CMS Region 7 Updates

04/07/2017

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ACA/Marketplace Updates

Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment report: November 1, 2016 – January 31, 2017

On March 15, 2017, the U.S. Department of Health and Human Services (HHS) released a report summarizing enrollment activity in the individual Marketplaces for all 50 states and the District of Columbia. The report shows that during the 2017 Open Enrollment Period between November 1, 2016 and January 31, 2017, approximately 12.2 million consumers selected or were re-enrolled in a Qualified Health Plan (QHP) through the Healthcare.gov platform or a State-based Marketplace (SBM) platform.

Of this approximately 12.2 million, thirty-one percent of plan selections were new to the Marketplaces, and thirty-six percent of all Marketplace consumers were younger than 35 years old. Nationally, 83 percent, or nearly 10.1 million consumers, who selected a plan had premiums reduced by the advance payment of the premium tax credit (APTC).

An accompanying public use file includes detailed state-level data on plan selections as well as data on dental plan selections and Basic Health Plan (BHP) enrollments.

To read more, click here.

###

Role of Assisters after Open Enrollment

Assisters play a vital role in the weeks and months after open enrollment ends. Similar to years past, assisters continue many of their existing functions throughout the year, including:

- Assisting eligible consumers with enrolling in Medicaid or the Children's Health Insurance Program (CHIP),
- Helping American Indian and Alaska Natives enroll in Marketplace coverage,
- Helping consumers report life changes to the Marketplace,
- Helping consumers with questions related to using their coverage, and
- Helping consumers appeal enrollment decisions or a health plan's decision not to pay a claim.

Outside of open enrollment, instead of focusing on enrollment, assisters will spend a greater percentage of their time focused on answering consumers' questions about their health care coverage and continuing to ensure that consumers know about all of the benefits available to them.

For example, an assister can help consumers who have questions about how to pay their first premium; or if they're unsure about their benefits, can help them understand what their plan covers. This would also include helping consumers who need assistance understanding key terms in their health coverage materials, like ''deductible'' and ''coinsurance." Assisters can also help consumers understand how to make a doctor's appointment and how to prepare for the visit,

identify in-network providers, get a prescription filled, use emergency services, and other common situations like these.

###

Notices Were Mailed to Consumers Who May Be Enrolled in Marketplace Coverage with and without APTC AND Medicare (also called Medicare Periodic Data Matching)

Key Takeaway: Recently, the Federally-facilitated Marketplace (FFM) mailed paper notices to the household contacts of consumers who may be enrolled in a Marketplace plan with and without APTC and Medicare that qualifies as minimum essential coverage (MEC). The notices include instructions on what to do next. Generally, consumers determined eligible for MEC Medicare should not be enrolled in Marketplace coverage and are not eligible for a Marketplace plan with APTC or income-based CSRs. If consumers who receive this notice contact assisters with questions, assisters can help them understand the notice and complete the necessary next steps.*

***Medicare Parts A and C are considered MEC. Medicare Parts B and D are not considered MEC.*

Overview

The Federally-facilitated Marketplace (FFM) confirms MEC Medicare enrollment through a Medicare Periodic Data Matching (PDM) process. During Medicare PDM, the Marketplace identifies consumers aged 65 and up who are enrolled in MEC Medicare and Marketplace coverage with and without APTC and CSRs (i.e. "dually enrolled" consumers). If the FFM confirms MEC it's possible that this consumer may be at risk for a tax liability if they are receiving financial assistance (i.e., APTC) for their Marketplace coverage. Therefore, those consumers who are identified as enrolled in MEC Medicare should return to their application to end their Marketplace coverage because they are receiving MEC through Medicare.

Recently, as part of Medicare PDM, the FFM mailed paper notices to the household contact for any consumers aged 65 and up found to be dually enrolled in MEC Medicare and Marketplace coverage with and without APTC. The notices included:

- Names of consumers who were found to be dually enrolled;
- A recommendation that individuals who are found to be enrolled in MEC Medicare should not be enrolled in Marketplace coverage and are not eligible for APTC/CSR through the Marketplace;
- Instructions on the correct action to take on Marketplace coverage (for consumers enrolled in MEC Medicare); and
- Contact information to confirm if they are enrolled in Medicare or if they have any questions.

Q&A: How to help consumers who receive the notice.

Q1: Who does this notice impact?

A1: Consumers who were identified as aged 65 and up who are enrolled in both MEC Medicare and a Marketplace plan with and without APTC were notified.

Q2: Why is this important for consumers?

A2: If the Marketplace confirms MEC Medicare enrollment through Medicare PDM, the consumer's application must be updated to reflect that he or she has other MEC. These consumers should be encouraged to return to their application and follow the instructions listed on their Medicare PDM notice. If such consumers still want a Marketplace plan after having been determined eligible for MEC Medicare, they will have to pay full price for their share of the Marketplace plan.

Q3: What is the impact on consumers who are enrolled in both MEC Medicare and a Marketplace plan with APTC?

A3: Consumers who are enrolled in both MEC Medicare and a Marketplace plan are not eligible for APTC or CSRs. They may need to pay back all or some of the APTC received while dually enrolled when they file their federal income taxes, so those consumers who are enrolled in MEC Medicare are encouraged to return to their application and follow the instructions listed on their Medicare PDM notice.

Q4: When and how are these notices being sent to consumers?

A4: The Marketplace recently mailed paper notices to the household contact for applications with consumers aged 65 and up who may be dually enrolled in MEC Medicare and a Marketplace plan with and without APTC. The notices are not available electronically in consumer user accounts.

Q5: How will consumers identify these notices, and what do the notices say?

A5: The notice reads "You're getting this notice because our records show that the people in your household listed below are enrolled in both Medicare and a Marketplace health plan." The notice lists the consumers the Marketplace found to be dually enrolled, and tells them to follow the instructions listed in the notice based on the type of Medicare he or she is enrolled in. The notice also provides instructions for consumers who want more information about Medicare, or if they aren't sure whether they are enrolled in Medicare or if it qualifies as MEC. Copies of the notices sent to consumers are available in **English** and **Spanish**.

Q6: As an assister, why might consumers contact me, and how can I help them?

A6: Consumers who receive the notice may contact assisters: (a) for help understanding the notice or, (b) for help ending Marketplace coverage with or without APTC/CSRs. Here are some examples of the ways that assisters can help consumers who contact them:

- **Help consumers understand the notice**. Explain that this notice has been sent to them because the Marketplace has identified them as being dually enrolled in MEC Medicare and Marketplace coverage with or without APTC. This is important because consumers who have been determined eligible for MEC Medicare are not eligible for a Marketplace plan with APTC/CSRs; these consumers must follow the instructions listed on their Medicare PDM notice.
- **Help consumers understand the special opportunity to enroll in Medicare Part B**. Explain to consumers that this notice can be taken to their local Social Security office to request

help. Assisters should refer to the **Assistance for Individuals with Medicare Part A and Marketplace Coverage Information for SHIPs and Marketplace Assisters** fact sheet.

- **Encourage consumers who are enrolled in MEC Medicare to follow the instructions listed on their Medicare PDM notice based on the type of Medicare they are enrolled in**.

o See **these instructions on HealthCare.gov to help a consumer end Marketplace coverage altogether once determined eligible for MEC Medicare.**

- **Inform consumers who unsure of their Medicare eligibility or enrollment status** that they may want to contact Medicare to confirm their enrollment status. If Medicare confirms that the consumer is not enrolled in Medicare coverage, no further action is needed with the Marketplace.
- **Advise consumers who want more information about Medicare** to call 1-800-MEDICARE (1-800-633-4227; TTY users should call 1-877-486-2048) or their local State Health Insurance Assistance Program (SHIP) at 1-877-839-2675 or by going to www.SHIPTACenter.org. Consumers who are interested in signing up for Medicare should contact the Social Security Administration (SSA) at 1-800-772-1213 or visit their local Social Security office. TTY users should call 1-800-325-0778.

Q7: What if the consumer is enrolled in MEC Medicare but believes he or she is actually eligible to remain enrolled in Marketplace coverage with APTC?

A7: Consumers who are enrolled in MEC Medicare are not eligible for APTC or CSRs. They may need to pay back all or some of the APTC they received while dually enrolled when they file their federal income taxes. A consumer enrolled in both premium-free Medicare Part A and Part B OR Medicare Part C should end their Marketplace coverage immediately. A consumer enrolled in premium-free Medicare Part A (but not Medicare Part B) should contact their local Social Security Administration to sign up for Medicare Part B. They should wait to receive confirmation that they are covered by Medicare Part B before calling to end their Marketplace coverage. A consumer enrolled in premium Medicare Part A (because they are not entitled to premium-free Medicare Part A) can compare their benefits and total premiums under Medicare coverage (Medicare Part A, Part B, and, if applicable, Medicare Part C) with their Marketplace plan to see which one best meets their needs and fits their budget. Because they pay a premium for Medicare Part A, they have the option to stop all Medicare coverage and continue their Marketplace coverage with APTC, if applicable.

###

Offering States Flexibility to Increase Market Stability and Affordable Choices

On March 13, 2017, 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.

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, click here.

###

NEW Summary of Webinar presentation on "Coverage to Care"

On Friday, March 17, 2017 the assister webinar, included a presentation on Coverage to Care (C2C) by the CMS Office of Minority Health. From Coverage to Care is an effort to help educate consumers about their new coverage and to connect them with primary care and preventive services that are right for them so they can live long, healthy lives. The presentation outlined resources available through the initiative, including the Roadmap to Better Care and a Healthier You. The Roadmap to Better Care and a Healthier You explains what health coverage is and how to use it to get primary care and preventive services.

Resources are available in multiple languages; please go to the Partner Toolkit to view and order materials online.

What resources are available for consumers?

C2C offers a number of helpful consumer resources in different languages (English, Arabic, Chinese, Haitian Creole, Korean, Russian, Spanish, and Vietnamese.) Some of our key resources include:

- *A Roadmap to Better Care and a Healthier You*- The roadmap explains what health coverage is and how to use it to get primary care and preventive services you need.
- *5 Ways to Make the Most of Your Health Coverage* – A quick reference on how to make the most of your health coverage.
- *Partner Toolkit* - This toolkit provides ready-to-use language and social media graphics to help you share C2C resources with people in your community.
- *Animated Videos* – A series of short YouTube videos show how you can maximize your health coverage.

How can my organization use *From C2C* materials?

Please use the resources available on the coverage to care website at your existing community outreach events. You can distribute the materials or use them to help create your own. Use the fillable PDF of the Roadmap to customize our Roadmap with your information so consumers can contact you directly if they have questions about accessing care. The 5 Ways makes a great

resource for when you only have a few minutes, while the Roadmap offers a more detailed explanation of connecting to coverage. In addition to paper and PDF material, animated videos and social graphics can be shared online.

How can I become a C2C partner?

Becoming a partner is simple. All you have to do is download the *Partner Toolkit* and begin sharing information. The Partner Toolkit contains a web badge you can use to link to our site, a drop-in newsletter article, a blog post, social media posts and graphics, and information about the program. You can download it on our website: go.cms.gov/c2c.

###

CMS Released the Interim Summary Report on Risk Adjustment for the 2016 Benefit Year

This report provides issuers and states with preliminary risk adjustment information reflecting the 2016 benefit year. The risk adjustment program was created to offset the costs of issuers that enroll sicker and higher cost consumers. The program transfers payments from issuers that have healthier enrollees with lower health care costs to issuers that have sicker enrollees with higher health care costs, such as those with chronic conditions. The final risk adjustment report for the 2016 benefit year will be released on June 30, 2017.

###

Ending Special Enrollment Periods for Coverage during Calendar Year 2016

The Centers for Medicare & Medicaid Services (CMS) released guidance consistent with our practice in prior years, as of April 1, 2017, CMS is no longer accepting new requests for a Special Enrollment Period (SEP) that would enable consumers to enroll in a Qualified Health Plan (QHP) with 2016 coverage effective dates through the Federally-facilitated Marketplace, Federally-facilitated Marketplaces where States perform plan management functions, or State-based Marketplace using the Federal Platform. SEP requests for 2016 coverage that were received on or before March 31, 2017 may be processed by CMS after April 1, 2017.

However, as of April 1, 2017, all new SEP requests to CMS seeking 2016 coverage, with the exception of SEPs issued as a result of an eligibility appeal described below, will be given a coverage effective date no earlier than January 1, 2017, if eligible for retroactive coverage.

For additional information click here: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-for-Ending-Special-Enrollment-Periods-for-Coverage-during-Calendar-Year-2016.pdf

###

MACRA/Quality Payment Program (QPP) Updates

Final Evaluation Reports

The Centers for Medicare & Medicaid Services (CMS) Innovation Center released final evaluation reports on the Advance Payment (AP) Accountable Care Organization (ACO) Model Evaluation Report, Pioneer ACO Model Final Evaluation Report and Skilled Nursing Facility (SNF) 3-Day Waiver Report. Medicare Accountable Care Organizations (ACOs) are designed to provide financial incentives for fee-for-service (FFS) Medicare providers.

These final evaluation report focuses on describing participating organizations, their activities, and their aligned beneficiaries during their initial three-year performance period (2012-2014).

Advance Payment ACO Model Evaluation Report
The final evaluation report for the Advance Payment (AP) Accountable Care Organization (ACO) Model provided 36 small, physician-based Medicare Shared Savings Program ACOs with up-front payments to invest in resources to improve care delivery. Twenty AP ACOs started in 2012; 16 AP ACOs started in 2013. AP ACOs comprised 15 to 20 percent of all Shared Savings Program ACOs that launched in 2012 or 2013.

Adv Pay ACO report (PDF): https://innovation.cms.gov/Files/reports/advpayaco-fnevalrpt.pdf

Pioneer ACO Model Final Evaluation Report
The final evaluation report for the Pioneer Accountable Care Organization (ACO) Model was the first ACO initiative launched at CMS; it began in January 2012 and concluded at the end of December 2016. The Pioneer ACO Model was designed for organizations with experience with risk-based contracting and coordinating patients' care across care settings. The final Pioneer ACO evaluation report focuses on describing participating organizations, their activities, and their aligned beneficiaries during their initial three-year performance period (2012-2014).

Pioneer ACO report (PDF): https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf

Skilled Nursing Facility (SNF) 3-day Waiver Report
An additional report was also released that goes into greater detail on the skilled nursing facility (SNF) 3-day waiver, which was introduced as part of the model in 2014. SNF Medicare benefit is intended for beneficiaries requiring short term skilled nursing or therapy services to manage, observe, and evaluate care after a hospitalization.
SNF Report (PDF): https://innovation.cms.gov/Files/reports/pioneeraco-snf-evalrpt.pdf

###

Quality Payment Program Website Update MIPS Outreach and Education

As part of the Quality Payment Program (QPP) final rule, CMS committed to issuing sub-regulatory guidance (by way of educational resources) for the Merit-based Incentive Payment System (MIPS). These documents aim to provide additional outreach and education for MIPS registration, which is a requirement for some groups who choose to participate.

For more information, see more at the QPP website here: https://qpp.cms.gov/learn/about-group-registration

###

Opening April 1st: Registration Period for Merit-based Incentive Payment System (MIPS) Group Web Interface and CAHPS Reporting

Groups Must Register to Utilize the CMS Web Interface and/or CAHPS for MIPS Survey by June 30, 2017

Groups participating in the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program are **not** required to register, **except** for groups that intend to utilize the CMS Web Interface and/or administer the Consumer Assessment of Health Providers and Systems (CAHPS) for MIPS survey. To register, please visit the Quality Payment Program website. The registration period is from April 1, 2017 through June 30, 2017.

Under MIPS, a group is defined as a single Taxpayer Identification Number (TIN) with two or more eligible clinicians (including at least one MIPS eligible clinician), as identified by their National Provider Identifiers (NPI), who have reassigned their billing rights to the TIN. Eligible clinicians who participate as a group will be assessed a at a group level across all four MIPS performance categories. The group will receive one payment adjustment for the group's performance.

Note: Groups that participate in a Shared Savings Program ACO are not required to register or report; the Shared Savings Program ACO is required to report quality measures on behalf of participating eligible clinicians for purposes of MIPS.

For 2017, only groups of 25 or more eligible clinicians that have registered can report via the CMS Web Interface. Groups that participate in MIPS through qualified registry, qualified clinical data registry, or electronic health record data submission mechanisms do not need to register. For 2017, only groups of 2 or more eligible clinicians that have registered can participate in the CAHPS for MIPS survey.

As a courtesy, CMS automatically registered groups for the CMS Web Interface for the 2017 performance period that previously registered for group reporting under the Physician Quality Reporting System (PQRS) via the Group Practice Reporting Option (GPRO) Web Interface. If you need to remove your registration for Web Interface submission because your group now has fewer than 25 eligible clinicians, you should "cancel" your registration. If your group wants to administer the CAHPS for MIPS survey, your group will need to make an election via the registration system.

The registration period for groups who choose Web Interface or CAHPS for MIPS Survey as their data submission method is April 1 – June 30, 2017.

Note: For individual or group participation, registration is not required for any other submission method.

How to Register

To register, visit Quality Payment Program website. You will need a valid Enterprise Identity Management (EIDM) account with a Physician Value – Physician Quality Reporting System (PV-PQRS) role in order to register.

EIDM Account Information

- ***Open a New Account:*** To create or modify an EIDM account, review the Guide for Obtaining a New EIDM Account.
- ***Reactivate an Account:*** To reactivate or confirm the status of an account, contact the Quality Payment Program at 1-866-288-8292 (TTY: 1-877-715-6222) or qpp@cms.hhs.gov, Monday – Friday 8:00am – 8:00pm Eastern Time and provide the group name and TIN.
- ***Use a Current Account:*** To request a role to access the 'Physician Quality and Value Programs' application in the CMS Enterprise Portal, review the Guide for Obtaining a 'Physician Quality and Value Programs' Role for an Existing EIDM User.

For More Information

Visit the Quality Payment Program website and review the following materials:

- An Introduction to: Group Reporting in MIPS in 2017
- 2017 CAHPS for MIPS Fact Sheet
- 2017 MIPS: CMS Web Interface Fact Sheet

Coming Soon

CMS will be hosting webinars to explain group reporting and registration for the CMS Web Interface and CAHPS for MIPS Survey soon. More information will be coming soon.

###

LTCH QRP Listserv/Spotlight Announcement- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Spotlight-Announcements.html

Review and Correct Reports Now Available

The LTCH review and correct reports are now available within the CASPER application. Review and Correct reports contain quality measure information at the facility level and are available on demand. These reports allow LTCH providers obtain aggregate performance for the past four full quarters (when data is available). These reports only contain data submitted prior to the applicable quarterly data submission deadlines and display whether the data correction period for a given CY quarter is "open" or "closed". Providers can access their review and correct reports in the CASPER system at https://web.qiesnet.org/qiestosuccess/.

###

CMS' Accountable Health Communities Model selects 32 participants to serve as local 'hubs' linking clinical and community services

Note: None are in Region 7

Last year, the Centers for Medicare & Medicaid Services (CMS) released a Funding Opportunity Announcement (FOA) for applications for the Center for Medicare and Medicaid Innovation's (Innovation Center) Accountable Health Communities (AHC) model. Over a five-year period, CMS will implement and test the three-track AHC model to support local communities in addressing the health-related social needs of Medicare and Medicaid beneficiaries by bridging the gap between clinical and community service providers. Social needs include housing instability, food insecurity, utility needs, interpersonal violence and transportation.

Today, CMS has announced the participants for two of the tracks, the Assistance and Alignment Tracks, of the AHC model. By addressing critical drivers of poor health and high health care costs, the model aims to reduce avoidable health care utilization, impact the cost of health care, and improve health and quality of care for Medicare and Medicaid beneficiaries. The organizations in the AHC Assistance Track will provide person-centered community service navigation services to assist high-risk beneficiaries with accessing needed services. The organizations in the AHC Alignment Track will also provide community service navigation services, as well as encourage community-level partner alignment to ensure that needed services and supports are available and responsive to beneficiaries' needs.

"We know that innovation at the state and community level is essential to improve health outcomes and lower costs. In this model, we will support community-based innovation to deliver local solutions that address a broader array of health-related needs of people across the country," said Dr. Patrick Conway, CMS Deputy Administrator for Innovation & Quality. "As a practicing pediatrician, I know the power of a model like this to help address the health and social support needs of beneficiaries, and their families and caregivers."

CMS received applications for the Assistance and Alignment Tracks from a variety of organizations across the country. After a review process, 12 Assistance Track and 20 Alignment Track bridge organizations representing rural and urban communities across 193 counties in 23 states were chosen to participate in the model. The 32 bridge organizations in the AHC model are diverse —varying in type (e.g., county governments, hospitals, universities, and health departments), size, location, and beneficiary demographics.

As two examples of how AHC bridge organizations will operate:

- In the AHC Assistance Track, Community Health Network Foundation in Indianapolis will partner with the Eastside Redevelopment Committee, an organization representing 50 businesses and community-based organizations focused on improving health through high-quality support services, educational programs, and workforce development. Together, they will serve residents of East Indianapolis, a community where 40% of the population received Indiana Medicaid services in 2015 and an emergency room utilization rate above the national average. Through their participation in the AHC Assistance Track, they hope to reduce health care costs for high-risk beneficiaries who receive navigation services.

- In the AHC Alignment Track, the Oregon Health & Science University (OHSU) will seek to reduce healthcare utilization and cost to beneficiaries across nine rural counties in Oregon by working with over 50 clinical sites, community service providers, and local health departments. In Oregon, the AHC model is targeting over 300,000 Medicare and Medicaid beneficiaries. OHSU will coordinate the model activities through the Oregon Rural Practice-based Research Network, a statewide network of primary care clinicians, community partners, and academicians dedicated to studying the delivery of health care to rural residents and to reducing rural health disparities.

The Assistance and Alignment Tracks of the Accountable Health Communities Model will begin on May 1, 2017 with a five-year performance period.

To view a list of the Assistance and Alignment Tracks bridge organizations in the Accountable Health Communities Model, please visit: https://innovation.cms.gov/initiatives/ahcm.

The Accountable Health Communities Model is authorized under Section 1115A of the Social Security Act, which established the Innovation Center to test innovative payment and service delivery models to reduce Medicare, Medicaid, and Children's Health Insurance Program expenditures while maintaining or enhancing the quality of beneficiaries' care.

For more information about the Accountable Health Communities Model, please visit: https://innovation.cms.gov/initiatives/ahcm.

###

Medicare and Medicaid Updates

Home Health Services Pre-Claim Review Demonstration Pause

As of April 1, 2017, the Pre-Claim Review demonstration for home health services is paused in Illinois and didn't expand to Florida. We will process claims under normal processing rules. The Centers for Medicare & Medicaid Services will notify providers at least 30 days in advance of further developments related to the demonstration. For more information, see the Pre-Claim Review Demonstration webpage and FAQs.

###

Clinical Laboratory Fee Schedule 60 Day Reporting Extension

Under the new private payer, rate-based Medicare Clinical Laboratory Fee Schedule (CLFS), entities are required to report applicable laboratory data to CMS by March 31, 2017. Industry feedback indicates many reporting entities will not be able to submit a complete set of applicable information to CMS by the March 31, 2017 deadline and these entities require additional time. CMS is adopting a 60-day enforcement discretion period (through May 30, 2017) to provide additional reporting item for these entities.

To see the announcement, click here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-regulations.html

###

Medicare and Medicaid Programs; Conditions of Participation for Home Health Agencies; Delay of Effective Date (CMS-3819-P2)

CMS is proposing to delay the effective date of the final home health agency (HHA) Conditions of Participation (CoP) rule by an additional six months beyond the original July 13, 2017 effective date. The new HHA CoPs would be effective on January 13, 2018.

For more information, click here to view proposed rule in the Federal Register (PDF): https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-06540.pdf and on 04/03/2017 will be available online at https://federalregister.gov/d/2017-06540

###

CMS finalizes 2018 payment and policy updates for Medicare Health and Drug Plans, and releases a Request for Information

Rate Announcement supports benefit flexibility, efficiency, and innovation in Medicare Advantage and Part D

The Centers for Medicare & Medicaid Services (CMS) released final updates to the Medicare Advantage and Part D Prescription Drug Programs for 2018. Through these changes, CMS seeks

to support benefit flexibility and efficiency that allows Medicare enrollees to choose the care that best fits their health needs.

"Medicare is committed to strengthening Medicare Advantage and the Prescription Drug Program by supporting flexibility and efficiency," said CMS Administrator Seema Verma, MPH. "These programs have been successful in allowing innovative approaches that give Medicare enrollees options that best fit their individual health needs."

The final policies are similar to those proposed and discussed in the Advance Notice and draft Call Letter in February but incorporate several changes in response to feedback received during the public comment period. On average, plans can expect a revenue change of 0.45 percent, though individual experiences will vary. When accounting for the expected growth in coding acuity, plans can expect a total change of 2.95 percent in revenue. Plans that improve the quality of care they deliver to enrollees will see higher updates and can grow and enhance the benefits they offer to enrollees.

The updated policies provide additional flexibility and incentives to encourage organizations to develop new plan offerings with innovative provider network arrangements that may further encourage enrollee use of and improve access to high quality health care services. CMS anticipates that the updated policies will provide an increased variety of Medicare Advantage and Part D plans for enrollees to choose from.

The policies in the Rate Announcement provide incentives for plans to submit complete encounter data. In 2018, CMS is modifying the phase-in of the use of encounter data and will use encounter data for 15 percent of the risk adjustment payment to Medicare Advantage plans.

CMS is also finalizing policies that will further combat opioid overutilization by encouraging safeguards before an opioid prescription is dispensed at the pharmacy, while preserving flexibility that will maintain access to needed medications for Medicare enrollees in the Part D prescription drug benefit. CMS believes that Medicare Advantage Organizations and Part D sponsors, working with prescribing physicians, are in the best position to identify and employ best practices and the most appropriate care management interventions for enrollees using high dosage opioids. CMS expects all Part D sponsors to focus on improving the coordination of care among these enrollees using high dosage of opioids, and in particular, Medicare Advantage plans that include prescription drug coverage should consider expanding the care management they provide enrollees.

In addition to today's payment and policy updates for Medicare Advantage and Part D, CMS is releasing a Request for Information to welcome continued feedback on Medicare Advantage and Part D. CMS is soliciting ideas for regulatory, sub-regulatory, policy, practice and procedural changes to better accomplish transparency, flexibility, program simplification and innovation in Medicare Advantage and Part D. CMS is accepting comments on the Request for Information through April 24, 2017.

For a fact sheet on the 2018 Rate Announcement and Call Letter, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-04-03.html.

The 2018 Rate Announcement and Call Letter, and the Request for Information may viewed through: https://www.cms.gov/Medicare/Health-

Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html and selecting "2018 Announcement."

###

Upcoming Webinars and Events and Other Updates

CDC NetConference Series About Adult Immunizations

Please join the Centers for Disease Control and Prevention (CDC) for a NetConference series on *Vaccinating Adults*, addressing key issues related to protecting adults from vaccine-preventable diseases. A collaborative effort between the CDC and Maryland Partnership for Prevention and the state immunization program, the *Vaccinating Adults* series will feature six presentations by experts in promoting, administering, and securing reimbursement for adult immunizations.

The *Vaccinating Adults* series objectives are to provide information and share insights on the unique challenges associated with vaccinating various subgroups within the adult population.

Audience
Immunization providers: Physicians, nurses, nurse practitioners, pharmacists, physician assistants, DoD paraprofessionals, medical students, state and local immunization programs, etc.

Continuing Education
Continuing education will be available for each event.

Registration
The link to register is: https://www2.cdc.gov/vaccines/ed/adultreg/

Advanced registration is required to participate. Registrants will receive an email with instructions for accessing the webinar no later than the morning of the scheduled event. *Note that you will be registered for all, or remaining, events. Should you wish to opt out of future webinar events or emails, please send an email to izlearn@cdc.gov.*

Attendance
Attendance for each live webinar is limited to 1,500 registrants. We advise registrants to log in early before a webinar begins to secure a virtual "seat." Should you miss the live event, you can watch the archived version when it is posted later on CDC's website.

Schedule

· Wednesday, April 12 - Burden of Vaccine-preventable Diseases in Adults: Medical, Social, and Economic Costs
· Wednesday, April 19 - Provider Reimbursement for Adult Immunizations
· Wednesday, April 26 - Immunizing Adults: Immunization Schedule, Coverage, and Challenges
· Wednesday, May 17 - Immunizing Older Adults and the Chronically Ill
· Wednesday, May 24 - Immunizing Pregnant Women, Health Care Personnel, and in the Workplace
· Wednesday, May 31 - Clinic Logistics: Vaccine Administration, Storage, and Handling

Each session will start at 11:00 a.m. Central Time.

The series will be archived later on CDC's website.

If you have questions regarding the CDC NetConference Series About Adult Immunizations, please contact Sherry Mirador.

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###

Addressing Opioid Overdose: Perspectives from the Field

April 28, 2017
8:00 am to 5:00 pm
Clayton Plaza Hotel, Clayton, MO

Medical Professionals should Register Today!

The Addressing Opioid Overdose: Perspectives from the Field conference will be fully accredited. We invite physicians to attend and receive Continuing Medical Education credit. Medical experts in the fields of opioid use research and practice will speak on the overdose public health crisis. Dr. Alexander Walley (Boston University School of Medicine, Boston Medical Center, Massachusetts Department of Public Health) will be the keynote speaker and review the epidemiology of opioid overdose and how to incorporate prevention into your practice; Dr. Naazia Azhar (VA St. Louis Healthcare System, Washington University) will discuss how to address overdose risk among Veterans in a medication assisted treatment program; and Dr. Phillip Coffin (University of California, San Francisco; San Francisco Department of Public Health) will present on the indications and benefits of naloxone provision across healthcare settings.

Contact:
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Chief, Office on Women's Health
Missouri Department of Health and Senior Services
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Be a Part of the Healthy People 2030 Development Process!

Register Now | April 27, 2017 from 12:00 p.m. to 2:00 p.m. ET

Register for the third meeting of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030 (Committee).

The Committee will discuss:

- The development of the Nation's health promotion and disease prevention objectives
- Recommendations for the Healthy People 2030 mission, vision, framework, and organizational structure

This Committee meeting will be held online via webcast and is open to the public.

Register today!

Registration is limited and will close once it reaches capacity. Please consider registering early and gathering in one location to view the event with your colleagues.

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Medicare Learning Network Publications & Multimedia

News & Announcements

- MIPS Annual Call for Measures and Activities through June 30
- CMS Voluntary Self-Referral Disclosure Protocol: New Form
- Clinical Laboratory Data Reporting: Enforcement Discretion
- Open Payments Program Year 2016 Review and Dispute Period Ends May 15
- MIPS Group Web Interface and CAHPS Reporting: Registration Period Open through June 30
- Home Health and LTCH Quality Reporting Program Review and Correct Reports Available
- 2018 Medicare Shared Savings Program: Notice of Intent to Apply Guidance Document Available
- April Quarterly Provider Update Available
- Help Prevent Alcohol Misuse or Abuse
-

Provider Compliance

- Billing For Stem Cell Transplants
- Lumbar Spinal Fusion CMS Provider Minute Video

Upcoming Events

- Open Payments: Prepare to Review Reported Data Call — April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19
- Global Surgery: Required Data Reporting for Post-Operative Care Call — April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27
- Hospice Quality Reporting Program: Public Reporting Webinar — April 27

Medicare Learning Network Publications & Multimedia

- NPI: What You Need to Know Booklet — New
- IRF-PAI Call: Video Presentation — New
- ESRD QIP Call: Follow-up Questions and Answers — New
- SNF Consolidated Billing Web-Based Training Course — Revised
- Remittance Advice Resources and FAQs Fact Sheet — Revised
- Reading a Professional Remittance Advice Booklet— Revised
- Medicare Home Health Benefit Booklet — Revised
- MLN Learning Management System FAQs Booklet — Revised
- Medicare Enrollment for Physicians and Other Part B Suppliers Booklet — Reminder
- Medicare Enrollment for Institutional Providers Booklet — Reminder
- Safeguard Your Identity and Privacy Using PECOS Booklet — Reminder
- Denial of Home Health Payments When Required Patient Assessment Is Not Received: Additional Information MLN Matters® Article — New
- SNF Value-Based Purchasing Call: Audio Recording and Transcript — New
- Dementia Care Call: Audio Recording and Transcript — New
- Reading an Institutional RA Booklet — Revised
- PECOS for Physicians and Non-Physician Practitioners Booklet — Reminder

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New Publications On-line

What to do if your Marketplace appeal is "Invalid" – Spanish

Medicare Hospice Benefits

Medicare Home Health Benefits

Your Medicare Benefits - Spanish

Welcome to Medicare - Spanish

Your Discharge Planning Checklist - Spanish

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