

CMS Region 7 Updates

03/24/2017

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ACA/Marketplace Updates

HHS Launches Webpage Highlighting Administrative Actions to Empower Patients

This week the Health and Human Services Department launched a new page on HHS.gov highlighting the regulatory and administrative actions the Department is taking to relieve the burden of the current healthcare law and support a patient-centered healthcare system.

"We're taking action to improve choices for patients, stabilize the individual and small-group insurance markets, and expand access to more affordable coverage," said Secretary Tom Price, M.D. "This page will be the place to go for updates on our ongoing efforts."

The actions are part of a broader plan to repeal and replace the Affordable Care Act.

[Click here to see the newly launched webpage explaining the Department's actions.](#)

New measures will be announced as soon as is allowable by law. In particular, future actions will:

- Lower costs and increase choices by providing relief from the burdensome regulations and fostering competition in insurance markets;
- Work to ensure a stable transition period;
- Offer states greater flexibility of their Medicaid programs to meet the needs of their most vulnerable populations; and
- Increase the opportunities for patients to get the care they need when they need it.

Offering states flexibility to increase market stability and affordable choices - Providing opportunity through Section 1332 State Innovation Waivers

The Department of Health and Human Services (HHS), in partnership with the Department of the Treasury, suggested ways to help foster healthcare innovation by giving states greater flexibility.

"States need the flexibility to develop innovative healthcare models that will improve patient access to care, increase affordability and choices offered, lower premiums, and improve market stability," said Health and Human Services Secretary Tom Price, M.D. "Today's letter highlights State Innovation Waivers as opportunities for states to modify existing laws or create something entirely new to meet the unique needs of their communities."

Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing its residents with access to high quality, affordable health insurance. The Departments are promoting these waivers to give states the opportunity to develop strategies that best suit their individual needs. Through innovative thinking, tailored to specific state circumstances, states can lower premiums for consumers, improve market stability, and increase consumer choice.

For example, Alaska has made significant improvements to its individual health insurance market by implementing a state-operated reinsurance program. Initial rate information in Alaska indicated that premiums would increase over 40 percent for the 2017 plan year. To mitigate this anticipated increase, the state created a reinsurance program prior to Open Enrollment for plan year 2017 to significantly offset the projected increase, helping to stabilize premiums. Based on this success, Alaska is now requesting a Section 1332 State Innovation Waiver, which is currently under review by the Departments, to permit it to receive funding based on the savings to the government related to lower premium tax credits and continue this program for future plan years. If a state's plan under its waiver proposal is approved, a state may be able to receive pass-through funding to help offset a portion of the costs for the high-risk pool/state-operated reinsurance and other premium stabilization programs while also lowering costs for consumers. The Departments welcome the opportunity to work with states on Section 1332 State Innovation Waivers, and in particular, invite states to pursue approval of waiver proposals that include high-risk pool/state-operated reinsurance programs.

To find further information regarding section 1332 State Innovation Waivers visit:

https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html

###

Health Insurance Marketplaces 2017 Open Enrollment Period

Final enrollment report: November 1, 2016 – January 31, 2017

This report summarizes enrollment activity in the individual Marketplaces^[1] during the 2017 Open Enrollment Period (2017 OEP) for all 50 states and the District of Columbia. Approximately 12.2 million^[2] consumers selected or were automatically re-enrolled^[3] in Marketplace plans during the 2017 OEP. An accompanying public use file includes detailed state-level data on plan selections as well as demographic characteristics of consumers. The methodology for this report and detailed metric definitions are included in the public use file.

The 2017 OEP Report and the accompanying public use file include data for the 39 states that use the HealthCare.gov eligibility and enrollment platform, as well as for the 12 State-Based Marketplaces (SBMs) that use their own eligibility and enrollment platforms.^[4] Demographic and plan information for consumers with a plan selection provided by all 50 states plus DC include:

^[1] This report includes Qualified Health Plan (QHP) plan selections made on the individual Marketplace; an accompanying public use file also includes data on dental plan selections and Basic Health Plan (BHP) enrollments. We do not include data for the Small Business Health Options Program (SHOP).

^[2] In addition to the total plan selections in this report are 764,972 individuals in New York and Minnesota signed up for coverage through a BHP. States have the option of establishing BHPs to provide health coverage for low-income residents who would might otherwise be eligible for Marketplace coverage. Without the availability of BHP, many of these consumers might instead be enrolled in a Marketplace plan.

^[3] Consumers with 2016 coverage who did not make an active selection were generally automatically re-enrolled for 2017. When consumers had 2017 Marketplace plans available to them from their 2016 issuer, they were automatically re-enrolled into the same plan as 2016 or a different plan from the same issuer; depending on the Marketplace, they could also be automatically re-enrolled into a suggested alternate plan from a different issuer.

^[4] SBM data are retrieved from the respective states' information systems and have not been validated by CMS, thus metric calculations for these states may vary. The 12 SBMs are California, Colorado, Connecticut, the District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington.

gender, age, metal level, and whether the consumer had advance payments of the premium tax credit (APTC) or cost sharing reductions (CSR).

For the 39 states that use the HealthCare.gov platform, additional data are available, including self-reported race/ethnicity, rural location, and household income as a percent of the federal poverty level (FPL). Also included are the proportion of returning consumers who switched plans and the average premiums among consumers with APTC. For HealthCare.gov states, additional data files with information on plan selections and APTC at the county and zip code levels are also provided.

- Approximately 12.2 million consumers selected or were automatically re-enrolled in a Marketplace plan in the 50 states, plus DC. Thirty-one percent of plan selections were new to the Marketplaces.
- Nationally, 83 percent, or nearly 10.1 million consumers, who selected a plan had premiums reduced by advance payments of the premium tax credit (APTC).
- In HealthCare.gov states, 74 percent of consumers in the 2017 OEP selected or were automatically reenrolled in silver plans compared to 71 percent the previous year.

Consumers Selecting Plans through the Marketplaces: 50 States, plus DC

Approximately 12.2 million consumers selected or were automatically re-enrolled in a Marketplace plan during the 2017 OEP. This includes more than 9.2 million consumers in the 39 states using the HealthCare.gov platform and 3.0 million consumers in SBMs (see Figure 1).

Figure 1: Plan Selections during the 2014 – 2017 Open Enrollment Periods^[5]

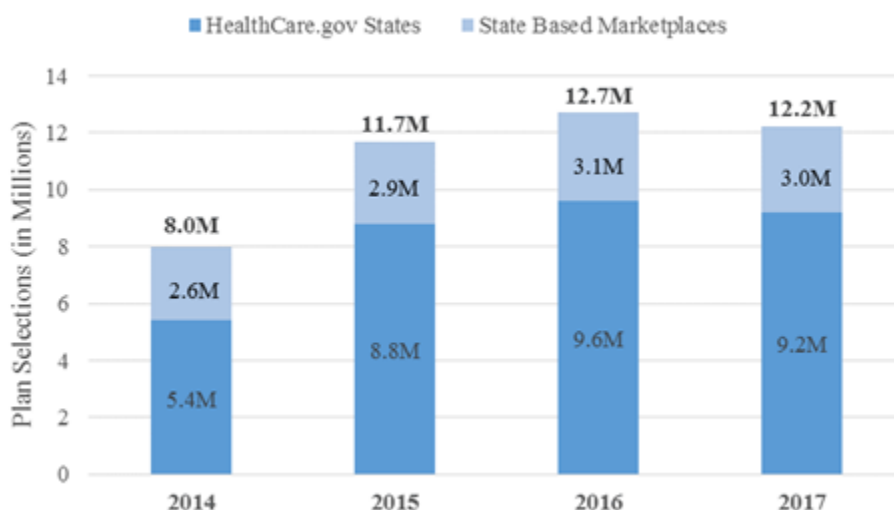


Table 1 shows the summary of enrollment by type for consumers who enrolled during the 2017 OEP. Thirty-one percent of consumers were new to the Marketplace and 43 percent of consumers actively returned to select a plan on the Marketplace.

Table 1: Summary of 2017 OEP Plan Selections by Enrollment Type

^[5] The data for the 2014 OEP was from 10/1/2013 to 4/19/2014; the 2015 OEP was from 11/15/2014 to 2/22/2015; the 2016 OEP was from 11/1/2015 to 2/1/2016 (1/31/2016 for some states); the 2017 OEP was from 11/1/2016 to 1/31/2017. Plan selections by Marketplace model for each OEP reflects the status of the state's Marketplace model at the time of that OEP. Caution should be used when comparing plan selections across OEPs since some states have transitioned platforms between years. Additionally, state expansion of Medicaid may affect enrollment figures from year to year; Louisiana expanded Medicaid in July 2016, which may have affected Marketplace enrollments in 2017.

	Number	% of Total
2017 New Consumers	3,822,114	31%
Returning Consumers Re-enrolling in 2017 Coverage	8,393,889	
Active Re-enrollees	5,271,245	43%
Automatic Re-enrollees	2,784,013	23%
Unknown Re-enrollment type	338,631	3%
Total 2017 Plan Selections	12,216,003	100%

Table 2 summarizes selected demographic and plan characteristics for consumers during the 2017 OEP; additional information is contained in the accompanying public use file. Thirty-six percent of all Marketplace consumers were younger than 35 years old and 71 percent of consumers had a silver plan. Nationally, 83 percent of consumers had their premiums reduced by APTC.

Table 2: Demographic and Plan Characteristics of Consumers with 2017 OEP Plan Selections

Age	Number^[6]	% of Total^[7]
0 to 34	4,377,618	36%
35 to 54	4,459,781	37%
55+	3,378,582	28%
Metal Level		
Catastrophic	110,821	1%
Bronze	2,802,676	23%
Silver	8,691,150	71%
Gold	494,969	4%
Platinum	118,534	1%
Financial Assistance		
With APTC	10,100,808	83%
With CSR ^[8]	7,050,298	58%

Consumers Selecting Plans through the HealthCare.gov Platform

Additional information is available for the 9.2 million consumers in states that use HealthCare.gov. Table 3 shows selected demographic and plan characteristics among consumers who selected plans during the 2017 OEP. One-third of consumers were new to HealthCare.gov and half actively re-enrolled in coverage. Seventy-one percent of consumers reported household incomes between 100% and 250% FPL.^[9]

^[6] Some SBMs were unable to verify enrollee age and metal level characteristics, therefore those figures do not sum to 12,216,003; more information is available in the public use file.

^[7] The figures reported reflect data as a percent of the total. In previous years, these figures were reported as a percent of the known (i.e. excluded “Unknown” consumers from the denominator); therefore, care should be taken when comparing these metrics to last year. Note, totals may not sum to 100% due to rounding error.

^[8] Please note, Washington does not report its count of plan selections with CSR.

^[9] In 2017, for a family of four, a household income between 100% and 250% of FPL generally corresponds to an annual household income between \$24,300 and \$60,750.

Table 3: Demographic and Plan Characteristics of Consumers with 2017 OEP Plan Selections on HealthCare.gov

Consumer Type	Number	% of Total^[10]
New consumers	3,013,107	33%
Returning consumers who actively re-enrolled	4,560,680	50%
Returning consumers automatically re-enrolled	1,628,018	18%
Gender		
Male	4,204,498	46%
Female	4,997,307	54%
Location		
Rural	1,636,711	18%
Non-rural	7,565,094	82%
Race		
Asian	600,313	7%
African-American	660,655	7%
White	4,446,285	48%
Multiracial and Other ^[11]	145,823	2%
Unknown	3,348,731	36%
Ethnicity		
Hispanic/Latino	956,516	10%
Not Hispanic/Latino	8,245,289	90%
Financial Assistance		
With APTC	7,765,735	84%
With CSR	5,513,078	60%
Household Income		
100% - 250% FPL	6,571,317	71%
251% - 400% FPL	1,539,081	17%
Other ^[12]	1,091,407	12%

A higher proportion of consumers selected silver plans during the 2017 OEP than in the 2016 OEP (see Figure 2).^[13] Seventy-four percent of consumers in 2017 selected a silver plan while 71 percent of consumers selected a silver plan in 2016. In both the 2016 OEP and 2017 OEP, 21 percent of consumers selected a bronze plan.

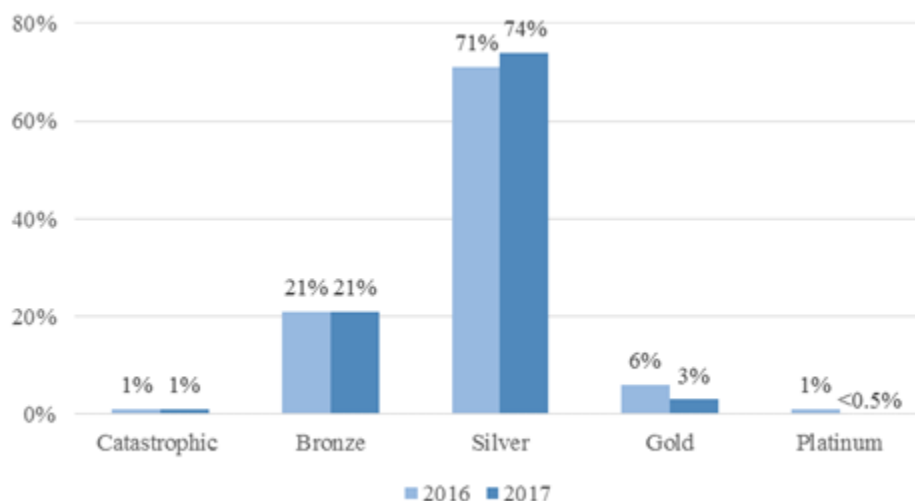
^[10] The figures reported reflect data as a percent of the total. In previous years, these figures were reported as a percent of the known (i.e. excluded “Unknown” consumers from the denominator); therefore, care should be taken when comparing these metrics to last year. Note, totals may not sum to 100% due to rounding error.

^[11] Other includes American Indian/Alaskan Native and Native Hawaiian/Pacific Islander

^[12] Other includes plan selections for which consumers did not provide an income, incomes below 100% FPL and incomes above 400% FPL. Please see the public use file for more information.

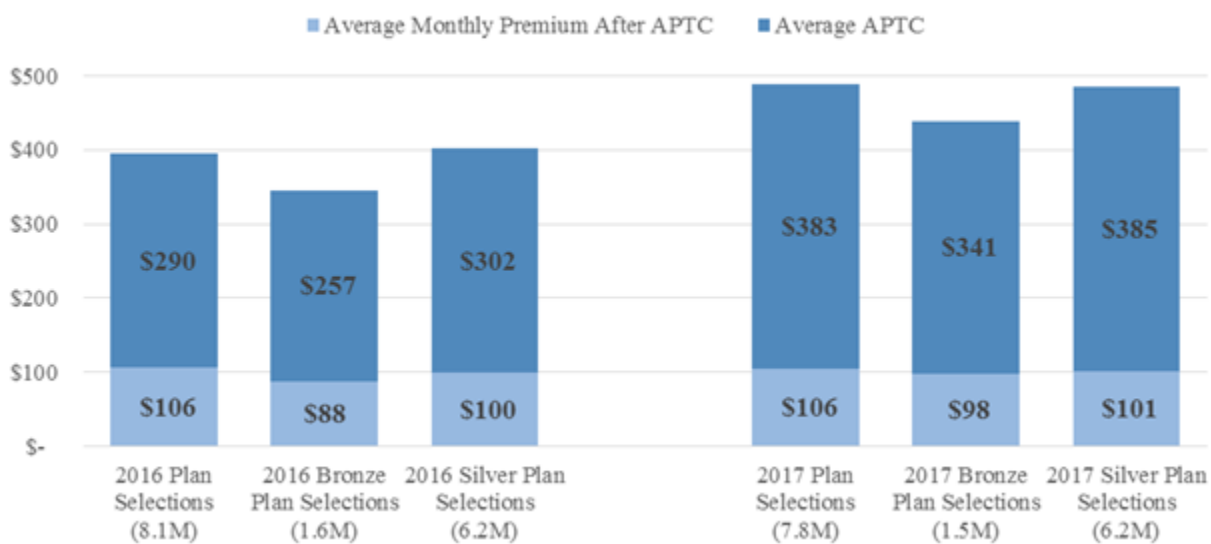
^[13] Kentucky switched from an SBM in 2016 to a HealthCare.gov state in 2017, thus not included in 2016 figures.

Figure 2: Plan Selections by Metal Level among HealthCare.gov Consumers



Advance payments of the premium tax credit are available to reduce premiums for eligible consumers. Eighty-four percent of consumers who selected or were automatically re-enrolled in a 2017 plan through HealthCare.gov had APTC, with an average value of \$383 per person per month (see Figure 3).^[14] Among consumers with APTC, the average APTC covered about 73 percent of the gross premium, resulting in an average premium after APTC of \$106 per month. For those consumers who selected bronze plans and received APTC, the average premium after APTC was \$88 in 2016 compared to \$98 in 2017. For those consumers who selected silver plans and received APTC, the average premium after APTC was \$100 in 2016 and \$101 in 2017.

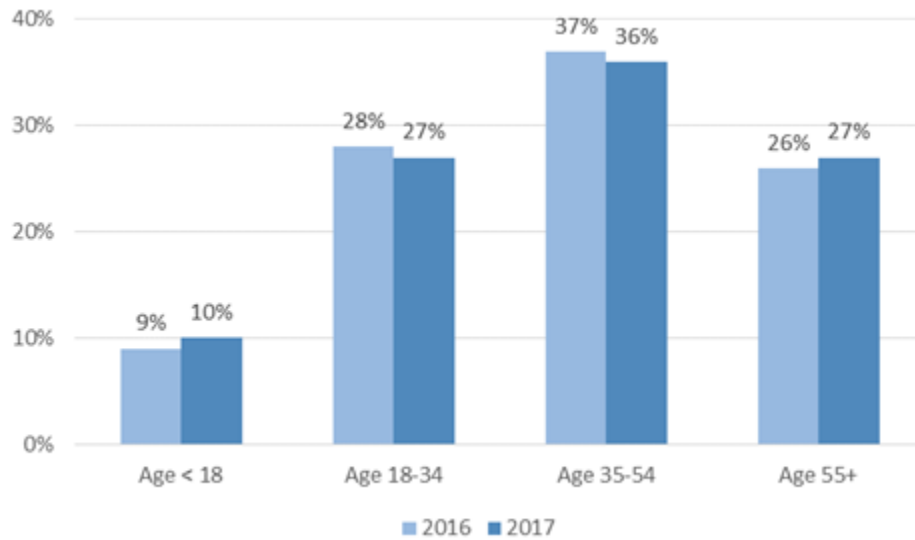
Figure 3: Average Monthly Premiums after APTC among HealthCare.gov Consumers with APTC



^[14] Kentucky switched from an SBM in 2016 to a HealthCare.gov state in 2017, thus not included in 2016 figures.

During the 2017 OEP, 10 percent of consumers were younger than 18 compared to nine percent in 2016 (see Figure 4).^[15] Twenty-seven percent of consumers were between 18 and 34 years old in 2017 compared to 28 percent in 2016. Twenty-seven percent of 2017 OEP consumers were 55 years or older, while 26 percent of 2016 OEP consumers were 55 years or older.

Figure 4: Proportion of Open Enrollment HealthCare.gov Consumers, by Age

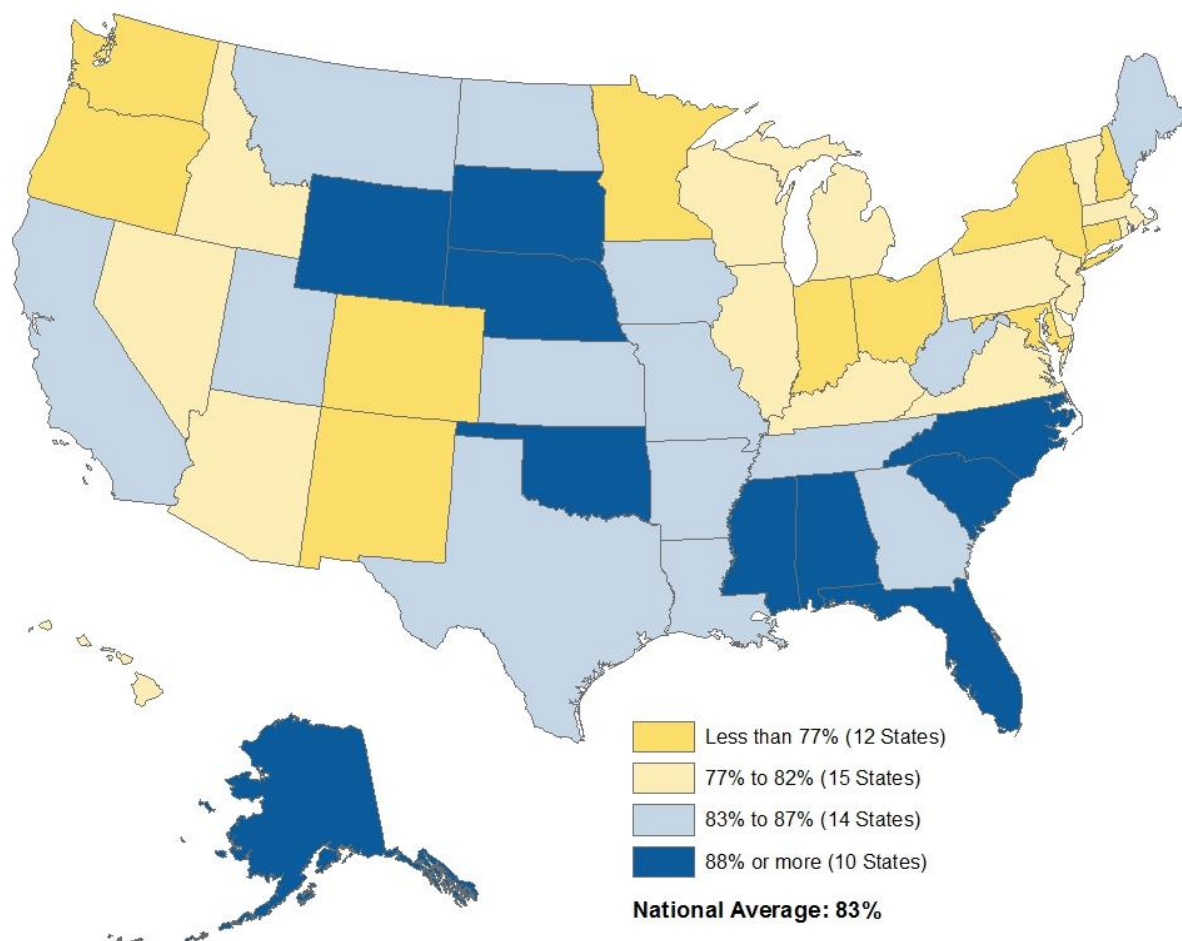


^[15] Kentucky switched from an SBM in 2016 to a HealthCare.gov state in 2017, thus not included in 2016 figures.

Geographic Variation: Selected Marketplace Metrics

Figure 5 shows the proportion of Marketplace plan selections with financial assistance in the form of advance payments of the premium tax credit, by state. Nationally, about 83 percent of consumers who enrolled in a plan during the 2017 OEP had premiums reduced by APTC. This ranges^[16] from 59 percent of consumers in New York, to 91 percent in Nebraska.

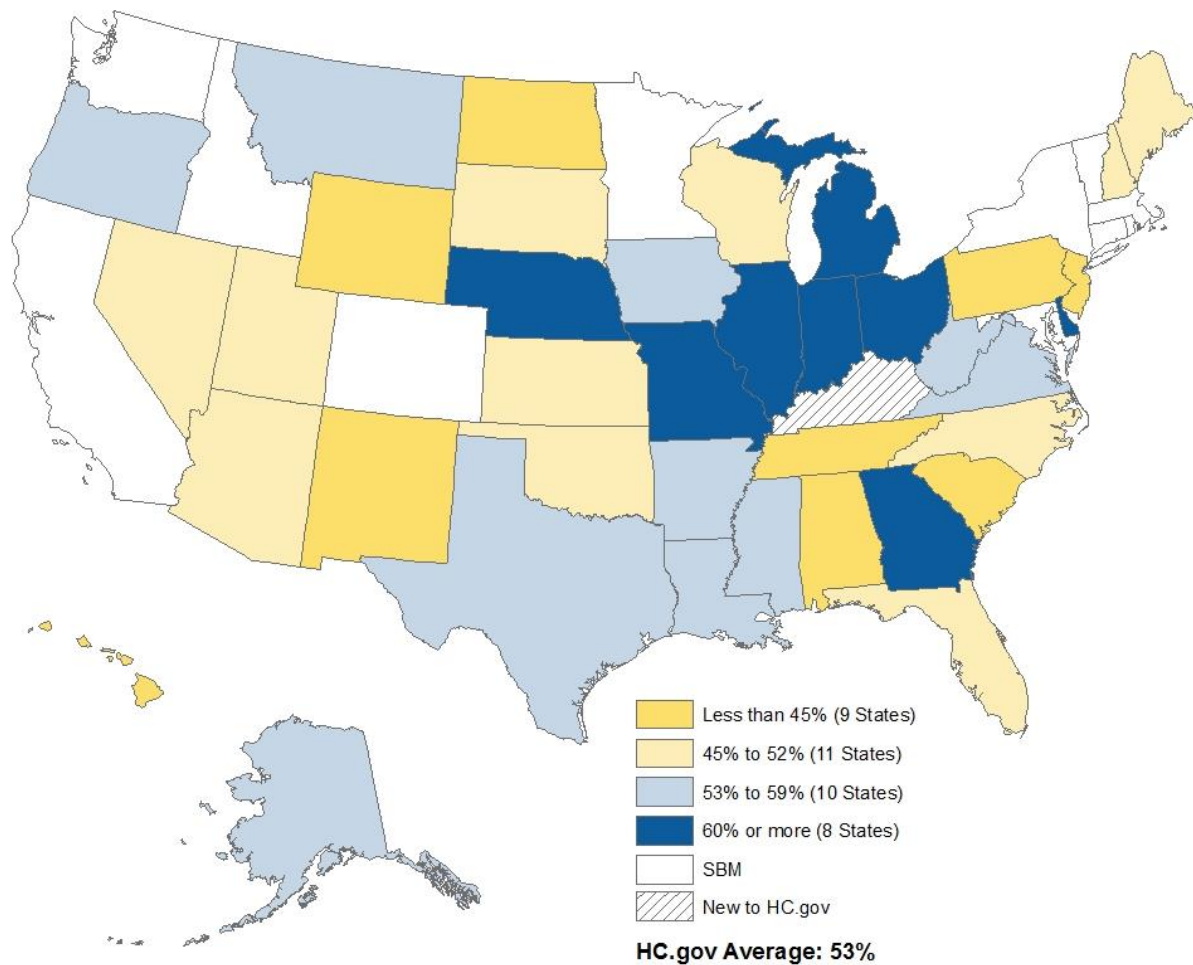
Figure 5: Percent of 2017 OEP Marketplace Plan Selections with APTC, by State



^[16] Four percent of consumers in the DC Marketplace have APTC. In DC, coverage in the individual and small group markets is only available through the DC Marketplace which effects the mix of consumers able to purchase coverage with or without APTC.

Figure 6 shows the proportion of active re-enrolling consumers who switched to a new plan, by state.^[17] In the 38 states using HealthCare.gov in both 2016 and 2017, about half of returning consumers switched plans. Alabama had the lowest proportion of active re-enrollees who switched plans at 31 percent, and Indiana had the highest proportion at 71 percent.

Figure 6: Percent of 2017 OEP HealthCare.gov Consumers who Switched plans, by State



Helpful weblinks:

Final Report: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html>

PUF files: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html

^[17] Consumers are counted as switching plans if they picked a plan different from the plan they would have been auto-enrolled into had they taken no action.

MACRA/Quality Payment Program (QPP) Updates

CMS Extends Deadline for 2016 PQRS EHR Submission

CMS extends the submission deadline for 2016 Quality Reporting Document Architecture (QRDA) data submission for the EHR reporting mechanism of the Physician Quality Reporting System (PQRS) program. Individual eligible professionals (EPs), PQRS group practices, qualified clinical data registries (QCDRs), and qualified EHR data submission vendors (DSVs) now have until Friday, March 31, 2017 to submit 2016 EHR data via QRDA. The deadline is extended to March 31, 2017 for EPs to electronically report electronic Clinical Quality Measures (eCQMs) for the Medicare EHR Incentive Program.

Please Note: The deadline for eCQM data submission for hospitals participating in the Hospital Inpatient Quality Reporting (IQR) Program and to meet the electronic reporting of Clinical Quality Measures (CQMs) portion of the EHR Incentive Program is Monday, March 13, 2017 at 11:59 p.m. Pacific Time (PT). The deadline for reporting via attestation and Meaningful Use objective and measure submission for providers participating in the Medicare EHR Incentive Program is Monday, March 13, 2017 at 11:59 p.m. Eastern Time (ET).

A complete list of 2016 data submission timeframes is below:

March 13, 2017 deadline:

- eCQM reporting for hospitals – 1/3/17 - 3/13/17
- CQM reporting via attestation – 1/3/17 - 3/13/17
- Meaningful Use objectives and measures – 1/3/17 - 3/13/17

March 17, 2017 deadline:

- Web Interface – 1/16/17 - 3/17/17

March 31, 2017 deadlines:

- EHR Direct or Data Submission Vendor (QRDA I or III) – 1/3/17 - 3/31/17
- Qualified Clinical Data Registries (QRDA III) – 1/3/17 - 3/31/17
- Qualified Registries (Registry XML) – 1/3/17 - 3/31/17
- QCDRs (QCDR XML) – 1/3/17 - 3/31/17
- eCQM reporting for EPs – 1/3/17 - 3/31/17

Submission ends at 8:00 p.m. Eastern Time (ET) on the end date listed for PQRS reporting. 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>

###

Visit the Educational Resources Page for New Materials on the Quality Payment Program

The Centers for Medicare & Medicaid Services (CMS) recently posted new resources to the Quality Payment Program [website](#) to help clinicians successfully participate in the first year of the Quality Payment Program.

CMS encourages these clinicians to visit the website to review the new materials and information, including:

[MIPS Measures for Cardiologists](#)– This brand new resource provides a non-exhaustive sample of measures for Quality, Advancing Care Information, and Improvement Activities that may apply to cardiologists participating in MIPS.

[Alternative Payment Models \(APMs\) in the Quality Payment Program](#)– Includes a comprehensive list of all APMs operated by CMS, including Advanced APMs and MIPS APMs for the Quality Payment Program.

[Support for Small Practices](#)– Contains contact information for the local, experienced organizations that will help clinicians in small and rural practices participate in the Quality Payment Program.

Review Draft Measure Packages for Electronic Clinical Quality Measures Used in CMS Quality Reporting Programs

The Centers for Medicare & Medicaid Services invites vendors and stakeholders to review and provide feedback on draft electronic clinical quality measure (eCQM) measure packages that include logic and header changes for eCQMs under consideration for CMS quality reporting and payment programs. This opportunity will allow CMS to learn from EHR vendors who have the technical capabilities to test the Health Quality Measures Format (HQM) code by directly consuming machine readable XML files for eCQMs. Testing will help CMS to identify instances in which XML code produces errors so that issues can be resolved prior to posting the fully specified measures this spring. The measures in both HTML and XML formats will be available through **March 28, 2017**.

The draft measure packages are now available on the [ONC CQM Issue Tracker](#) via the following tickets:

- Eligible hospital and critical access hospital measures ([CQM-2550](#))
- Eligible professional and eligible clinician measures ([CQM-2551](#))

The updated eCQMs will be posted in Spring 2017 and will reflect 4.3 of the Quality Data Model (QDM). Measures will not be eligible for 2018 reporting unless and until they are proposed and finalized through notice-and-comment rulemaking for each applicable program.

Please report questions and comments regarding the draft measure packages to the [ONC CQM Issue Tracker](#) tickets listed above.

###

2017 eCQM Annual Update

CMS is updating Eligible Hospital and Eligible Professional/Eligible Clinician eCQMs for potential inclusion in the following programs:

- The Hospital Inpatient Quality Reporting Program (IQR);
- The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for eligible hospitals, critical access hospitals and eligible professionals; and
- The Merit-based Incentive Payment System (MIPS).

The updated eCQMs will be posted in Spring 2017 and will reflect version 4.3 of the Quality Data Model (QDM). Measures will not be eligible for 2018 reporting unless and until they are proposed and finalized through notice-and-comment rulemaking for each applicable program.

###

Medicare Program; Advancing Care Coordination - Delay of Effective Date (CMS-5519-IFC)

Centers for Medicare & Medicaid Services (CMS) announced Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model; Delay of Effective Date (CMS-5519-IFC) an interim final rule with comment that further delays the effective date of the cardiac and orthopedic bundled payment models until May 20, 2017 and is also delaying the implementation date for these models from July 1, 2017 until October 1, 2017. CMS previously delayed the effective date of the final rule from February 18, 2017 to March 21, 2017.

This IFC also delays the applicability date of the regulations at 42 CFR part 512 from July 1, 2017 to October 1, 2017 and effective date of the specific CJR regulations itemized in the DATES section from July 1, 2017 to October 1, 2017. We seek comment on the appropriateness of this delay, as well as a further applicability date delay until January 1, 2018.

For more information, click here to view IFC in the Federal Register (PDF): https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-05692.pdf?utm_campaign=pi%20subscription%20mailing%20list&utm_source=federalregister.gov&utm_medium=email and on 03/21/2017 will be available online at <https://federalregister.gov/d/2017-05692>

###

CMS Response to MAP Recommendations for Measure Removal

At the Centers for Medicare & Medicaid Services (CMS), we are working with public and private partners to build a healthcare delivery system that delivers improved care, spends healthcare dollars more wisely, and makes communities healthier. CMS thanks the Measure Applications Partnership (MAP) for their suggestions on measure selection for various quality reporting and value-based payment programs. Since 2011, CMS has been collaborating with the MAP to

provide recommendations for the measures to be included for rulemaking for Medicare. CMS also currently works with the MAP on its voluntary reporting quality measures reporting programs for state Medicaid and CHIP programs.^[1]

The MAP reports provide strategic guidance for the various health programs and highlight cross-cutting measurement challenges and opportunities. The MAP's insights have significantly enhanced the breadth and depth of the measures that assist healthcare providers in providing high quality care to the American public. CMS sees the upcoming *Maximizing the Value of Measurement: MAP 2017 Guide*^[2] as an important continuation of this effort.

CMS shares the MAP's concern for reducing burden for reporting measures. Some of the measures that the MAP has recommended to be removed have already been finalized for removal through rulemaking. CMS will continue to closely review the report and work with the National Quality Forum (NQF) and the MAP on developing a stronger, more parsimonious portfolio of patient-centered, outcomes-oriented, and meaningful measures in our programs.

We thank all who contributed comments to the MAP reports, and we look forward to continued work with them.

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Comprehensive Primary Care Fast Facts

CMMI has posted a fact sheet outlining 2016 statistics on the Comprehensive Primary Care initiative. The fact sheet can be found here: <https://innovation.cms.gov/Files/x/cpci-fastfacts2016.pdf>

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^[1] NQF is scheduled to host the Adult and Medicaid NQF Task Force Webinar meeting in March 16, 2017 (http://www.qualityforum.org/MAP_Task_Forces.aspx).

^[2] Measure Applications Partnership (March 2017). *Maximizing the Value of Measurement: MAP 2017 Guide*. National Quality Forum (<http://www.qualityforum.org/map/>).

Medicare and Medicaid Updates

Inpatient Rehabilitation Facility (IRF) and Long-term Care Hospital (LTCH) Quality Reporting Program (QRP) Provider Preview Reports are now available.

We encourage providers to review their performance data on each quality measure based on Quarter 3 - 2015 to Quarter 2 - 2016 data, prior to the June 2017 LTCH Compare refresh, during which this data will be publicly displayed. Providers have until the end of the 30-day preview period (March 30, 2017) to review their data. Corrections to the underlying data will not be permitted during this time. However, providers can request a CMS review during the preview period if they believe their data is inaccurate.

For more information:

- [IRF Quality Public Reporting](#) webpage and [Preview Report Access Instructions](#)
- [LTCH Quality Public Reporting](#) webpage and [Preview Report Access Instructions](#)

###

Medicaid/CHIP Periodic Data Matching Notices

Today, CMS sent Periodic Data Matching Notices (PDM) notices to a small number of consumers identified as enrolled in both Marketplace coverage with financial assistance and Medicaid or CHIP coverage that counts as qualifying health coverage (also known as minimum essential coverage, or MEC). These notices will hit consumer email inboxes starting on Friday (3/24) and will hit mailboxes starting on Tuesday (3/28).

Both notices are now posted and made public at the same time as the initial warning notices are sent to consumers are available here:

- Medicaid and CHIP: initial warning notice (March 2017)
[English](#) | [Spanish](#)
- Medicaid and CHIP: final notice/ending financial help (Spring/Summer 2017)
[English](#) | [Spanish](#)

###

Connected Care: New Educational Initiative to Raise Awareness of Chronic Care Management

The Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH) and the Federal Office of Rural Health Policy at the Health Resources and Service Administration (HRSA) introduced *Connected Care*, an educational initiative to raise awareness of the benefits of chronic care management (CCM) services for Medicare beneficiaries with multiple chronic conditions and to provide health care professionals with support to implement CCM programs.

Connected Care is a nationwide effort within fee-for-service Medicare that includes a focus on racial and ethnic minorities as well as rural populations, who tend to have higher rates of chronic disease.

Two-thirds of Medicare beneficiaries have two or more chronic conditions, and one-third have four or more chronic conditions. Many health care professionals are providing these patients with chronic care management, non-face-to-face services such as reviewing test results or coordinating with other providers, but are not aware of the separate payments under the Medicare Physician Fee Schedule and are not receiving the full separate payments that are now available for CCM services under Medicare Part B.

"This important initiative builds on our efforts to help providers care for patients with multiple chronic conditions. We are excited to be working with the Health Resources and Services Administration to reach vulnerable populations," said Cara James, PhD, Director of the Centers for Medicare & Medicaid Services Office of Minority Health.

As part of the *Connected Care* education initiative, CMS and HRSA or FORHP developed new resources to help educate patients and provide information for health care professionals. Some of the resources include:

- A toolkit for **health care professionals** with detailed information about CCM, and resources to help providers implement CCM;
- A **partner toolkit** that includes downloadable resources and suggested activities to get involved in the *Connected Care* initiative; and
- **Patient education** resources, including a poster and postcard that can be used in a clinical or community setting.

All resources are available online at go.cms.gov/ccm and can be ordered at no cost.

"We are thrilled to be joining CMS to educate health care professionals and patients about the value of chronic care management with the goal of improving overall patient care for millions of Americans and reducing overall health care costs," said Tom Morris, Associate Administrator, Federal Office of Rural Health Policy at the Health Resources and Services Administration.

By offering CCM services, health care professionals can deliver the coordinated care their patients need and deserve and help patients stay on track by getting support between visits.

For more information on how to get involved with the CCM initiative and learn more about chronic care management, visit go.cms.gov/ccm.

###

Medicare-Medicaid Financial Alignment Initiative Issue Briefs

Centers for Medicare & Medicaid Services (CMS) announced three issue briefs on the evaluation of the Medicare-Medicaid Financial Alignment Initiative.

The Financial Alignment Initiative is designed to provide Medicare-Medicaid enrollees with a better care experience and to better align the financial incentives of the Medicare and Medicaid programs.

To read the Issue briefs issued today, click here:

1. Care coordination: <https://innovation.cms.gov/Files/reports/fai-carecoordination-issuebrief.pdf>
2. Beneficiary experience: <https://innovation.cms.gov/Files/reports/fai-focusgroup-issuebrief.pdf>
3. Special populations: <https://innovation.cms.gov/Files/reports/fai-specialpop-issuebrief.pdf>

To read more about Financial Alignment Initiative for Medicare-Medicaid Enrollees, click here: <https://innovation.cms.gov/initiatives/Financial-Alignment/>

CMMI [data and reports webpage](#).

###

Upcoming Webinars and Events and Other Updates

Medicare Learning Network

News & Announcements

- [Social Security Number Removal Initiative: New Details](#)
- [Clinical Laboratories: Report Lab Data through March 31](#)
- [New Release of PEPPER for Short-term Acute Care Hospitals](#)
- [Hospice Quality Reporting Program: Rerun Your Quality Measure Reports](#)
- [LTCs: Exceptions to Moratorium on Increasing Beds](#)
- [Therapeutic Continuous Glucose Monitors Classified as Durable Medical Equipment](#)
- [Influenza Activity Continues: Are Your Patients Protected?](#)
- [Revised CMS-855O Application: Enrollment Solely to Order, Certify, or Prescribe](#)
- [Comparative Billing Report on Sudomotor Function Testing in April](#)
- [IRF and LTCH QRP Preview Reports Available: Review by March 30](#)
- [Improve Health during National Nutrition Month®](#)

Provider Compliance

- [Chiropractic Services: High Improper Payment Rate within Medicare FFS Part B](#)
- [Inpatient Skilled Nursing Facility Denials](#)
- [Connected Care: New Educational Initiative to Raise Awareness of Chronic Care Management](#)
- [Quality Payment Program: New Materials](#)
- [IRF and LTCH Compare Quarterly Refresh](#)

Claims, Pricers & Codes

- [April 2017 Average Sales Price Files Available](#)

- [Chronic Care Management Payment Correction for RHCs and FQHCs](#)
- [Preventive Services CMS Provider Minute Video](#)

Upcoming Events

- [IMPACT Act: Standardized Patient Assessment Data Activities Call — March 29](#)
 - During this call, find out about efforts to develop, implement, and maintain standardized Post-Acute Care (PAC) patient assessment data, including pilot testing results and plans for the upcoming national field test.
- [Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call — April 6](#)
- [Open Payments: Prepare to Review Reported Data Call — April 13](#)
- [Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19](#)
- [Comparative Billing Report Webinar on Sudomotor-Function Testing — May 10](#)

Medicare Learning Network Publications & Multimedia

- [Medicare Enrollment Resources Educational Tool — New](#)
- [Chronic Care Management Services Call: Audio Recording and Transcript — New](#)
- [IMPACT Act Call: Audio Recording and Transcript — New](#)
- [Suite of Products & Resources Educational Tools — Revised](#)
- [Federally Qualified Health Center Fact Sheet — Revised](#)
- [PECOS for DMEPOS Suppliers Fact Sheet — Revised](#)
- [PECOS Technical Assistance Contact Information Fact Sheet — Reminder](#)
- [Advance Care Planning Fact Sheet — Reminder](#)
- [Rural Health Clinic Fact Sheet — Revised](#)
- [Provider Enrollment Revalidation: Cycle 2 MLN Matters® Article — Revised](#)
- [Medicare-Required SNF PPS Assessments Educational Tool — Revised](#)
- [Items and Services Not Covered under Medicare Booklet — Revised](#)

###

National Medicare Education Program (NMEP) Webinar

Wednesday, March 29, 2017 1:00 p.m. – 2:30 p.m. EDT Conference Call / Webinar



National Medicare Education Program (NMEP) Meeting

Wednesday, March 29, 2017 / 1:00 p.m. – 2:30 p.m. EDT
Conference Call / Webinar

The focus of the NMEP meeting is to enlist national and local organizations to support outreach and education around the Medicare program. We have expanded the focus of these meetings to reflect additional CMS programs such as Medicaid and the Children's Health Insurance Program. Many national and local organizations that work on behalf of the aged, disabled, the uninsured, children, and families are involved in this public-private partnership. Together with CMS, these partners reach out to other organizations at the state and local levels that in turn work with those eligible for CMS programs to help them understand the health care options available to them.

REGISTER NOW!

<https://www.eventbrite.com/e/national-medicare-education-program-nmep-meeting-tickets-31993856486>



###

New Publications On-line

- [Your Discharge Planning Checklist](#)
- [How income affects your Medicare prescription drug coverage premiums](#)
- [SHOP Billing and Payment System User Guide for Agents/Brokers](#)
- [Things to Think About When Choosing a Plan](#) – Spanish
- [The Small Business Health Care Tax Credit and Premium Assistance Programs](#) – Spanish
- [Report Life Changes When You Have Marketplace Coverage](#)

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If you wish to unsubscribe from future CMS Region 7 emailings, please send an email to Lorelei Schieferdecker at Lorelei.Schieferdecker@cms.hhs.gov with the word "Unsubscribe" in the subject line.