them be successful in the Quality Payment Program. For example, clinicians will receive help choosing and reporting on quality measures, as well as guidance with all aspects of the program, including supporting change management and strategic planning and assessing and optimizing health information technology.

This funding is one part of a multi-level outreach effort to help clinicians understand and provide feedback about the new Quality Payment Program. Through [webinars](#) and in-person presentations, thousands have received free training and education from CMS staff since the Quality Payment Program Final Rule was released last October. In addition, through the established [Quality Innovation Networks](#), the [Transforming Clinical Practice Initiatives](#), and the

[Alternative Payment Model Learning Systems](#), every clinician in the Quality Payment Program can receive in-person training, including information about the Merit-based Incentive Payment System, as well as the Alternative Payment Model track.

As part of that outreach effort, CMS also launched a new telephone helpline for clinicians seeking assistance with the Quality Payment Program. Clinicians may contact the Quality Payment Program by calling 1-866-288-8292 from 8AM – 8PM EST or emailing gpp@cms.hhs.gov.

CMS awarded contracts to the following organizations to provide the on-the-ground training and education to small practices:

- Altarum
- Georgia Medical Care Foundation (GMCF)
- HealthCentric
- Health Services Advisory Group (HSAG)
- IPRO
- Network for Regional Healthcare Improvement (NRHI)
- QSource
- Qualis
- Quality Insights (West Virginia Medical Institute)
- Telligent
- TMF Health Quality Institute

For more information on the Quality Payment Program, please visit: gpp.cms.gov

###

Reconsideration Forms for the 2017 Payment Adjustment Based on the 2015 EHR Reporting Period are due February 28, 2017

The deadline for Eligible Professionals (EPs) to submit Reconsideration forms for the 2017 payment adjustment—based on the 2015 EHR reporting period—is **February 28, 2017**. No applications will be accepted after the deadline.

Please visit the CMS website to find the [EP Reconsideration Application](#). Complete this application if you received a letter from CMS that said you are subject to the 2017 Medicare EHR payment adjustment and you believe this payment adjustment is in error.

For more guidance on completing the application, review the [EP Reconsideration Instructions](#) or e-mail pareconsideration@provider-resources.com.

For More Information

For more information on Payment Adjustments and Hardship applications, or for information on reporting requirements, please visit the EHR Incentive Programs [webpage](#).

###

CMS Extends Deadline for 2016 Physician Quality Reporting System (PQRS) Electronic Health Record (EHR) Submission

CMS is extending the submission deadline for 2016 Quality Reporting Document Architecture (QRDA) data submission for the EHR reporting mechanism. Individual eligible professionals (EPs), PQRS group practices, qualified clinical data registries (QCDRs), and qualified EHR data

submission vendors (DSVs) now have until March 13, 2017 to submit 2016 EHR data via QRDA. The original submission deadline was February 28, 2017.

A complete list of 2016 data submission timeframes is below:

March 13, 2017 deadlines:

- EHR Direct or Data Submission Vendor (QRDA I or III) – 1/3/17 - 3/13/17
- Qualified Clinical Data Registries (QRDA III) – 1/3/17 - 3/13/17

March 17, 2017 deadline:

- Web Interface – 1/16/17 - 3/17/17

March 31, 2017 deadlines:

- Qualified Registries (Registry XML) – 1/3/17 - 3/31/17
- QCDRs (QCDR XML) – 1/3/17 - 3/31/17

Submission ends at 8:00 p.m. Eastern Time (ET) on the end date listed. An Enterprise Identity Management (EIDM) account with the "Submitter Role" is required for these PQRS data submission methods. Please see the [EIDM System Toolkit](#) for additional information.

EPs who do not satisfactorily report 2016 quality measure data to meet the PQRS requirements will be subject to a downward PQRS payment adjustment on all Medicare Part B Physician Fee Schedule (PFS) services rendered in 2018. For questions, please contact the QualityNet Help Desk at 1-866-288-8912 or via email at Qnetsupport@hcqis.org from 7:00 a.m. - 7:00 p.m. Central Time. Complete information about PQRS is available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>

###

Medicare and Medicaid Updates

Medicare Outpatient Observation Notice (MOON) Instructions

Manual instructions regarding implementation of the Medicare Outpatient Observation Notice (MOON) / CMS-10611 now are available on the CMS website. The new manual instructions provide more specific detail on notice delivery and are available at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni>

CMS released the MOON, along with its form instructions, December, 2016. Hospitals and critical access hospitals (CAHs) must begin using the MOON no later than March 8, 2017. Please visit the above webpage for more information.

For questions concerning the MOON, please send an email to: MoonMailbox@cms.hhs.gov

###

Market Saturation and Utilization Data Tool

The Centers for Medicare & Medicaid Services (CMS) has developed a Market Saturation and Utilization Data Tool, formerly called the Moratoria Provider Services and Utilization Data Tool, that includes interactive maps and a dataset that shows national-, state-, and county-level provider services and utilization data for selected health service areas. Market saturation, in the present context, refers to the density of providers of a particular service within a defined geographic area relative to the number of the beneficiaries receiving that service in the area.

The fourth release of the data tool includes a quarterly update of the data to the eight health services areas from release 3, and also includes Physical and Occupational Therapy and Clinical Laboratory (Billing Independently) data. Release 4 will therefore include four, twelve-month reference periods and the following health service areas: Home Health, Ambulance (Emergency, Non-Emergency, Emergency & Non-Emergency), Independent Diagnostic Testing Facilities (Part A and Part B), Skilled Nursing Facilities, Hospice, Physical and Occupational Therapy, and Clinical Laboratory (Billing Independently).

The Market Saturation and Utilization Data Tool can be used by CMS to monitor and manage market saturation as a means to prevent fraud, waste, and abuse. The data can also be used to reveal the degree to which use of a service is related to the number of providers servicing a geographic region. Provider services and utilization data by geographic regions are easily compared using an interactive map. There are a number of research uses for these data, but one objective of making these data public is to assist health care providers in making informed decisions about their service locations and the beneficiary population they serve. The tool is available through the CMS website at: <https://data.cms.gov/market-saturation>. Future releases may include comparable information on additional health service areas.

Methodology

The analysis is based on paid Medicare claims data from the CMS Integrated Data Repository (IDR). The IDR contains Medicare and Medicaid claims, beneficiary data, provider data, and plan data. Claims data are analyzed for a 12-month reference period, and results are updated quarterly to reflect a more recent 12-month reference period.

The Market Saturation and Utilization methodology is different from other public use data with respect to determining the geographic location of a provider. In this analysis, claims are used to define the geographic area(s) served by a provider rather than the provider's practice address. Further, a provider is defined as "serving a county" if, during the 12-month reference period, the provider had paid claims for more than ten beneficiaries located in a county. A provider is defined as "serving a state" if that provider serves any county in the state.

The Market Saturation and Utilization methodology is also different from other public use data with respect to determining the number of Medicare beneficiaries who are enrolled in a fee-for-service (FFS) program. In this analysis, a FFS beneficiary is defined as being enrolled in Part A and/or Part B with a coverage type code equal to "9" (FFS coverage) for at least one month of the 12-month reference period. There must not be a death date for that month or a missing zip code for the beneficiary so that the beneficiary can be assigned to a county. Other public use data may define a FFS beneficiary using different criteria, such as requiring the beneficiary to be enrolled in the FFS program every month during the reference period.

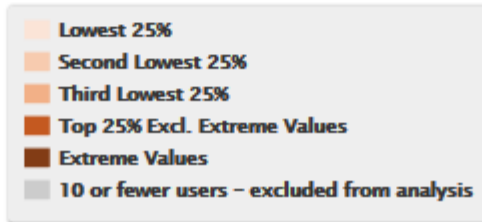
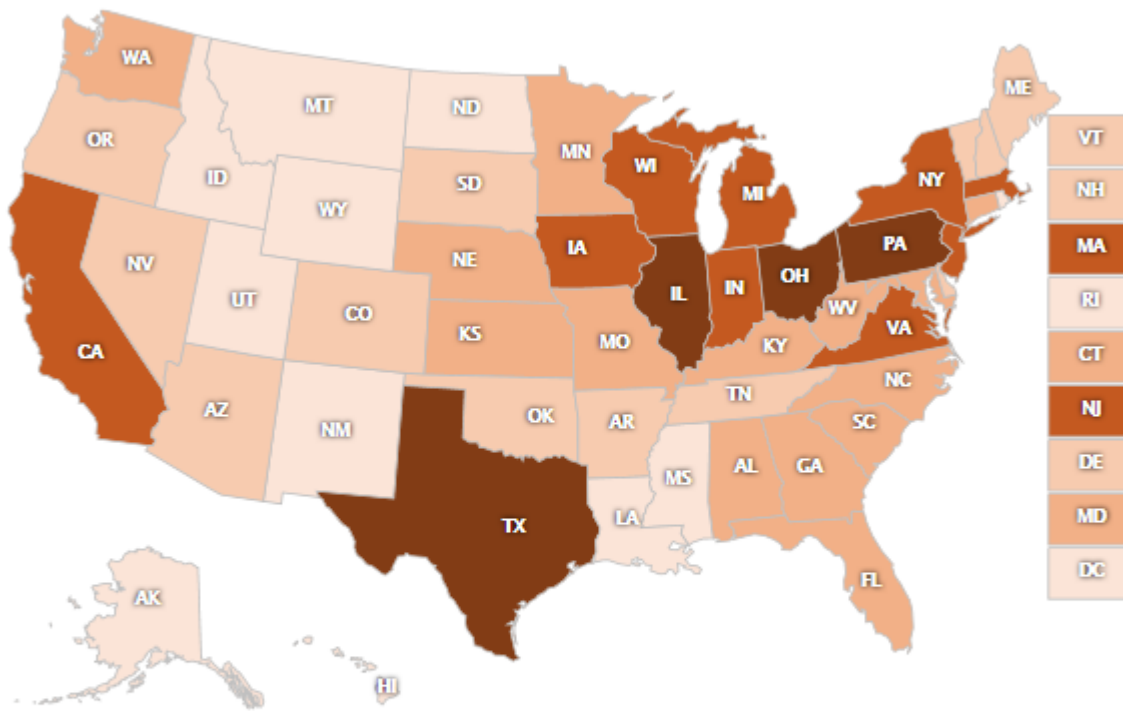
The Market Saturation and Utilization Data Tool includes an interactive map that is color-coded based on an analysis that separates the distribution into the following categories of states/counties for the selected metric: lowest 25 percent, second lowest 25 percent, third lowest 25 percent, top 25 percent excluding extreme values, and extreme values. An extreme value is one that greatly differs from other values in its field (e.g., Number of Providers). For those interested in states and counties affected by CMS' temporary provider enrollment moratoria during the reference periods for which data are available, the interactive map permits a visualization that identifies those states and counties. In this visualization, ambulance and home health service areas for moratoria versus non-moratoria states/counties are also identified based on color scheme. Counties that are excluded from the analysis are colored gray in the interactive map.

The examples below utilize the Ambulance (Emergency & Non-Emergency) service area data (selected for illustration purposes only). Similar maps can be created through the Data Tool for all of the health service areas included in the fourth release and for the four, twelve-month reference periods: 2014-10-01 to 2015-09-30, 2015-01-01 to 2015-12-31, 2015-04-01 to 2016-03-31, and 2015-07-01 to 2016-06-30.

Map 1 displays the distribution of providers by state for the Ambulance (Emergency & Non-Emergency) service area for the October 1, 2014 through September 30, 2015 reference period. This map utilizes a single color scale, which does not distinguish between moratoria and non-moratoria states.

Map 1. Ambulance (Emergency & Non-Emergency):
National Distribution of Number of Providers
October 1, 2014 – September 30, 2015
Single Color Scale

Market Saturation and Utilization Map:
 Ambulance (Emergency & Non-Emergency) – Number of Providers

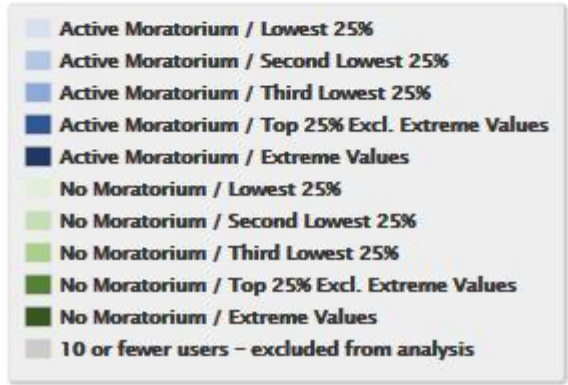
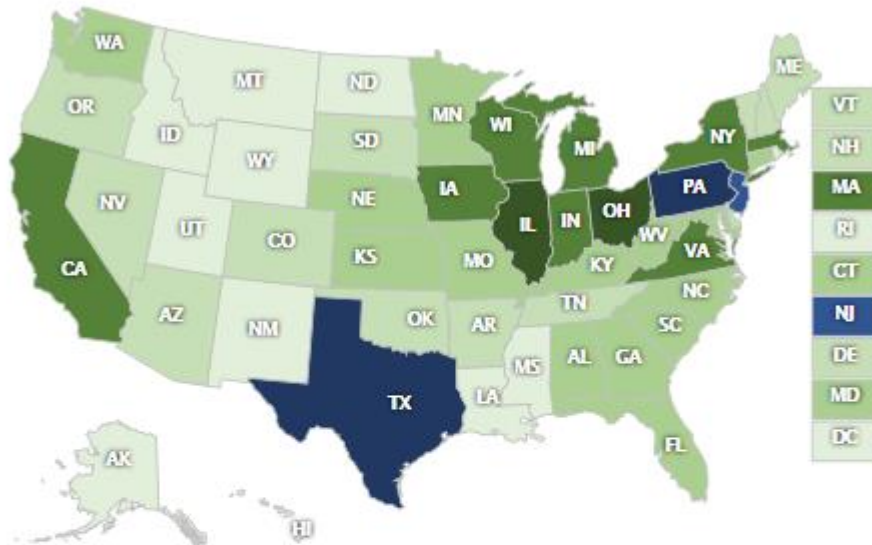


Map 2 displays the distribution of providers by state for the October 1, 2014 through September 30, 2015 reference period. This map utilizes a dual color scale, which distinguishes between moratoria and non-moratoria states.

Map 2. Ambulance (Emergency & Non-Emergency):
 National Distribution of Number of Providers
 October 1, 2014 – September 30, 2015
 Color by Moratoria Status

Market Saturation and Utilization Map:

Ambulance (Emergency & Non-Emergency) – Number of Providers

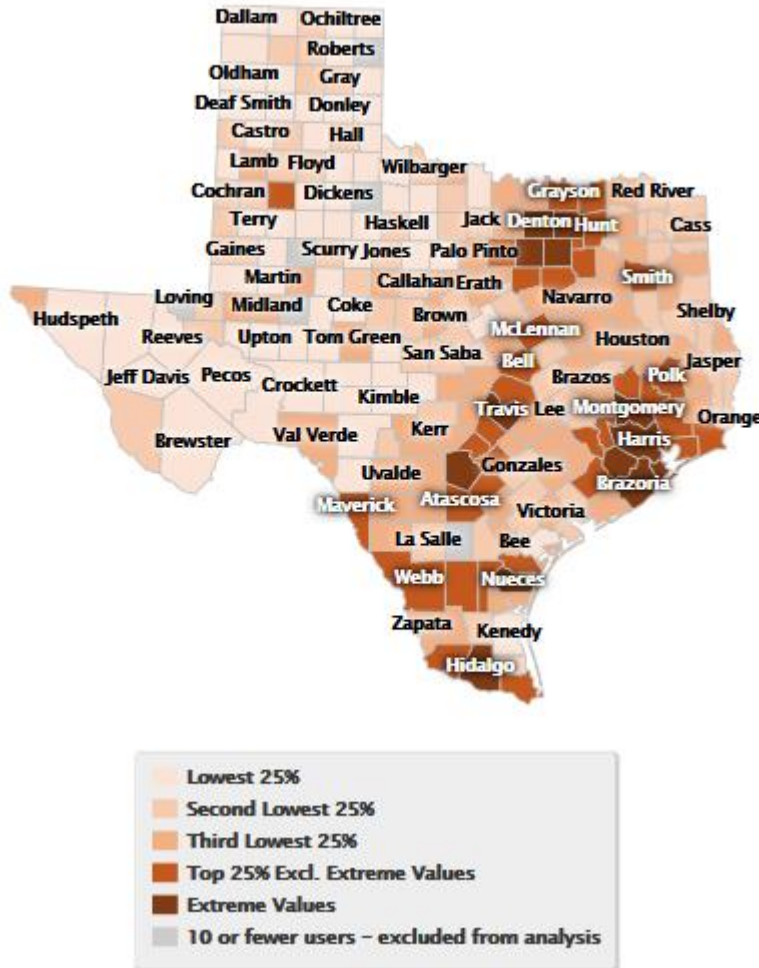


Map 3 drills down to the county level and displays the distribution of providers by county within the State of Texas for the October 1, 2014 through September 30, 2015 reference period. This map utilizes a single color scale, which does not distinguish between moratoria and non-moratoria counties.

Map 3. Ambulance (Emergency & Non-Emergency):
 County Distribution of Number of Providers
 October 1, 2014 – September 30, 2015
 Single Color Scale

Market Saturation and Utilization Map:

Ambulance (Emergency & Non-Emergency) – Number of Providers



Map 4 drills down to the county level and displays the distribution of providers by county within the State of Texas for the October 1, 2014 through September 30, 2015 reference period. This map utilizes a dual color scale, which distinguishes between moratoria and non-moratoria counties.

Map 4. Ambulance (Emergency & Non-Emergency):

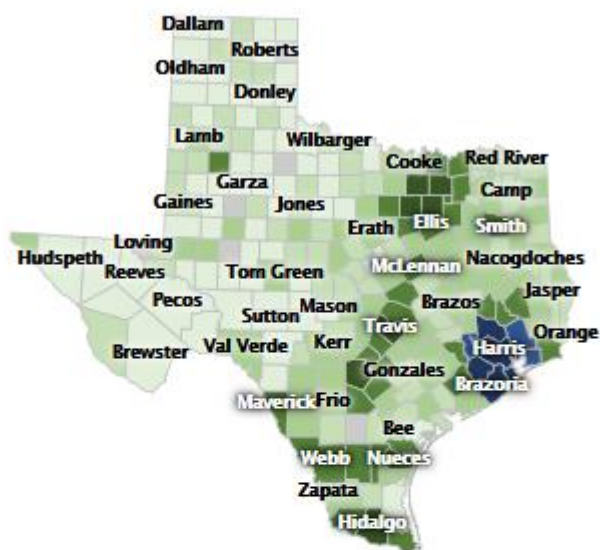
County Distribution of Number of Providers

October 1, 2014 – September 30, 2015

Color by Moratoria Status

Market Saturation and Utilization Map:

Ambulance (Emergency & Non-Emergency) – Number of Providers



Similar maps can be created at the national- and state-level for the other metrics included in the Data Tool: Number of FFS Beneficiaries, Average Number of Users per Provider, Percentage of Users out of FFS Beneficiaries, and Average Number of Providers per County.

###

2016-2025 Projections of National Health Expenditures Data Released

National health expenditure growth is expected to average 5.6 percent annually over 2016-2025, according to a report published today as a 'Web First' by Health Affairs and authored by the Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary (OACT). These

projections are constructed using a current-law framework and do not assume potential legislative changes over the projection period.

National health spending growth is projected to outpace projected growth in Gross Domestic Product (GDP) by 1.2 percentage points. As a result, the report also projects the health share of GDP to rise from 17.8 percent in 2015 to 19.9 percent by 2025. Growth in national health expenditures over this period is largely influenced by projected faster growth in medical prices compared to recent historically low growth. This faster expected growth in prices is projected to be partially offset by slowing growth in the use and intensity of medical goods and services.

According to the report, for 2016, total health spending is projected to have reached nearly \$3.4 trillion, a 4.8-percent increase from 2015. The report also found that by 2025, federal, state and local governments are projected to finance 47 percent of national health spending, a slight increase from 46 percent in 2015.

"After an anticipated slowdown in health spending growth for 2016, we expect health spending growth to gradually increase as a result of faster projected growth in medical prices that is only partially offset by slower projected growth in the use and intensity of medical goods and services," says Sean Keehan, the study's first author. "Irrespective of any changes in law, it is expected that because of continued cost pressures associated with paying for health care, employers, insurers, and other payers will continue to pursue strategies that seek to effectively manage the use and cost of health care goods and services."

Additional findings from the report:

- **Total national health spending growth:** Growth is projected to have been 4.8 percent in 2016, slower than the 5.8 percent growth in 2015, as a result of slower Medicaid and prescription drug spending growth. In 2017, total health spending is projected to grow by 5.4 percent, led by increases in private health insurance spending. National health expenditure growth is projected to be faster and average 5.8 percent for 2018-2025 largely due to expected faster spending growth in both Medicare and Medicaid.
- **Medicare:** Medicare spending growth is projected to have been 5.0 percent in 2016 and is expected to average 7.1 percent over the full projection period 2016-2025. Faster expected growth after 2016 primarily reflects utilization of Medicare covered services increasing to approach rates closer to Medicare's longer historical experience. This results in Medicare spending per beneficiary growth of 4.1 percent over 2016-2025 (compared to 1.6 percent growth for 2010-2015).
- **Private health insurance:** Spending growth is projected to have slowed from 7.2 percent in 2015 to 5.9 percent in 2016, a trend that is related to slower growth in private health insurance enrollment. Spending growth is projected to increase to 6.5 percent in 2017, due in part to faster premium growth in Marketplace plans related to previous underpricing of premiums and the end of the temporary risk corridors.
- **Medicaid:** Projected spending growth slowed significantly in 2016 to 3.7 percent, down from 9.7 percent in 2015, largely reflecting slower growth in Medicaid enrollment. Spending growth is expected to accelerate and average 5.7 percent for 2017-2025 as projected per-enrollee spending growth rises over that timeframe. Underlying the faster per enrollee growth is the increasingly larger share of the Medicaid population who are aged and disabled and who tend to use more intensive services.
- **Medical price inflation:** Medical prices are expected to increase more rapidly after historically low growth in 2015 of 0.8 percent to nearly 3 percent by 2025. This faster

projected growth in prices is influenced by an acceleration in both economy-wide prices and medical specific prices and is projected to be partially offset by slowing growth in the use and intensity of medical goods and services.

- **Prescription drug spending:** Drug spending growth is projected to have been 5.0 percent in 2016, following growth of 9.0 percent in 2015, mainly due to slowing use of expensive drugs that treat Hepatitis C. Growth is projected to average 6.4 percent per year for 2017-2025, influenced by higher spending on expensive specialty drugs.
- **Insured Share of the Population:** The proportion of the population with health insurance is projected to increase from 90.9 percent in 2015 to 91.5 percent in 2025.

The OACT report will appear at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>

An article about the study also being published by Health Affairs here: <http://content.healthaffairs.org/lookup/doi/10.1377/hlthaff.2016.1627>

###

Quality Reporting Program (QRP)

CMS is extending the February 15th submission deadline for the Inpatient Rehabilitation Facility (IRF) and Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) **for data submitted via the Centers for Disease Control and Prevention's (CDC) National Health and Safety Network (NHSN)** during Quarter 3 2016, allowing providers to submit their data until Monday, May 15, 2017. This extension will provide facilities additional time to submit this quality reporting data and run applicable reports to ensure accurate submission.

For more information, visit:

- [IRF LTCH QRP NHSN Data Submission Deadline Extension February 2017](#) Guidance Document
- [IRF Quality Reporting Data Submission Deadlines](#) webpage
- [LTCH Quality Reporting Data Submission Deadlines](#) webpage

###

Upcoming Webinars and Events and Other Updates

Medicare Learning Network News & Announcements

- [CMS Awards Approximately \\$100 Million to Help Small Practices Succeed in the Quality Payment Program](#)
- [NHSN Data Submission Deadline for IRF and LTCH QRP: Extended to May 15](#)

Provider Compliance

- [Reporting Changes in Ownership](#)

Upcoming Events

- [SNF VBP: Understanding Your Facility's Confidential Feedback Report Call — March 15](#)
- [National Partnership to Improve Dementia Care and QAPI Call — March 21](#)
- [Comparative Billing Report on Physical Therapy Webinar — March 29](#)

Medicare Learning Network Publications & Multimedia

- [Collecting Data on Sexual Orientation and Gender Identity in Health Care Settings Web-Based Training Course — New](#)
- [Audio Recordings and Transcripts from Recent Calls — New](#)
- [Medicare Outpatient Observation Notice Instructions MLN Matters Article — Revised](#)
- [Acute Care and the IPPS Web-Based Training Course — Revised](#)

###

CMS Hospital/Quality Initiative Open Door Forum

Date: Tuesday, February 28, 2017 Start Time: 2:00 PM Eastern Time (ET)
Please dial-in at least 15 minutes before call start time.

****This Agenda is Subject to Change****

I. Opening Remarks

Chair – Tiffany Swygert (Center for Medicare)
Moderator – Jill Darling (Office of Communications)

II. Announcements & Updates

- Medicare Outpatient Observation Notice (MOON) Update
- Wage Index Time Table Update
- National Health and Safety Network submission deadline extension update – Inpatient Rehabilitation Facilities and Long Term Care Hospitals
- IRFs: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF_LTCH-QRP-NHSN-Data-Submission-Deadline-Extension-February-2017.pdf

- LTCHs: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Data-Submission-Deadlines.html>

III. Open Q&A

****DATE IS SUBJECT TO CHANGE****

Next CMS Hospital/Quality Initiative Open Door Forum: April 4, 2017

###

Strategies for Your Registered Dietitian Nutritionist to Add Value and Increase Your Organization's Engagement in the Healthcare Arena

Monday, March 6 from 3:30 p.m. to 4:30 p.m. ET. [Click here to register](#)

Join the National Resource Center on Nutrition & Aging (NRCNA) to learn more about the importance to healthcare entities and caregivers of having an RDN perform an in-home nutrition assessment.

Participants will be informed on:

- A walk-through of a home visit scenario
- Step-by-step instruction on observational, performance-based and self-reported nutrition indicators
- Guidance on the questions to add or include in your assessment process

Webinar presenters:

- Holly Kellner Greuling, RDN, National Nutritionist, ACL
- Susan Saffel-Shrier, MS, RDN, Adjunct Professor, Division of Nutrition, University of Utah

*Credits toward a Meals on Wheels Leadership Academy Certificate **are not** earned through participation in these webinars.

###

SAVE THE DATE: National Medicare Education Program (NMEP) Webinar

Wednesday, March 29, 2017 1:00 p.m. – 2:30 p.m. EDT Conference Call / Webinar
Registration and agenda coming soon!

###

New Publications On-line

How to Enroll in the SHOP Marketplace: For Employees

<https://marketplace.cms.gov/outreach-and-education/how-employees-enroll-in-shop.pdf>

How to Enroll in the SHOP Marketplace for Employers

<https://marketplace.cms.gov/outreach-and-education/how-employers-enroll-in-shop.pdf>

SHOP Employer Billing & Premium Payment Process

<https://marketplace.cms.gov/outreach-and-education/shop-billing-premium-payment.pdf>

SHOP Employer Enrollment User Guide

<https://marketplace.cms.gov/outreach-and-education/shop-employer-enrollment-user-guide-2016.pdf>

SHOP Employee Enrollment User Guide

<https://marketplace.cms.gov/outreach-and-education/shop-employee-enrollment-user-guide.pdf>

Special Enrollment Periods Available to Consumers

<https://marketplace.cms.gov/outreach-and-education/special-enrollment-periods-available-to-consumers.pdf>

Speaking with a Friend or Family Member's Doctor During an Office Visit

<https://www.medicare.gov/Pubs/pdf/11441-Speaking-with-Doctor-During-Office.pdf>

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