

CMS Region 7 Updates

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ACA/Marketplace Updates

CMS Issues Final Rule to Increase Choices and Encourage Stability in Health Insurance Market for 2018

The Centers for Medicare & Medicaid Services (CMS) today issued the final Market Stabilization rule, to help lower premiums and stabilize individual and small group markets and increase choices for Americans. Individuals obtaining coverage in the Marketplace created by the Affordable Care Act have faced double-digit premium increases, fewer plans to choose from, and a market that continues to be threatened by insurance issuer exits.* The CMS rule is designed to provide some relief for patients and issuers now.

"CMS is committed to ensuring access to high quality affordable healthcare for all Americans and these actions are necessary to increase patient choices and to lower premiums," said CMS Administrator Seema Verma. "While these steps will help stabilize the individual and small group markets, they are not a long-term cure for the problems that the Affordable Care Act has created in our healthcare system."

The final rule makes several policy changes to improve the market and promote stability, including:

- **2018 Annual Open Enrollment Period: The final rule adjusts the** annual open enrollment period for 2018 to more closely align with Medicare and the private market. The next open enrollment period will start on November 1, 2017, and run through December 15, 2017, encouraging individuals to enroll in coverage prior to the beginning of the year.
- **Reduce Fraud, Waste, and Abuse:** The final rule promotes program integrity by requiring individuals to submit supporting documentation for special enrollment periods and ensures that only those who are eligible are able to enroll. It will encourage individuals to stay enrolled in coverage all year, reducing gaps in coverage and resulting in fewer individual mandate penalties and help to lower premiums.
- **Promote Continuous Coverage:** The final rule promotes personal responsibility by allowing issuers to require individuals to pay back past due premiums before enrolling into a plan with the same issuer the following year. This is intended to address gaming and encourage individuals to maintain continuous coverage throughout the year, which will have a positive impact on the risk pool.
- **Ensure More Choices for Consumers: For the 2018 plan year and beyond, the final rule** allows issuers additional actuarial value flexibility to develop more choices with lower premium options for consumers, and to continue offering existing plans.
- **Empower States & Reduce Duplication:** The final rule reduces waste of taxpayer dollars by eliminating duplicative review of network adequacy by the federal government. The rule returns oversight of network adequacy to states that are best positioned to evaluate network adequacy.

CMS also made a number of other announcements today regarding the process that issuers must follow to meet the law's requirements for the 2018 plan year. The additional guidance

released includes updates that would make the guidance consistent with today's final rule and information needed by issuers in order to have their plans certified for 2018, including: [Key Dates for 2017](#); [Issuer Guidance on Uniform Rate Review Timeline](#); [Good Faith Compliance Guidance](#); [QHP Certification Guidance for States](#); and [Final Actuarial Value \(AV\) Calculator for 2018](#) and [Methodology](#).

The final rule can be found, here: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-07712.pdf>

*Recent statistics related to the Affordable Care Act:

- Approximately one-third of counties in the U.S. have only one insurer participating in their exchange for 2017.
- Five states have only one insurer participating in their exchange for 2017.
- The premium for the benchmark second-lowest cost “silver plan” on Healthcare.gov increased by an average of 25 percent from 2016-2017.
- Approximately 500,000 fewer Americans selected a plan in the exchange open enrollment in 2017 than in 2016.
- Many states saw double digit increases in their insurance premiums including:
 - AZ - 116%
 - OK - 69%
 - TN - 63%
 - AL - 58%
 - PA - 53%

###

NEW Data on Race, Ethnicity, and Language Preference in the Health Insurance Marketplaces 2017 Open Enrollment Period

In recognition of National Minority Health Month, the CMS Office of Minority Health has released a data highlight that – for the first time ever – examines Marketplace enrollment activity by racial and ethnic subgroup, as well as spoken and written language preference. *Race, Ethnicity, and Language Preference in the Health Insurance Marketplaces 2017 Open Enrollment Period* provides information at the national level and state level for Marketplace consumers ages 18-64 in the 39 states utilizing the Healthcare.gov eligibility and enrollment platform during the 2017 Open Enrollment Period (OEP).

Some of the findings include:

- Of all 2017 OEP Marketplace consumers ages 18-64 who attested to a specific race, 10% were Asian. Among Asians, the most common subgroups selected were Vietnamese (26%) and Asian Indian (24%).
- Overall, 10% of consumers ages 18-64 attested to a Hispanic ethnicity. Of those adult consumers who indicated that they were Hispanic, almost half (44%) were Mexican.

- The far majority of consumers ages 18-64 who selected a preferred spoken language selected English (90%), followed by Spanish (8%).

- Among consumers with known spoken language preferences, the majority who preferred Spanish (56%) lived in Florida, while more than a third of those who preferred Vietnamese (35%) lived in Texas.

To access this data highlight, visit <https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/information-products/data-highlights/index.html>

or Download Data Highlight (PDF, 436KB) here: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Highlight-Race-Ethnicity-and-Language-Preference-Marketplace.pdf>

###



###

CMS Released the Market Stabilization Final Rule

[This rule](#) finalizes changes that will help stabilize the individual and small group markets, and affirm the traditional role of state regulators. The rule amends standards relating to SEPs, guaranteed availability, the timing of Open Enrollment in the individual market for the 2018 plan year, QHP standards on network adequacy and essential community providers, and rules around actuarial value requirements.

###

CMS Released Guidance on Ending SEPs for Coverage for Calendar Year 2016

[This document](#) notes that as of April 1, 2017, CMS is no longer accepting new requests for an SEP that would enable consumers to enroll in a qualified health plan (QHP) with 2016 coverage effective dates through the Federally-facilitated Marketplace (FFM). This practice is consistent with prior years.

###

CMS Posted Final Qualified Health Plan (QHP) Application Materials for Plan Year (PY)

CMS posted the final application materials to the [QHP website](#). Issuers applying for certification for QHPs, including stand-alone dental plans (SADPs), should use the application instructions, corresponding supporting documentation and justification forms, and application templates when applying for PY18 certification to participate in the Federally-facilitated Marketplace (FFM).

###

Agents and Brokers Should Still Complete Registration

There are many reasons for agents and brokers to [register](#) with the Marketplace outside of Open Enrollment. Agents and brokers who complete registration will be added to [Find Local Help](#), and can assist consumers who qualify for a SEP and help enrolled clients make effective use of their Marketplace coverage. Registered agents and brokers will also be eligible to take the refresher training next year, which takes only half the amount of time as the full training. Additionally, the Small Business Health Options Program (SHOP) Marketplace is open year-round, which means agents and brokers can still earn commissions on SHOP plan sales now.

###

Reminder: Help Consumers Resolve their DMIs

Key Takeaway: Temporary eligibility will soon end for a consumer who enrolled in Marketplace coverage toward the end of the Open Enrollment period and received an application Data Matching Issue (DMIs) that they have not yet resolved. Assistors are encouraged to follow up with the consumers they helped enroll during the Open Enrollment period to assist in resolving any outstanding DMIs. A consumer that fails to resolve his or her DMI during the 90/95 day inconsistency period will lose Marketplace coverage and/or have financial assistance adjusted, in some cases to \$0.

A) What is a Data Matching Issue (DMI)

For most consumers, the Marketplace immediately verifies the information submitted on their application. But in some cases, the information the applicant provides does not match existing records from trusted data sources (TDS) such as Internal Revenue Service, Social Security Administration and Department of Homeland Security, etc. or the applicant does not provide

enough information to match existing records from TDS. Under those circumstances, the application generates a DMI, and consumers are granted temporary eligibility and given 90/95 days to submit documentation to verify their application information.

It is important that consumers understand how and when to submit the requested information and the timeline to do so when they receive a notice from the Marketplace saying that they need to send documentation for eligibility verification purposes.

Temporary eligibility for Marketplace coverage and financial assistance may be granted during the 90/95 day period. During that time the consumer should submit supporting documentation to resolve the DMI. If the consumer fails to submit information within the 90/95-day window he or she will risk losing their Marketplace health care coverage and/or having his or her financial assistance adjusted, in some cases to \$0. For example, a consumer with a citizenship/immigration DMI will be terminated from coverage if he or she does not submit the requested information, and a consumer with an annual income DMI will have his or her advanced premium tax credits (APTCs) and/or cost sharing reductions (CSRs) re-determined based on available tax data. When Marketplace coverage is terminated as a result of an unresolved DMI, the consumer may be liable for any APTCs and/or CSRs they received during the 90/95-day period.

If a DMI is unresolved, the consumer will receive 90-day, 60-day, and 30-day warning notices as well as a 15-day reminder call before his or her DMI is set to expire. These notices will be mailed in English or Spanish based on the consumer's language preference. We encourage assisters to help consumers review their Marketplace DMI notices to identify what documents the Marketplace needs, and help them determine whether or not they have submitted sufficient supporting documentation.

Impact of DMI Expiration

DMI	Expiration Description	Impact
Annual Income	Applicant is unable to document annual household income is within 25% or \$6,000 of attested income	Household's eligibility for financial assistance is adjusted, possibly to nothing, based on the level of income on record with Marketplace trusted data sources
Citizenship/Immigration (Cit/Imm)	Consumer is unable to verify an eligible citizenship or lawful presence status	Consumer loses their eligibility for Marketplace coverage and is terminated if enrolled
American Indian/Alaskan Native (AIAN) Status	Consumer is unable to verify they are a member of a Federally recognized tribe or shareholder in an Alaska Native corporation (ANCSA)	Consumer loses their eligibility for financial assistance provided specifically to members of Federally recognized tribes, which is eliminated if enrolled
Non-Employer Sponsored Coverage Minimum Essential Coverage (non ESC MEC)	Consumer is unable to verify they are not eligible/enrolled in Non-Employer Sponsored Coverage	Consumer loses their eligibility for financial assistance, which is eliminated if enrolled
ESC MEC (OPM Only)	Consumer is unable to verify they are not eligible/enrolled in Employee Sponsored Coverage from OPM	Consumer loses their eligibility for financial assistance, which is eliminated if enrolled

B) Steps to Help Resolve DMIs

We strongly recommend that assisters work with consumers to reduce confusion and simplify the DMI process. Assisters can help consumers understand their DMI notices and identify the appropriate documents to submit, negating the potential for disruptions in coverage. In cases that do require follow-up, assisters should follow these steps to help consumers resolve DMIs:

- Help confirm if the consumer has a DMI through My Account and notices;
- Help the consumer go back to the application to confirm the information that is included is correct; and
- Help the consumer submit document(s) online or by mail to resolve his or her DMI.

C) Preventing DMIs

In many instances, DMIs are generated due to missing or incorrect information on the application. The most common mistakes producing DMIs are:

1. A consumer failed to provide a Social Security Number (SSN) on their application.
2. A consumer failed to provide all household income on the application.
3. A consumer's name used for their application differs from how it appears in his or her citizenship document or other document.
4. A consumer failed to provide his or her immigration documents and ID numbers

The following FAQs provide general information on how to prevent all DMI types:

Q1: What can an assister do to reduce cases that trigger DMIs?

A1: As assisters, you can help to review a consumer's Marketplace application to verify that he or she:

- Completes all possible fields in the application;
- Corroborates that the consumer's name exactly matches documents such as his or her social security card;
- Provides information on the application that is complete and free of errors or typos; and
- Includes non-applicant(s) SSN(s) to accurately estimate applicant household income

Q2: How can consumers prevent citizenship/immigration DMIs from occurring?

A2: To prevent consumers from receiving a citizen/immigration DMIs, assisters should:

- Encourage consumers to select an appropriate immigration document type, and provide all documents numbers and ID numbers; and
-
- Be aware that consumers not seeking health coverage for themselves do not need to provide their citizenship or immigration status.

Q3: How can assisters help consumers to prevent other types of DMIs?

A3: a) For Annual Income DMIs

- In order for the Marketplace to match annual household income data on an application with IRS data, the household must have filed taxes; and
- Not everyone is required to file taxes, but those who have not filed will likely have a DMI and need to submit documents.

b) For Minimal Essential Coverage DMIs

- Confirm that the applicants do not have other coverage and that any previous coverage has definitely ended.

c) American Indian/Alaska Native DMI

- Double-check that the applicant is a member of a Federally-recognized tribe, not solely a State-recognized tribe, since State tribe members are not eligible for special financial assistance.
- Everyone who claims to be a member of a Federally-recognized tribe will get a DMI and must submit documents to receive special financial assistance.

For more information about how to prevent and resolve DMIs, please refer to the following documents:

- **How do I Resolve an Inconsistency? Webpage:** <https://www.healthcare.gov/help/how-do-i-resolve-an-inconsistency/>
- **Tips to Resolve Outstanding Data Matching Issues Presentation:** <https://marketplace.cms.gov/technical-assistance-resources/resolve-data-match-issues.pdf>
- **DMI Blog Post:** <https://www.healthcare.gov/blog/the-marketplace-might-need-more-information-from-you/>
- **Sample Data Matching Notices to consumers:** <https://marketplace.cms.gov/applications-and-forms/notices.html>
- **How do I Upload a Document? Webpage:** <https://www.healthcare.gov/help/how-to-upload-documents/>
- **Uploading Documents Tips Webpage:** <https://www.healthcare.gov/tips-and-troubleshooting/uploading-documents/>
- **Tips for Submitting Supporting Documents to the Marketplace Presentation:** <https://marketplace.cms.gov/technical-assistance-resources/submitting-supporting-documents.pdf>
- **Five Things Assistants Should Know About Data Matching Terminations Factsheet:** <http://marketplace.cms.gov/technical-assistance-resources/data-matching-terminations.pdf>

Consumer Action Needed - Initial Warning Notices Sent to Consumers Who May Be Enrolled in Marketplace Coverage with APTC/CSRs and Medicaid or CHIP (also called Medicaid/CHIP Periodic Data Matching)

Key Takeaway: Consumers determined eligible for minimum essential coverage ([MEC](#))[1] Medicaid or CHIP are not eligible for a Marketplace plan with advance payments of the premium tax credit (APTC) and/or income-based cost-sharing reductions (CSRs). The Marketplace has identified consumers who may be dually-enrolled in a Marketplace plan receiving APTC/CSRs and in MEC Medicaid/CHIP and has sent them notification of their dually-enrolled status. This process is called Medicaid/CHIP Periodic Data Matching (PDM). This summer, the Marketplace will end APTC/CSRs for dually-enrolled consumers who do not take action in response to the Medicaid/CHIP PDM initial warning notice; these consumers will remain enrolled in a Marketplace plan at full cost. Assistors can help affected consumers understand the notice(s) and complete the necessary next steps.

Overview

- Consumers who are determined eligible for or are enrolled in MEC Medicaid or CHIP are ineligible for APTC and CSRs to help pay for the cost of their Federally-Facilitated Marketplace (Marketplace)[2] plan premium and covered services.[3], [4]
- Medicaid/CHIP PDM is the process the Marketplace uses to identify, notify, and reduce the number of consumers who are enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP (i.e. "dually-enrolled" consumers).
- This month, the Marketplace sent an **initial warning notice** to the household contact for dually-enrolled[5] consumers, stating that if they do not take action by the date in the notice, the Marketplace will end any APTC/CSRs being paid on behalf of affected consumers, and those consumers' Marketplace coverage will continue without financial help. [6]
- The notice tells the household contact (and provides instructions) to do one of the following by a specified date:
 - end affected consumers' Marketplace coverage with APTC/CSRs if they are enrolled in Medicaid or CHIP; or
 - update their Marketplace application to tell the Marketplace that affected consumers are not enrolled in Medicaid/CHIP.
- In late Spring/early Summer 2017, at least 30 days following the initial notice, a **final notice** will be sent to the household contact for applications with affected consumers who did not respond to the initial warning notice by the specified date. This notice will let consumers know that they are still enrolled in a Marketplace plan but will no longer receive financial help.
- For anyone else on the application who is still enrolled in a Marketplace plan, their coverage will continue and eligibility for APTC/CSRs, if applicable, will be redetermined. **Dually-enrolled consumers who do not want to pay full cost for their share of the Marketplace plan premium and covered services should end their Marketplace coverage immediately.** The final notice includes instructions for next steps, such as ending Marketplace coverage, confirming whether or not someone is enrolled in Medicaid/CHIP, and appealing the Marketplace's decision; it also includes the date that the changes to financial assistance become effective. The Marketplace will also send an updated Eligibility Determination Notice (EDN).

Q&A: How to help consumers who receive the notice(s)

Q1: When and how are these notices being sent to consumers?

A1: The Marketplace sent initial warning notices in March 2017 to the household contact for applications with one or more dually-enrolled consumers. In late Spring/early Summer 2017, the Marketplace will send a final notice to the household contact for applications with consumers who did not take action by the date in the initial warning notice. The Marketplace will also send an updated EDN for all consumers in the household. All notices are mailed to the household contact and/or posted to their Marketplace accounts, depending on what they selected as their communication preference.

Q2: How will consumers identify the Medicaid/CHIP PDM notices, and what do the notices say?

A2: The subject of the initial warning notice reads *"Warning: Members of your household may lose financial help for their Marketplace coverage."* The notice lists the dually-enrolled consumers, and provides instructions to either end their Marketplace coverage with APTC/CSRs, or update their Marketplace application to tell the Marketplace that they're not enrolled in Medicaid or CHIP. The notice also provides instructions for consumers who want more information about Medicaid or CHIP, who aren't sure if their Medicaid or CHIP coverage qualifies as MEC, or who aren't sure whether they're enrolled in or have been determined eligible for Medicaid or CHIP.

The subject of the final notice reads *"IMPORTANT: Members of your household are still enrolled in a Marketplace plan but will no longer get financial help."* The notice lists the dually-enrolled consumers who did not take action by the date in the initial warning notice, tells them the date that Marketplace coverage without financial assistance becomes effective, and alerts the impacted consumers that they should end Marketplace coverage immediately if they don't want to pay full cost for their share of the Marketplace plan premium and covered services. The notice also provides instructions for consumers who want more information about Medicaid or CHIP, who aren't sure if their Medicaid or CHIP coverage qualifies as MEC, OR who aren't sure whether they're enrolled in or eligible for Medicaid or CHIP, as well as information on how to submit an appeal to the Marketplace if a consumer believes his or her financial assistance was ended incorrectly.

Copies of both notices will be available in English and Spanish.

Q3: As an assister, why might consumers contact me, and how can I help them?

A3: Consumers who receive either/both of the Medicaid/CHIP PDM notices may contact assisters: (a) for help understanding the notice(s); (b) for help ending Marketplace coverage with APTC/CSRs; (c) for help updating their Marketplace application to tell the Marketplace they're not enrolled in Medicaid/CHIP; (d) if they don't think they're enrolled in Medicaid or CHIP; (e) if they aren't sure if they've been determined eligible for Medicaid or CHIP, (f) if they aren't sure if they're enrolled in Medicaid or CHIP; or (g) if they want more information about whether their Medicaid or CHIP coverage qualifies as MEC. Here are some examples of the ways that assisters can help consumers who contact them:

- **Help consumers understand the notice(s).** Explain that the notice has been sent to them because the Marketplace has identified them as being enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP. This is important because consumers who've been determined eligible for Medicaid or CHIP are not eligible for a Marketplace plan with APTC/CSRs. Consumers who receive the notices should take immediate action.

- **Encourage consumers who have been determined eligible for or are enrolled in Medicaid or CHIP to take immediate action** to end their Marketplace coverage with APTC/CSRs. Explain the financial impact of not ending Marketplace coverage.

o See [these instructions on HealthCare.gov to help a consumer end Marketplace coverage when he or she has Medicaid or CHIP.](#)

- <https://www.healthcare.gov/help/end-marketplace-plan/>

o Medicaid/CHIP PDM User Interface Guide

- www.healthcare.gov/downloads/marketplace-medicaid-chip-guide.pdf

- **Help consumers who aren't enrolled in Medicaid or CHIP to update their Marketplace application accordingly.**

o Medicaid/CHIP PDM User Interface Guide

- www.healthcare.gov/downloads/marketplace-medicaid-chip-guide.pdf

- **Inform consumers who don't think they're enrolled in Medicaid or CHIP, who aren't sure if their Medicaid or CHIP benefits qualify as MEC, or if they aren't sure if they've been determined eligible for or if they're enrolled in Medicaid or CHIP**, that they should contact their state Medicaid or CHIP agency to confirm their enrollment status (instructions for doing so are in the notices). If the state agency confirms that the consumer is not eligible for or enrolled in MEC Medicaid or CHIP coverage, he or she should update his or her Marketplace application to tell the Marketplace that he or she is not enrolled in Medicaid or CHIP. However, if the state agency confirms that the consumer is eligible for or enrolled in MEC Medicaid or CHIP coverage, the consumer should end his or her Marketplace coverage with APTC/CSRs immediately (refer to the Medicaid/CHIP PDM User Interface Guide, above, for more information).
- **Advise consumers who want more information about Medicaid or CHIP** to contact their state Medicaid or CHIP agency.

Q4: What if a consumer is enrolled in Medicaid or CHIP that counts as qualifying coverage and Marketplace coverage with APTC/CSRs, but believes they are actually eligible to remain enrolled in Marketplace coverage with APTC/CSRs?

A4: A consumer who's enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP that counts as qualifying coverage may believe they are eligible to remain enrolled in Marketplace coverage with APTC/CSRs if they experienced a change in household or income that makes them no longer eligible for Medicaid/CHIP that counts as qualifying coverage. The consumer should contact the state Medicaid/CHIP agency to inform them of these circumstances. If the state Medicaid or CHIP agency informs the consumer that they are no longer eligible for Medicaid or CHIP that counts as qualifying coverage, the consumer should update their Marketplace application to state that they are not enrolled in Medicaid or CHIP that counts as qualifying coverage; they can remain in their Marketplace coverage with APTC/CSRs, if otherwise eligible.

Q5: How soon after the final notice is sent will the Marketplace end APTC/CSRs on behalf of affected consumers?

A5: The Medicaid/CHIP PDM final notice will include the date on which changes to financial assistance will become effective for the household.

For more information, please see [this FAQ document](#) for assisters:

[1] Most Medicaid is considered qualifying health coverage (also known as minimum essential coverage, or MEC). Some forms of Medicaid cover limited benefits (like Medicaid that only covers emergency care, family planning or pregnancy-related services) and aren't considered MEC. (For more information on which Medicaid programs are considered MEC, visit [HealthCare.gov/medicaid-limited-benefits/](https://www.healthcare.gov/medicaid-limited-benefits/)).

[2] References to the "Marketplace" throughout refer to the Federally-Facilitated Marketplace and State-Based Marketplaces using the federal eligibility and enrollment platform.

[3] Generally, a consumer who is eligible for income-based CSRs will also be eligible for APTC. However, not all consumers who are eligible for APTC will be eligible for income-based CSRs.

[4] In accordance with recent guidance from the Internal Revenue Service (IRS), if a Marketplace makes a determination or assessment that an individual is ineligible for Medicaid or CHIP and eligible for APTC when the individual enrolls in Marketplace coverage, the individual is treated as not eligible for Medicaid or CHIP for purposes of the premium tax credit while they are enrolled in Marketplace coverage for that year.

For more information, visit: https://www.irs.gov/PUP/taxpros/best-practices/resolving_1095_conflicts.pdf.

[5] Due to technical limitations, dually-enrolled consumers in the following Marketplace states will not receive notices in this round of Medicaid/CHIP PDM: Arkansas, Georgia, New Jersey, and Ohio. Consumers in these states will not be affected by this round of Medicaid/CHIP PDM.

[6] If a consumer still wants a Marketplace plan after having been determined eligible for MEC Medicaid or CHIP, he or she will have to pay full price for his or her share of the Marketplace plan premium and covered services, without APTC or income-based CSRs, if otherwise eligible.

###

How to Remove a Deceased Consumer from a Marketplace Account

CMS has provided guidance for how to terminate coverage for a deceased consumer. Consumers who are enrolled through the Federal Marketplace must report the death of an enrollee through their online Marketplace account or by calling the Marketplace Call Center. Assisters should be aware of the following:

- The application filer, or anyone in the household of the deceased enrollee who was included in the initial application for Marketplace coverage and is at least 18 years old, may report the termination of an enrollee's coverage. If the person taking the action to terminate the deceased person's coverage is the application filer, he or she can do so online through [HealthCare.gov](https://www.healthcare.gov) and then contact the Marketplace Call Center to report the date of death to make sure the termination is effective retroactive to the date of death, or he or she can take both actions through the Call Center. If the person taking the action to terminate the deceased person's coverage is not the application filer, but was on the original application and is at least 18 years old, they must contact the Marketplace Call Center.

- Consumers reporting a death should also contact the issuer regarding any applicable premium refunds or adjustments.
- If the consumer reporting the death is not the application filer, or not anyone in the household of the deceased who was included in the initial application for Marketplace coverage and is at least 18 years old, he or she must submit documentation of death to the Federal Marketplace. Consumers in this circumstance may submit documentation to the Marketplace prior to calling the Marketplace Call Center. Documentation may include a death certificate, obituary, power of attorney, proof of executor, or proof of estate. The documentation, or an attached cover note, should provide the following information: Full name of the deceased, date of birth of the deceased, FFM application ID (if known) of the deceased, Social Security Number (if known) of the deceased, and contact information for the person submitting the documentation. All documentation should be mailed to:

**Health Insurance Marketplace ATTN: Coverage Removal
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0001**

The Marketplace Call Center will contact the individual who submits documentation of death regarding the termination of the deceased and re-enrollment of any remaining enrollment group members. The remaining qualified individuals or enrollees may need to update tax filing status, financial information, or other information on their FFM application. These additional changes may qualify the remaining enrollees for a special enrollment period (SEP).

Assisters may read the guidance provided to issuers at this link:

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR-RemovalDueToDeath-102414-5CR-102414.pdf>

###

MACRA/Quality Payment Program (QPP) Updates

New Quality Payment Program Resources Available

Learn More about Merit-based Incentive Payment System (MIPS) Participation and the Improvement Activities Performance Category

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

CMS encourages MIPS clinicians to visit the website to review the following new materials:

- **[MIPS Participation Fact Sheet](#)**: Provides information about who is eligible to participate in MIPS, and how clinicians might be able to participate voluntarily in the program.
- **[MIPS Improvement Activities Fact Sheet](#)**: Includes information about choosing and submitting improvement activities, reporting criteria, and scoring.
- **[2017 CMS-Approved Qualified Registries](#)**: Includes the qualified registries that will be able to report data for the Quality, Advancing Care Information, and Improvement Activities performance categories in 2017.

###

Visit the EHR Incentive Programs Website to Access the Centralized Repository for Public Health Agency and Clinical Data Registry Reporting

The Centers for Medicare & Medicaid Services (CMS) developed a [Centralized Repository](#) for public health agencies (PHA) and clinical data registries (CDR) to provide a centralized source of information for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) looking for public health, clinical data, or specialized registry electronic reporting options.

[The Medicare and Medicaid EHR Incentive Programs](#) include several public health measures that require EPs, eligible hospitals, and CAHs to engage with a PHA or CDR to submit electronic public health data. The repository will assist providers in finding entities that accept electronic public health data.

Please Note: CMS' Centralized Repository is not the authoritative source of all public health reporting options currently available. For the Medicare or Medicaid EHR Incentive Program, the absence of an entry in the CMS Centralized Repository is not sufficient documentation for claiming an exclusion and should not prevent a provider from reporting to a registry. Providers must check with the jurisdictional public health agencies or specialty societies to which they belong and document that information to satisfy Medicare or Medicaid reporting.

For More Information

Review [FAQ 13657](#) and [FAQ 14117](#) for steps providers should take to determine if there is a specialized registry available, or if they can claim an exclusion. To learn more about what qualifies as a specialized registry, please review [FAQ 13653](#)

###

Review 2017 Program Requirements in the 2017 OPPS/ASC Final Rule on the EHR Incentive Programs Website

Providers who have not demonstrated meaningful use successfully in a prior year and are seeking to demonstrate meaningful use for the first time in 2017 to avoid the 2018 payment adjustment must attest to Modified Stage 2 objectives and measures. Providers who have demonstrated meaningful use successfully in a previous year may attest to Stage 3 objectives and measures starting in 2017.

CMS encourages eligible hospitals, CAHs, and dual-eligible hospitals to visit the [EHR Incentive Programs website](#) for more details about the [2017 program requirements](#) outlined below.

OPPS/ASC Final Rule with Comment Period:

- Eliminated the Clinical Decision Support (CDS), and the Computerized Provider Order Entry (CPOE) objectives and measures beginning in 2017;
- Reduced the threshold for the View, Download or Transmit (VDT) measure of the Patient Electronic Access Objective to at least one unique patient (or patient-authorized representative) for Modified Stage 2;
- Reduced the thresholds for a subset of Patient Electronic Access to Health Information, Coordination of Care through Patient Engagement, Health Information Exchange, and Public Health Reporting and Clinical Data Registry measures for Stage 3;
- Added [new naming conventions for measures](#); and
- Requires that actions occur within the EHR reporting period, or the calendar year in which the EHR reporting period occurs, in order to be included in the numerators for specific measures.

For More Information

Visit the EHR Incentive Programs website and review the following materials:

- Modified [Stage 2](#) and [Stage 3](#) Attestation Worksheets for Eligible Hospitals, CAHs, and Dual-Eligible Hospitals.
[Overview of the OPPS/ASC Final Rule Changes for the EHR Incentive Programs](#)

###

Submit Comments on Proposed Changes to EHR Incentive Programs by June 13

The Centers for Medicare & Medicaid Services (CMS) issued the FY 2018 Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) rule on April 14, 2017, which proposes a number of changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The publication date is scheduled for April 28, 2017.

The proposals include:

- For CY 2018, modifying the EHR reporting period from the full calendar year to a minimum of any continuous 90-day period for new and returning participants in the Medicare and Medicaid EHR Incentive programs.
- Adding a new exception from the Medicare payment adjustments for Eligible Professionals (EPs), Eligible Hospitals, and Critical Access Hospitals (CAHs) that demonstrate through an application process that complying with the requirement for being a meaningful EHR user

is not possible because their certified EHR technology has been decertified under ONC's Health IT Certification Program.

- Implementing a policy in which no payment adjustments will be made for EPs who furnish "substantially all" of their covered professional services in an ambulatory surgical center (ASC); applicable for the 2017 and 2018 Medicare payment adjustments.
- Using Place of Service (POS) code 24 to identify services furnished in an ASC as well as requesting public comment on whether other POS codes or mechanisms should be used to identify sites of service in addition to or in lieu of POS code 24.

Submit a Formal Comment by 5:00 p.m. ET on Tuesday, June 13

The public can submit comments in several ways:

- Electronically
- By regular mail
- By express or overnight mail
- By hand or courier

Please review the Proposed Rule for specific instructions for each method and submit by ONLY one method.

For More Information

To learn more, review the [proposed rule](#) and visit the [CMS website](#).

###

Join the Conversation about Fostering Innovation in Electronic Data Exchange for eMeasurement and Quality Improvement

On Thursday, May 4, from 9:00 a.m. to 1:00 p.m. ET, the Office of the National Coordinator for Health Information Technology (ONC), supported by Discern Health, will host a roundtable discussion on opportunities to foster innovation in electronic data exchange for eMeasurement and quality improvement. National thought leaders will share their experiences and insights about innovative approaches. The public is invited to participate and comment.

The meeting will offer a summary of research on the current state and future opportunities to promote better health and care, improved communication and transparency, rapid translation of knowledge for all stakeholders, and reduction in the burden of data collection and reporting for providers. The discussion will focus on various approaches to innovation, including evolving ideas of how registries, data aggregators, and technology solutions interact with systems at the point of care; how organizations are approaching data standardization and quality improvement; and key attributes of evolving eMeasurement and quality improvement models.

Participation Information

Please register for the **Innovations in the Use of Electronic Health Data for eMeasurement and Quality Improvement webinar** [here](#) to participate. After you register, you will receive a dial-in number and webinar link. Please check your spam filter if you do not receive an email confirmation.

###

Complete a Short Online Exercise to Help CMS Improve its Quality Payment Program Website

CMS is looking for participants to complete a 10- to 15-minute online exercise to improve the design and usability of the [Quality Payment Program \(QPP\) website](#). The goal is to improve how information should be organized on the QPP website and to make it easier to use. If you are interested in helping CMS improve the QPP website, please [complete the exercise now](#).

###

2017 MIPS Data Validation and Auditing

The Centers for Medicare & Medicaid Services (CMS) posted a data validation factsheet and excel document for all categories of Merit-based Incentive Payment System (MIPS). The purpose of these documents is to publically provide the criteria used to audit and validate measures and activities for the transition year of MIPS in the Quality, Advancing Care Information and Improvement Activities performance categories.

Eligible clinicians are encouraged to retain documentation for six years as required by the CMS document retention policy. These documents provide guidance on what records and data to maintain in the event that a clinician or group is selected for a data validation or audit request in future years.

For more information click here under "Documents & Downloads" dated April 26th, 2017:
<https://app.cms.gov/resources/education>

###

CAPG Complimentary Educational Series 2017: Quality Payment Program Webinars with CMS

This Session: How to Select Measures and Maximize Quality Performance in MIPS

- **Date:** Friday, May 5, 2017
- **Time:** 3:00 to 4:30 PM ET / 12:00 – 1:30 PM
- **Registration link:** <http://eventcenter.commpartners.com/se/Rd/Rg.aspx?527230>

CAPG is pleased to present a complimentary new webinar series for physicians and physician groups implementing the Medicare Access and CHIP Reauthorization Act (MACRA) through the [Quality Payment Program \(QPP\)](#). Through a co-branding agreement with the [Centers for Medicare & Medicaid Services \(CMS\)](#), the sessions will combine CMS expertise on the regulation's content with CAPG members' knowledge of how clinicians are responding on the ground to these important changes.

In this session, CMS's Dr. David Nilasena will review MACRA's requirement for quality reporting, reporting mechanisms, and scoring methodology, and will answer questions on the specific quality component of the Quality Payment Program (QPP). CAPG members Dr. Susan Merrill and Dr. Matt Poffenroth will describe how they're selecting measures for optimal success, and will share the rationale behind their strategies and its implications for their organizations. Speakers are:

- David S. Nilasena, MD, Chief Medical Officer, CMS Region 6
- Susan Merrill, PhD, MPH, Director, Ambulatory Quality and Patient Safety, John Muir Physician Network
- Matt Poffenroth, MD, CEO and CMO, Signature Partners, Inova Health System

###

MIPS Group Reporting 101

- **Date:** Thursday, May 11, 2017
- **Time:** 1:00 – 2:30 PM ET
- **Registration link:** <https://engage.vevent.com/rt/cms/index.jsp?seid=773>

During the webinar, CMS will provide an overview of group reporting under MIPS and highlight requirements for participation, including:

- Individual vs. Group Reporting
- Group Reporting Requirements
- Performance Category Measures
- Data Submission Mechanisms
- Post-Data Submission
- Participation Milestones

###

MIPS Participation Status Letter

The Centers for Medicare & Medicaid Services is reviewing claims and letting practices know which clinicians need to take part in [MIPS](#), the Merit-based Incentive Payment System. MIPS is an important part of the new [Quality Payment Program](#). In late April through May, practices will get a letter from the [Medicare Administrative Contractor that processes Medicare Part B claims](#). This letter will tell the participation status of each MIPS clinician associated with the Taxpayer Identification Number or TIN in a practice.

Clinicians should participate in MIPS for the 2017 transition year if they bill more than \$30,000 in Medicare Part B allowed charges a year AND provide care for more than 100 Part B-enrolled Medicare beneficiaries a year.

The Quality Payment Program intends to shift reimbursement from the volume of services provided toward a payment system that rewards clinicians for their overall work in delivering the best care for patients. It replaces the Sustainable Growth Rate formula and streamlines the “Legacy Programs” Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM), and the Medicare Electronic Health Records (EHR) Incentive Program. During this first year of the program CMS is committed to diligently working with you to streamline the process as much as possible. Our goal is to further reduce burdensome requirements so that you can deliver the best possible care to patients. Learn more about the [Quality Payment Program](#) and the [Quality Payment Program MIPS Participation status mailing](#) (these materials can also be found on [the Education & Tools page of the Quality Payment Program website](#)).

###

CMS is Accepting Measure Submissions for the Advancing Care Information Performance Category until June 30

There's still time to submit measures for the Advancing Care Information performance category of the Merit-based Incentive Payment System (MIPS). **The Centers for Medicare and Medicaid Services' (CMS) Annual Call for Measures and Activities ends June 30, 2017.**

CMS encourages providers to identify and submit measures for the MIPS Advancing Care Information performance category. To be considered, proposals must include specific criteria including, but not limited to, measure description, measure type and numerator and denominator descriptions.

CMS requests that stakeholders consider outcome-based measures, patient safety measures, and measures are cross cutting which use certified EHR technology to support the improvement activities and quality performance categories of MIPS.

How to Submit

Please use the [Advancing Care Information Submission Form](#) to propose measures for inclusion, and send the form to CMSCallforMeasuresACI@ketchum.com.

For More Information

To learn more about the process for submitting measures, please visit the [Call for Measures](#) webpage, and review the [Call for Measures and Activities fact sheet](#).

###

Getting Started with the Quality Payment Program - Small, Rural, and Underserved Practices: Micro Videos Now Available

On February 1, 2017, we held a webinar specific to clinicians in small, rural, and underserved practices on Getting Started with the Quality Payment Program. While the [75-minute recording is available for review](#), we have heard that most of our stakeholders are pressed for time. Therefore, we have taken the master recording and created seven short, self-paced educational videos that are 15 minutes or less. This allows you to choose the information that is important to you, as well as the pace you want to learn. These micro videos are available on [YouTube](#) and at the bottom of our [Events page](#), under "Informational videos."

###

Quality Payment Program YouTube Playlist Reorganization

We have recently reorganized the resources available on the Quality Payment Program YouTube playlist. We hope this reorganization makes it easier for you to locate educational materials. Here's what's on YouTube and how it's organized:

Quality Payment Program main playlist: http://go.cms.gov/QPP_YouTube

All Quality Payment Program videos are posted to this list, in addition to being posted on one of the other related lists below.

Quality Payment Program: MIPS (Merit-based Incentive Payment System) playlist:
http://go.cms.gov/MIPS_YouTube

All MIPS-related videos are posted to this list.

Quality Payment Program: APMs (Alternative Payment Models) playlist:
http://go.cms.gov/APM_YouTube

All APM-related videos are posted to this list.

Quality Payment Program: Virtual Groups playlist: http://go.cms.gov/VG_YouTube
All virtual group-related videos are posted to this list.

Quality Payment Program: Small, Rural, and Underserved Practices playlist:
http://go.cms.gov/Rural_YouTube
All small, rural, and underserved practices-related videos are posted to this list.

###

Now Available: Accredited Online Course – Quality Payment Program in 2017: Pick Your Pace

A new, online and self-paced course on participating in the Quality Payment Program and Picking a Pace that meets the needs of your practice is now available through the [MLN Learning Management System](#)! Learners will receive information on:

- The basics of the Quality Payment Program;
- Steps to take to actively participate in the Quality Payment Program to avoid a payment penalty and possibly earn a positive payment adjustment; and
- Factors to consider in choosing how to participate in the program through either the Merit-based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (APM).

This course is part of an evolving curriculum on the Quality Payment Program, where learners will gain knowledge and insight on the program all while earning valuable continuing education credit. Keep checking back with us for updates on new courses.

The Centers for Medicare & Medicaid Services designates this enduring material for a maximum of 0.5 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Credit for this course expires May 30, 2020.

AMA PRA Category 1 Credit™ is a trademark of the American Medical Association.

[Please click here for accreditation statements.](#)

###

Accountable Health Communities Model Update

The Centers for Medicare & Medicaid Services (CMS) has announced the participants for the Assistance and Alignment Tracks of the Accountable Health Communities (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 Accountable Health Communities Model Assistance Track will provide person-centered community service navigation services to assist high-risk beneficiaries with accessing needed services. The organizations in the

Accountable Health Communities Model 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 the needs of beneficiaries.

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, please visit the [Accountable Health Communities Model web page](#).

###

National Minority Health Month: Bridging Observance and Action to Achieve Health Equity

Each April we observe National Minority Health Month. This year's theme was, [Bridging Health Equity Across Communities](#). This theme acknowledges the important role that social determinants of health play in individual and community well-being. It also evokes action and activity around health equity. For it is not enough for us to simply observe National Minority Health Month and share statistics on long-standing health and health care disparities. We should strive to move the needle by reducing these disparities and improving health care quality and outcomes for all. As this National Minority Health Month, comes to a close, I'm hoping each of us can take a moment and consider the following question:

What will it take to achieve health equity?

CMS has adopted a health equity framework that focuses on increasing understanding and awareness of disparities, developing and disseminating solutions, and implementing sustainable action. As we have sought to implement this framework, we have identified a number of areas that need to be considered when addressing a specific disparity– the social determinants of health, data, and the seven “A’s”.

First and foremost, we need to **acknowledge** there is a problem to be addressed. We need to **agree** on the goal and identify what resources will be necessary to meet it. Resources can be difficult to come by, so determining how the goal **aligns** with existing priorities may be key. Next we must decide what **actions** do we need to take to achieve our goal? Are we already doing some or all of them?

Seven A's for Addressing Health Equity

1. **Acknowledge** there is a problem to be addressed.
2. **Agree** on the goal, and identify what resources are necessary to meet it.
3. **Align** the goal with existing priorities.
4. Determine what **actions** are needed to achieve the goal.
5. Create **alliances** to implement the actions.
6. **Analyze** progress, and adjust the plan as necessary.
7. Have shared **accountability** for reaching the goal.

We know that health equity cannot be achieved by a single individual or organization, so forging **alliances** and working together is critical. We also know that we must be able to measure our progress. Having data and doing **analysis** of it are important for the development, assessment, and revision of our health equity plan. The last of the A's requires us to be **accountable** and ask

the question – what happens if we do not reach our goal? There shouldn't be one person or organization responsible for the success or failure of a plan, but a shared accountability.

While we are considering each of the seven A's, we must also consider the myriad of social factors that influence health and well-being of individuals and the communities in which they reside. Whether we refer to them as social risk factors or social determinants of health, we know that things such as socioeconomic position, race, ethnicity, cultural context, gender, social relationships, and residential and community context affect our health more than the care we receive from our health care providers. We must consider these factors as we think about our goals, the actions we need to take, and the alliances we forge.

Finally, achieving health equity is going to require the collection, analysis, and reporting of data across various demographic categories, including race, ethnicity, disability, and geography. Only through this process will we be able to identify disparities and measure their reduction or elimination and ultimately determine the success of our efforts.

The CMS Office of Minority Health is helping to embed these actions across CMS and HHS. For example, we routinely [share HEDIS and CAHPS quality measures](#) stratified by race, ethnicity, and gender, providing health plans with actionable data to innovate and prioritize health equity and quality improvement activities. Organizations participating in the [Accountable Health Communities Model](#) will be monitoring disparities as they link beneficiaries with community services. We are working with our sister agency, the Health Resources and Services Administration's, Federal Office of Rural Health Policy on a [Chronic Care Management Education and Outreach Campaign](#). The campaign is focused on professionals and consumers in underserved rural areas, and racial and ethnic minorities. We are also collaborating with organizations outside the federal government to help reduce [readmissions](#) among racially and ethnically diverse beneficiaries, and to develop their own [plans](#) for achieving health equity.

As we continue on our path to equity, we encourage you to consider the seven A's, the role of social risk factors, and the importance of data in your day-to-day activities. Recommit every day to the ultimate goal of achieving health equity by bridging observance and action during the remainder of National Minority Health Month and throughout the year.

To learn more about achieving health equity and other activities underway at the CMS Office of Minority Health, visit: go.cms.gov/omh.

###

Skilled Nursing Facilities: Proposed FY 2018 Payment and Policy Changes

CMS issued a proposed rule (CMS-1679-P) outlining proposed FY 2018 Medicare payment rates and quality programs for Skilled Nursing Facilities (SNFs). Additionally, CMS released an Advance Notice of Proposed Rulemaking (CMS-1686-ANPRM), which solicits comment on potential revisions to the SNF payment system, based on research conducted under the SNF Payment Models Research project.

Proposed Rule Details:

- Changes to payment rates under the SNF Prospective Payment System (PPS)
- SNF Quality Reporting Program
- SNF Value-Based Purchasing (VBP) Program
- End-Stage Renal Disease Quality Incentive Program

- Request for Information
- Survey team composition

For More Information:

- [Proposed Rule](#): CMS will accept comments until June 26
- [Advanced Notice of Proposed Rulemaking](#): CMS will accept comments until June 26
- [SNF PPS Payment Model Research](#) webpage
- [SNF PPS](#) website
- [SNF QRP](#) website
- [SNF VBP Program](#) website

See the full text of this excerpted [CMS Fact Sheet](#) (issued April 27).

###

Inpatient Rehabilitation Facilities: Proposed FY 2018 Payment and Policy Changes

CMS issued a proposed rule (CMS-1671-P) outlining proposed FY 2018 Medicare payment policies and rates for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program (QRP). In addition to the proposed rule, CMS is releasing a Request for Information to welcome continued feedback on the Medicare Program.

Proposed Rule Details:

- Proposed updates to IRF payment rates
- Proposed removal of 25 percent payment penalty for late transmissions of the IRF- Patient Assessment Instrument
- Proposed refinements to the 60 percent rule presumptive methodology
- Solicitation of comments regarding the criteria used to classify facilities for payment under the IRF PPS
- Proposed technical IRF process revisions
- Proposed changes to the IRF QRP

For More Information:

- [Proposed Rule](#): CMS will accept comments until June 26

See the full text of this excerpted [CMS Fact Sheet](#) (issued April 27).

###

Medicare Hospice Benefit: Proposed FY 2018 Updates to the Wage Index and Payment Rates

CMS issued a proposed rule (CMS-1675-P) that would update FY 2018 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries and releases Request for Information within the proposed rule. This proposed rule would update the hospice wage index, payment rates, and cap amount for FY 2018.

Proposed Rule Details:

- Routine annual rate setting changes
- Discussion and solicitation of comments regarding sources of clinical information for certifying terminal illness
- Hospice CAHPS® Experience of Care Survey
- Quality measure concepts under consideration for future years
- New data collection mechanisms under consideration: Hospice Evaluation & Assessment Reporting Tool (HEART)
- Public reporting

For More Information:

- [Proposed rule](#): CMS will accept comments until June 26
- [Hospice Center](#) webpage

See the full text of this excerpted [CMS Fact Sheet](#) (issued April 27).

###

Medicare and Medicaid Updates

New Mailbox Announcement

Effective April 13, 2017, questions regarding any of the Fee For Service Beneficiary Notice Initiative (BNI) notices may be sent to our new mailbox: BNImailbox@cms.hhs.gov.

The BNI notices are:

- FFS Advance Beneficiary Notice of Noncoverage (FFS ABN)
- FFS Home Health Change of Care Notice (FFS HHCCN)
- FFS Skilled Nursing Facility Advance Beneficiary Notice (FFS SNFABN) and SNF Denial Letters
- FFS Hospital-Issued Notices of Noncoverage (FFS HINNs)
- FFS Expedited Determination Notices for Home Health Agencies, Skilled Nursing Facility, Hospice and Comprehensive Outpatient Rehabilitation Facility (FFS Expedited Determination Notices)
- Important Message from Medicare (IM) and Detailed Notice of Discharge (DND) (Hospital Discharge Appeal Notices)
- FFS Notice of Exclusion from Medicare Benefits - Skilled Nursing Facility (FFS NEMB SNF)

There is an exception for the Medicare Outpatient Observation Notice (MOON). Continue to send questions regarding the MOON to MOONMailbox@cms.hhs.gov.

###

IMPACT Act Data Elements Public Comments Due June 26th

CMS has contracted with the RAND Corporation to develop standardized patient/resident assessment data elements in alignment with the Improving Medicare Post-Acute Care Transformation Act of 2014 ([IMPACT Act](#)).

CMS seeks comments from stakeholders on data elements that meet the IMPACT Act domains of cognitive function and mental status; medical conditions and co-morbidities; impairments; medication reconciliation; and care preferences. The Call for Public Comment period opens on April 26, 2017 and closes on June 26, 2017.

For more information, view the [public comment](#) webpage.

###

CMS Proposes 2018 Payment and Policy Updates for Medicare Hospital Admissions, Releases a Request for Information

Proposed rule seeks transparency, flexibility, program simplification and innovation to transform the Medicare program

On April 14, CMS issued a [proposed rule](#) that would update 2018 Medicare payment and policies when patients are admitted into hospitals. The proposed rule aims to relieve regulatory burdens

for providers; supports the patient-doctor relationship in health care; and promotes transparency, flexibility, and innovation in the delivery of care.

"Through this proposed rule we want to reduce burdens for hospitals so they can focus on providing high quality care for patients," said CMS Administrator Seema Verma. "Medicare is better able to support the work of dedicated hospitals and clinicians who provide the care that people need with these more flexible and simplified approaches."

CMS is committed to transforming the health care delivery system – and the Medicare program – by putting a strong focus on patient-centered care, so providers can direct their time and resources to patients and improve outcomes. In addition to the payment and policy proposals, CMS is releasing a Request for Information to solicit ideas for regulatory, policy, practice and procedural changes to better achieve transparency, flexibility, program simplification and innovation. This will inform the discussion on future regulatory action related to inpatient and long-term hospitals.

In relieving providers of administrative burdens and encouraging patient choice, CMS is proposing:

- a one year regulatory moratorium on the payment policy threshold for patient admissions in long-term care hospitals while CMS continues to evaluate long-term care hospital policies
- to reduce clinical quality measure reporting requirements for hospitals that have implemented electronic health records

Due to the combination of proposed payment rate increases and other proposed policies and payment adjustments, CMS projects that hospitals would see a total increase in inpatient operating prospective payments of 2.9 percent in fiscal year 2018. CMS also projects that, based on the changes included in the proposed rule, payments to long-term care hospitals would decrease by approximately 3.75 percent in fiscal year 2018.

For More Information:

- Full text of this excerpted [CMS press release](#) (issued April 14)
- [CMS fact sheet](#)

###

CMS Releases Quality Data Showing Racial, Ethnic and Gender Differences in Medicare Advantage Health Care During National Minority Health Month

In recognition of National Minority Health Month, the Centers for Medicare & Medicaid Services, Office of Minority Health (CMS OMH) released a pair of reports detailing the quality of care received by people enrolled in Medicare Advantage (MA). One report compares quality of care for women and men while the other report looks at racial and ethnic differences in health care experiences and clinical care, among women and men. Each April, in recognition of National Minority Health Month, CMS plans to make additional reports available online on the CMS OMH website.

"This is the first time that CMS has released Medicare Advantage data on racial and ethnic disparities in care separately for women and men. Showing the data this way helps us to understand the intersection between a person's race, ethnicity, and gender and their health care," said Dr. Cara James, Director of the CMS Office of Minority Health.

The first [report focusing on gender](#) revealed sizable differences in quality of treatment for certain conditions among MA beneficiaries. In particular, women received better treatment for chronic lung disease and rheumatoid arthritis and were more likely than men to receive proper follow-up care after being hospitalized for a mental health disorder. In contrast, women were less likely than men to receive timely treatment for alcohol or drug dependence, and they were more likely to be dispensed medications that are potentially harmful to people with certain medical conditions such as dementia.

The second [report on racial and ethnic group comparisons](#) separated by gender, is a follow-up to a November 2016 [report](#) released by CMS Office of Minority Health which presented racial and ethnic group comparisons without stratifying by gender. The report released today shows that disparities between Black and White MA beneficiaries in rates of colorectal cancer screening, treatment for chronic lung disease and acute myocardial infarction, and management of rheumatoid arthritis were larger for men than for women.

Healthcare professionals, organizations, researchers and hospital leaders can utilize today's reports along with other CMS tools and [resources](#) to help raise awareness on health disparities and develop interventions for racially and ethnically diverse Medicare beneficiaries.

The reports were prepared in collaboration with the RAND Corporation, and are based on an analysis of two sources of information scores received in 2014-2015 and may be used by plans to improve health care quality and accountability for different racial and ethnic groups by gender at the national level.

The first source is the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS collects information from medical records and administrative data on the technical quality of care that Medicare beneficiaries receive for a variety of medical issues, including diabetes, cardiovascular disease, and chronic lung disease. The second source of information is the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, which is conducted annually by CMS and focuses on the health care experiences of Medicare beneficiaries across the nation.

The information provided by these reports are not used to evaluate care through the Part C and D Star Ratings program and are not used for payment purposes.

The CMS Office of Minority Health welcomes your participation in promoting health observances throughout the year to raise awareness about health issues affecting people across our nation. Share our resources on today's reports, prevention, health equity, and research about health disparities.

###

Medicare Column on New Chronic Care Illness Benefits and Campaign

Q: What is the new Medicare benefit for those with Chronic Illness?

A. If you have Medicare, there's a good chance you have two or more chronic conditions such as arthritis, cancer, diabetes, heart disease, or dementia.

Two-thirds of the 57 million Americans with Medicare have two or more chronic illnesses. Having multiple chronic conditions increases the risk of death and functional limitations, decreases quality of life, and leads to higher health care spending.

Managing chronic diseases can be difficult, to say the least. You often face multiple visits to one or more doctors; you must take multiple drugs at different times on different days; you have to make extra trips for tests. It can all be a bit overwhelming.

At Medicare, we recognize the challenges you have in managing your conditions, working with your health care providers, and trying to stay healthy. Two years ago, we added a new benefit called Chronic Care Management, or CCM. This program provides additional payments to doctors and other providers to help you live with chronic disease.

For example, through the CCM benefit your primary-care doctor will help you keep track of your medical history, medications, and all the different health care providers you see. You'll receive a comprehensive care plan that outlines your treatments and goals. Additionally, you'll have 24-hour-a-day, 7-day-a-week access to health care professionals for urgent needs from the comfort of your home.

To be eligible for CCM services, you must be enrolled in Medicare or in both Medicare and Medicaid. And you must have two or more chronic diseases that are expected to last at least 12 months and place you at significant risk of death, acute exacerbation/decompensation, or functional decline.

Other examples of chronic conditions include, but are not limited to, asthma, atrial fibrillation, autism spectrum disorder, chronic kidney disease, chronic obstructive pulmonary disease, depression, heart failure, hepatitis, hypertension (high blood pressure), infectious diseases such as HIV/AIDS, ischemic heart disease, osteoporosis, schizophrenia and other psychotic disorders, and stroke.

Specific CCM services may include:

- At least 20 minutes a month of chronic care management services;
- Personalized assistance from a dedicated health care professional who will work with you to create your care plan;
- Coordination of care between your pharmacy, specialists, testing centers, hospitals, and more;
- Phone check-ins between visits to keep you on track;
- 24/7 emergency access to a health care professional;
- Expert assistance with setting and meeting your health goals.

How much do CCM services cost? You'll be responsible for the usual Medicare Part B cost-sharing and may have a deductible or coinsurance/co-pay. However, many people with Medicare have a Medigap supplemental insurance that may pay some of the costs of what Medicare does not pay.

Chronic Care Management means having a continuous relationship with a dedicated health care professional who knows you and your history, gives personal attention, and helps you make the best choices for your health. CCM gives you and your loved ones the assistance you need to manage your chronic conditions so you can spend more time doing the things you enjoy.

Ask your doctor about Chronic Care Management and get the connected care you need.

For more information, call 1-800-MEDICARE or visit: go.cms.gov/ccm.

You can always get answers to any of your Medicare questions by calling 1-800-MEDICARE (1-800-633-4227).

###

Learn about the FY 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule and Request for Information

On April 14, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to update 2018 Medicare payment and policies when patients are admitted into hospitals.

The agency also released a Request for Information (RFI) to solicit ideas for regulatory, policy, practice and procedural changes to better achieve transparency, flexibility, program simplification and innovation. This RFI is meant to inform the discussion on future regulatory action related to inpatient and long-term hospitals.

CMS will accept comments on the proposed rule and the RFI until Tuesday, June 13, 2017.

In the rule, CMS proposed an increase of about 1.6 percent in operating payment rates for general acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) that participate successfully in the Hospital Inpatient Quality Reporting (IQR) program and are meaningful electronic health record users. The agency projects the rate increase—together with other proposed changes to IPPS policies—will increase IPPS operating payments by about 1.7 percent.

In addition, CMS estimates that proposed changes in uncompensated care payments will increase IPPS operating payments by an additional 1.2 percent, for a total increase in IPPS operating payments of 2.9 percent.

Meanwhile, CMS has proposed a one-year regulatory moratorium on the payment policy threshold for patient admissions in long-term care hospitals while CMS continues to evaluate long-term care hospital policies. CMS also proposed to reduce clinical quality measure reporting requirements for hospitals that have implemented electronic health records.

For More Information

To find the press release and fact sheet about the proposed rule, please visit: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-04-14.html>

To learn more about the proposed rule (CMS-1677-P) and the Request for Information, please visit: <https://www.federalregister.gov/public-inspection/current>

###

Rural Community Hospital Demonstration

Overview

The Centers for Medicare & Medicaid Services (CMS) is conducting the Rural Community Hospital Demonstration Program, which was originally authorized for a 5-year period by section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and extended for another 5-year period by sections 3123 and 10313 of the Patient Protection and Affordable Care Act (Affordable Care Act). Section 15003 of the 21st Century Cures Act, enacted December 13, 2016, again amended section 410A of the MMA to require another 5-year extension period for the demonstration.

Section 15003 of the Cures Act allows for hospitals that were participating in the demonstration as of the last day of the initial 5-year period or as of December 30, 2014 to participate in this second extension period, unless the hospital makes an election to discontinue participation.

Section 15003 also requires that no later than 120 days after enactment of the Cures Act that the Secretary issue a solicitation for applications to select additional hospitals to participate in the demonstration program for this second 5-year extension period so long as the maximum number of 30 hospitals stipulated by the ACA is not exceeded.

Background

The MMA requires testing the feasibility and advisability of establishing rural community hospitals to furnish covered inpatient hospital services to Medicare beneficiaries. The demonstration tests payment under a reasonable cost-based methodology for Medicare inpatient hospital services furnished by rural hospitals with fewer than 51 acute care inpatient beds, that make available 24-hour emergency care services, and that are not eligible to be, or have not been designated as, Critical Access Hospitals (CAH).

CMS has conducted 3 previous solicitations for applications – in 2004 and 2008, in accordance with the MMA, and in 2010, upon re-authorization by the Affordable Care Act.

The MMA requires the demonstration to be budget neutral. Each year since 2004, CMS has included a segment specific to the demonstration program in the proposed and final rules for the Medicare inpatient prospective payment system (IPPS). On an annual basis, this segment has detailed the status of the demonstration, as well as the methodology for ensuring budget neutrality. CMS intends to continue this approach of proposing the budget neutrality methodology in annual IPPS rulemaking.

The MMA also requires a Report to Congress with recommendations for such legislation and administrative action as the Secretary determines appropriate. This evaluation will assess the impact of the demonstration on the financial viability of participating hospitals as well as their ability to serve the needs of the community.

Provisions of the 21 Century Cures Act

Section 15003 of the 21st Century Cures Act provides for the following regarding the second 5-year extension period:

- Hospitals that were participating as of the last day of the initial 5-year period or as of December 30, 2014 will be allowed to participate in the second extension period, unless the hospital makes an election to discontinue participation.
- Not later than 120 days after the date of enactment (December 13, 2016), the Secretary is required to issue a solicitation for applications to select additional hospitals to participate in the demonstration program.
- The requirement in the Affordable Care Act remains that the total number of hospitals participating in the demonstration at the same time not exceed 30.
- A newly selected hospital may be located in any state; however, priority for selection is to be given to hospitals located in one of the 20 states with the lowest population densities (as determined by the Secretary using the *2015 Statistical Abstract of the United States*).
- Applicant hospitals must meet the eligibility criteria in the original authorizing statute.
- Rural hospital closures in the 5-year period immediately preceding the date of the enactment of the Cures Act and the population density of the state may be considered in selecting hospitals.
- The Secretary shall submit a report to Congress no later than August 1, 2018.

Demonstration Payment Methodology

Hospitals participating in the demonstration will receive payment for Medicare inpatient hospital services, with the exclusion of services furnished in a psychiatric or rehabilitation unit that is a distinct part of the hospital, using the following rules:

- For discharges occurring in the first cost reporting period on or after the implementation of the extension, their reasonable costs of providing covered inpatient hospital services;
- For discharges occurring during the second or subsequent cost reporting period, the lesser of their reasonable costs or a target amount. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the Inpatient Prospective Payment System (IPPS) update factor (as defined in section 1886(b)(3)(B)) of the Social Security Act for that particular cost reporting period. The target amount in subsequent cost reporting periods is defined as the preceding cost reporting period's target amount increased by the IPPS update factor for that particular cost reporting period.

Implementation

CMS will develop a participation agreement specifying payment principles, as well as administrative, auditing, and reporting requirements. This participation agreement will apply to

each hospital participating in the second extension period. CMS will communicate with the hospitals on policy and operational issues.

Extension Period for Previously Participating Hospitals under the Cures Act

In general, each hospital that participated in the Affordable Care Act-authorized extension period began its period of performance under the extension period with the start of its cost report period (in 2010, 2011, or 2012 depending on when the hospital was originally selected), and concluded with the end of the fifth consecutive cost report period. Accordingly, hospitals ended their periods of performance under this first extension period on a rolling basis from December 31, 2014 through December 31, 2016. Twenty-one hospitals remained in the demonstration for the duration of their hospital-specific 5-year periods for this first extension period.

CMS is seeking public comment in the Fiscal Year 2018 IPPS proposed rule (CMS-1677-P) with regard to the initiation of the period of performance for those among these previously participating hospitals that decide to participate in the extension period authorized by the legislation. CMS is proposing that the 5-year period of performance for each of these hospitals, as well as for each of the additional hospitals newly selected would begin with the start of the first cost reporting period on or after October 1, 2017 following upon the announcement of the selection of additional hospitals. More information about this proposal can be found in the Fiscal Year 2018 IPPS/LTCH PPS proposed rule. CMS is accepting comments through 06-13-2017.

Request for Applications

The Request for Applications solicits information from interested hospitals regarding their financial and service-oriented challenges, as well as strategies and proposals for addressing them. We are also asking hospitals to describe the impact of rural hospital closures on the needs of their service area, and problems posed by the need to serve a sparse population.

As permitted by the 21st Century Cures Act, additional hospitals selected for the demonstration under this solicitation may be located in any State.

The solicitation identifies the 20 states with lowest population density according to the most recent data source, i.e., population estimates from the Census Bureau for 2013, from the *ProQuest Statistical Abstract of the United States, 2015*. The U.S. Census Bureau no longer publishes the *Statistical Abstract*; instead, ProQuest compiles data and tables from the Census Bureau and produces this compendium. These 20 States are: Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont, and Wyoming. CMS will give priority for selection among the highest scoring applications to applicants from these States.

The following eligibility requirements must be met for a hospital to be considered for participation in the demonstration. These requirements are specified in section 410A of the MMA, the original authorizing legislation. An applicant must be a hospital that:

- Is located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E) of the Act (42 U.S.C. 1395ww(d)(8)(E));

- Has fewer than 51 acute care inpatient beds, as reported in its most recent cost report (not including beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital);
- Makes available 24-hour emergency care services; and
- Is not eligible for Critical Access Hospital (CAH) designation, or has not been designated a CAH under section 1820 of the Social Security Act.

The due date for applications to CMS is **May 17, 2017**. The Request for Applications is available at <https://innovation.cms.gov/initiatives/Rural-Community-Hospital/>. The goal is to finalize selections by June 2017.

###

Medicare's Chronic Care Management Campaign Resources Available

Two-thirds of the 57 million Americans with Medicare have two or more chronic illnesses. Having multiple chronic conditions increases the risk of death and functional limitations, decreases quality of life, and leads to higher health care spending.

The Centers for Medicare & Medicaid Services, CMS, recognizes the challenges Medicare beneficiaries have in managing their conditions, working with their health care providers, and trying to stay healthy. Two years ago, CMS added a new benefit called Chronic Care Management, or CCM. This program provides additional payments to doctors and other providers to help beneficiaries live with chronic disease.

Just recently, CMS has launched *The Connected Care* campaign to educate health care professionals, and patients about the benefits of chronic care management. If a Medicare beneficiary lives with two or more chronic conditions, that are expected to last at least 12 months and place them at significant risk of death, acute exacerbation/decompensation, or functional decline, then they may be eligible for chronic care management (CCM) services to help them maximize their health and spend more time with their loved ones.

Example of chronic conditions include, but are not limited to, arthritis, cancer, diabetes, heart disease, dementia, asthma, atrial fibrillation, autism spectrum disorder, chronic kidney disease, chronic obstructive pulmonary disease, depression, heart failure, hepatitis, hypertension (high blood pressure), infectious diseases such as HIV/AIDS, ischemic heart disease, osteoporosis, schizophrenia and other psychotic disorders, and stroke.

Through the CCM benefit a beneficiary's primary-care doctor will help them keep track of their medical history, medications, and all the different health care providers they see. They'll receive a comprehensive care plan that outlines their treatments and goals. Additionally, they'll have 24-hour-a-day, 7-day-a-week access to health care professionals for urgent needs from the comfort of their home.

The education campaign to providers will help them better understand how to implement chronic care management resources and help them educate patients as well as make providers aware of the additional separate payment amounts available through three new billing codes implemented on January 1, 2017.

CMS Regional External Affairs teams are reaching out to organizations who work to educate Medicare beneficiaries to make them aware resources such as the [Connected Care Partner Toolkit](#) that includes shareable educational resources, such as sample language for newsletters, and blogs, factsheets and frequently asked questions FAQs. Also, available are posters, and postcards to reach Medicare beneficiaries with the message to ask their doctor about Chronic Care Management to get the connected care they need.

If you are interested in ordering the posters or postcards, please send which product, your quantity request, along with your shipping address to CCM@cms.hhs.gov.

We greatly appreciate your help in making Medicare beneficiaries aware that chronic care management benefits are available through their physician, and that they should talk to their doctor about them.

For more information, call 1-800-MEDICARE or visit: [Connected Care: The Chronic Care Management Resource website](#).

###

New Issue Brief: Opportunities to Improve Nutrition for Older Adults and Reduce Risk of Poor Health Outcomes

The Administration for Community Living (ACL) has announced a new Issue Brief that addresses opportunities to improve nutrition for older adults and also reduce the risk of poor health outcomes. The issue brief is available [here](#).

During National Nutrition Month, ACL focuses on the issue of nutrition, because as people age, they may experience malnutrition. Appetite and the body's ability to process food may decrease with age, while health conditions and use of medications that can affect nutrition status may increase. In addition, limited ability to shop for and prepare food can affect a person's access to it. Factors like isolation and depression also can affect nutrition.

Malnutrition may lead to poor health in older adults. Fortunately, states, aging and health service providers, and health plans can access evidence about opportunities to improve older adults' nutrition status. Interventions include provision of meals and meal enhancements. These interventions can improve the nutrition status of many older adults who are at risk of undernutrition in the community or in the hospital. Evidence shows that Older Americans Act nutrition programs also help older adults.

The issue brief offers examples for states and others to consider about how they might improve older adults' health and well-being through malnutrition interventions.

Examples the issue brief describes could assist state and local officials from State Units on Aging, Medicaid programs, and health care organizations that serve older adults. Please note that this issue brief does not address nutrition in group residences like nursing homes and assisted living.

###

February 2017 Medicaid and CHIP Application, Eligibility Determination, and Enrollment Report and Data Highlights

The Centers for Medicare & Medicaid Services (CMS) released a monthly report on state Medicaid and Children's Health Insurance Program (CHIP) data represents state Medicaid and CHIP agencies' eligibility activity for the calendar month of February 2017. The report is one of a [series of reports](#) on state Medicaid and CHIP data, and it includes data reported by states. This report measures eligibility and enrollment activity for the entire Medicaid and CHIP programs in all states, reflecting activity for all populations receiving comprehensive Medicaid and CHIP benefits in all states, including states that have not yet chosen to adopt the new low-income adult group established by the Affordable Care Act.

This data is submitted to CMS by states using a common set of indicators designed to provide information to support program management and policy-making related to application, eligibility, and enrollment processes. As with previous reports, this month's report focuses on those indicators that relate to the Medicaid and CHIP application and enrollment process.

Click here to view the report (PDF):

<https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

[Read additional background information about the monthly enrollment report.](#)

###

Upcoming Webinars and Events and Other Updates

Join the Conversation about Fostering Innovation in Electronic Data Exchange for eMeasurement and Quality Improvement

On Thursday, May 4, from 9:00 a.m. to 1:00 p.m. ET, the Office of the National Coordinator for Health Information Technology (ONC), supported by Discern Health, will host a roundtable discussion on opportunities to foster innovation in electronic data exchange for eMeasurement and quality improvement. National thought leaders will share their experiences and insights about innovative approaches. The public is invited to participate and comment.

The meeting will offer a summary of research on the current state and future opportunities to promote better health and care, improved communication and transparency, rapid translation of knowledge for all stakeholders, and reduction in the burden of data collection and reporting for providers. The discussion will focus on various approaches to innovation, including evolving ideas of how registries, data aggregators, and technology solutions interact with systems at the point of care; how organizations are approaching data standardization and quality improvement; and key attributes of evolving eMeasurement and quality improvement models.

Participation Information

Please register for the **Innovations in the Use of Electronic Health Data for eMeasurement and Quality Improvement webinar** [here](#) to participate. After you register, you will receive a dial-in number and webinar link. Please check your spam filter if you do not receive an email confirmation.

###

Medicare Basics Webinar for Partners

The Centers for Medicare & Medicaid Services (CMS) Kansas City Regional Office invites you to Medicare Basics Webinar for Partners. The webinar will provide high level information and resources, and will be beneficial to partners who are new to working with Medicare beneficiaries and those who would like a refresher.

Topics to be covered are:

- Medicare Part A
- Medicare Part B
- Medicare Part C
- Medicare Part D
- Medicare Supplements/Medigap
- Extra Help
- Q&A

When:

Wednesday, May 3, 2017, 2:00PM –3:00PM CT

Register:

<https://medicarebasicswebinar.eventbrite.com>

You will receive a confirmation email from Eventbrite after completing your registration, which will include the login information for the webinar.

We look forward to your participation. If you have any questions or have difficulty registering, please contact Elissa Balch at Elissa.Balch@cms.hhs.gov.

Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 E 12th Street
Kansas City, MO 64106
Ph: 816.426.5233
ROkcmORA@cms.hhs.gov

###

Join us for the Learning Series Webinar

May 11, 2017 1:00 - 2:30 pm EDT

The Center for Program Integrity will discuss CMS' approach to combating the opioid epidemic, including priority areas which aim to:

- Implement more effective strategies to reduce the risk of opioid use disorders, overdoses, inappropriate prescribing, and drug diversion
- Expand the use and distribution of naloxone
- Expand screening, diagnosis, and treatment of opioid use disorders
- Increase the use of evidence-based practices for acute and chronic pain management

To join the webinar, visit <https://goto.webcasts.com/starthere.jsp?ei=1129992>.

###

The Centers for Medicare & Medicaid Services (CMS) presents an
Informational Webinar Series for Agents and Brokers:

May 3, 2017 Webinar

Date	Time	Topic
Wednesday, May 03, 2017	1:00 PM – 2:00 PM ET	Special Enrollment Period (SEP) Overview for Agents and Brokers

This webinar will provide agents and brokers operating within the Marketplace an overview of SEP qualifying events, prior coverage requirements, and coverage start dates. Participants will learn about which SEPs are available to consumers, as well as when qualifying consumers' coverage may start based on SEP type and plan selection date.

Please visit www.REGTAP.info for further details

Registrar@REGTAP.info

###

New From Coverage to Care Video, Budget Guide

New resources are available to help consumers understand how to use health insurance and how to pay for their health care costs on a limited budget. From Coverage to Care can show consumers how to maximize health coverage to put health first and live a long and healthy life. Watch the [How to Maximize Your Health Coverage video](#) to learn more.

The [new Manage Your Health Care Costs guide](#) is a series of tools for assisters and other community organizations who are helping a consumer understand health insurance costs and terms, know their own specific health insurance costs, plan for health care costs, and know how to pay their premium.

For more information From Coverage to Care visit go.cms.gov/c2c.

###

CMS Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Open Door Forum

Date: Thursday, May 4, 2017 Start Time: 2:00 PM – 3:00 PM Eastern Time (ET);

Please dial-in at least 15 minutes before call start time.

Conference Leaders: Todd Smith & Jill Darling

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

I. Opening Remarks

Chair – Todd Smith (Center for Medicare)

Moderator – Jill Darling (Office of Communications)

II. Announcements & Updates

- FY 2018 SNF PPS Proposed Rule
- General Update
- Quality Reporting Program
- Value Based Purchasing
- FY 2018 SNF Advance Notice of Proposed Rulemaking
- PBJ Update
- Policy Questions should be sent to: NHStaffing@cms.hhs.gov
- Technical Issues/Questions should be sent to: NursingHomePBJTechIssues@cms.hhs.gov
- PBJ Website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html>
- Link to S&C memo for PBJ update: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-17-25.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>

III. Open Q&A **DATE IS SUBJECT TO CHANGE**

Next ODF: June 22, 2017

Mailbox: SNF_LTCODF-L@cms.hhs.gov

CMS Open Door Forums will now be available through Podcasts. Please visit:

<https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html>. Please allow a week or so to get it posted. Thank you.

Open Door Participation Instructions:

This call will be Conference Call Only.

To participate by phone:

Dial: 1-800-837-1935 & Reference Conference ID: 58669897

Persons participating by phone do not need to RSVP. TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

Encore: 1-855-859-2056; Conference ID: 58669897 Encore is an audio recording of this call that can be accessed by dialing 1-855-859-2056 and entering the Conference ID. Encores for ODFs held on Thursdays can be accessed the following Monday. The recording is available for 3 business days.

###

Open Door Forum: TEP on Development and Maintenance of Quality Measures for SNF QRP: Nominations due May 12, 2017

Nominations are due May 12, 2017 for a Technical Expert Panel (TEP) to develop and maintain quality measures reflective of quality of care for SNFs in support of the CMS quality missions. Quality measures will be developed consistent with the three broad aims and six priorities of the National Quality Strategy, and the CMS Quality Strategy.

Visit the [Technical Expert Panels](#) webpage for more information.

Spread the Word About National Women's Health Week: May 14–20, 2017

Background

[National Women's Health Week](#) is led by the U.S. Department of Health and Human Services (HHS) [Office on Women's Health](#) (OWH). The 18th annual observance kicks off on Mother's Day, May 14, and is celebrated through May 20, 2017. National Women's Health Week encourages women to make their health a priority and reminds them to take steps for better health at every age. HHS OWH encourages women to:

- Visit a doctor or nurse for a well-woman visit (checkup) and [preventive screenings](#).
- [Get active](#).
- [Eat healthy](#).
- Pay attention to [mental health](#), including getting enough sleep and managing stress.
- Avoid unhealthy behaviors, such as [smoking](#), [texting while driving](#), and not wearing a seatbelt or bicycle helmet.

We hope you'll join the celebration and help us spread the word using the ideas below. We've included some sample social media messages for you to share, but please feel free to create your own. Remember to use **#NWHW** in any messages you share about the week!

Promote Our Website Features

Share the National Women's Health Week "What's your health style?" quiz.

Encourage women to take our quiz to learn about their health style. Their results will reveal whether they're taking steps to be their healthiest selves.

- Social media message: *What's your health style? Find out if you're taking steps to be your healthiest you, because you're worth it.* <https://go.usa.gov/xXntC> #NWHW

Encourage women to take steps for a healthier life — no matter their age!

Women's health needs change as they age. Whether they're in their 20s or 90s, we offer steps women can take to improve their physical and emotional health. Visit our Steps for Better Health by Age pages and encourage your followers to do the same!

- Social media message: *Age is nothing but a number! You're never too young or too old to take steps for better health.* <https://go.usa.gov/xXkwN> #NWHW

Join Our Social Media Activities

Join the National Women's Health Week [Thunderclap](#). Please encourage your followers to do the same:

- Social media message: *Supporting women's health is as easy as donating a #NWHW tweet or post. Join the [@womenshealth](#) [@ThunderclapIt](#).* <http://bit.ly/2ITqGSE>

Share our social media messages or create your own. Use #NWHW in any messages you share about the week.

Facebook	Twitter
Messages for Sunday, May 14: Kickoff	
Happy Mother's Day and National Women's Health Week! Now's the time to learn what steps you can take to be your healthiest you: https://go.usa.gov/xXkwK . #NWHW	Happy Nat'l Women's Health Week! Learn what steps you can take to be your healthiest you: https://go.usa.gov/xXkwK . #NWHW #MothersDay
Where does your health fall on your to-do list? Take the National Women's Health Week quiz to find out. https://go.usa.gov/xXntC	Where does your health fall on your to-do list? Take the #NWHW quiz to find out. https://go.usa.gov/xXntC
Messages for Monday, May 15: Annual checkup	
Need help meeting your health goals? Who doesn't? No matter your age, scheduling an annual checkup can help you get started. https://go.usa.gov/xXkwK #NWHW	Need help meeting your health goals? No matter your age, scheduling a checkup can help you get started. https://go.usa.gov/xXkwK #NWHW
Messages for Tuesday, May 16: Get active	

Whether you're dancing, running, or hiking, get moving! Make sure you're getting 30 minutes of physical activity every day. https://go.usa.gov/xXkwK #NWHW	Whether you're dancing, running, or hiking, get moving for 30 minutes a day! https://go.usa.gov/xXkwK #NWHW
Messages for Wednesday, May 17: Eat healthy	
It's never too late to improve your eating habits! Pick ONE change you can make today. Try drinking water instead of soda or eating whole-grain bread instead of white bread. #NWHW https://go.usa.gov/xXkwK	Swap chips for apples or soda for water. Make 1 change to improve your eating habits. It's never too late! https://go.usa.gov/xXkwK #NWHW
Messages for Thursday, May 18: Pay attention to mental health	
Healthy bodies need healthy minds. Talk to your doctor about stress, depression, or any other mental health concerns you may have. #NWHW https://go.usa.gov/xXkwK	Your mind is just as important as your body. Talk to your doctor about stress, depression, or other concerns. https://go.usa.gov/xXkwK #NWHW
Messages for Friday, May 19: Avoid unhealthy behaviors	
Risky behaviors, like texting and driving, can put you and your loved ones in danger. It's up to you to take control! #NWHW https://go.usa.gov/xXkwK	Risky behaviors can put you in danger. In the car, buckle up and pull over to text. https://go.usa.gov/xXkwK #NWHW
Messages for Saturday, May 20: Wrap-up messages	
It may be the last day of National Women's Health Week, but it's not too late to learn what you can do to be healthy at any age. #NWHW https://go.usa.gov/xXkwK	It may be the last day of #NWHW, but it's not too late to learn what you can do to be healthy at any age. https://go.usa.gov/xXkwK

Like OWH on [Facebook](#) and follow us on [Twitter](#) and [Pinterest](#). Then share, retweet, and save our content!

Add Information to Your Website and Resources

Add the National Women's Health Week [logo or web banner](#) to your website. Use the [logo](#) on any materials you create for the week.

Write about National Women's Health Week. Share information about the week through your newsletter, blog, or website. For messaging ideas, check out our [National Women's Health Week fact sheet](#), our [ideas for celebrating](#), or use the language below.

Sample Newsletter, Blog, or Website Text
Say Yes! to your health this National Women's Health Week by taking steps toward a healthier you.

Led by the U.S. Department of Health and Human Services (HHS) Office on Women's Health (OWH), National Women's Health Week reminds women to take simple, manageable steps to improve their overall well-being. HHS OWH encourages women to:

- Visit a doctor or nurse for a well-woman visit (checkup) and [preventive screenings](#).
- [Get active](#).
- [Eat healthy](#).
- Pay attention to [mental health](#), including getting enough sleep and managing stress.
- Avoid unhealthy behaviors, such as [smoking](#), [texting while driving](#), and not wearing a seatbelt or bicycle helmet.

As women age, their health needs change. Whether you're in your 20s or 90s, HHS OWH offers specific [steps you can take toward a healthier you at every age](#). Decide that today is the day to take at least one step for better health, because you're worth the investment! Start by [learning about your health style](#)!

For more information about National Women's Health Week, visit www.womenshealth.gov/nwhw. You also can follow HHS OWH on [Facebook](#), [Twitter](#), and [Pinterest](#). And don't forget to use **#NWHW** in any messages you share about the week.

###

April is Alcohol Awareness Month



The National Institute on Alcohol Abuse and Alcoholism recommends that people over age 65 have no more than 7 alcoholic drinks a week and no more than 3 drinks on any one day. For more information visit the [National Institute on Alcohol Abuse and Alcoholism's website](#).

[Medicare Part B \(Medical Insurance\)](#) covers the alcohol misuse screening & counseling screening once per year for adults who don't meet the medical criteria for alcohol dependency. For more information, visit medicare.gov/coverage/alcohol-counseling.html or [watch this video](#).

###



Introducing a new section to our NTP update. It will provide links and resources to commonly asked questions. Some of the topics will be seasonal or tied to national health topic awareness campaigns and others will reflect your interests. If you have suggestions or comments about this section, email us at training@cms.hhs.gov.

Volunteer Appreciation Week is just around the corner. Be it on the front line helping people with Medicare or training other volunteers to help the over 100 million Americans that rely on our programs, the CMS National Training Program thanks you for your time and dedication. We have a variety of [job aids](#) to help you help others. Check out the overview of PowerPoint so you can easily edit our training modules to meet your audience's needs. Share your favorite tool with another volunteer to show your appreciation of his or her efforts.

April is also National Occupational Therapy (OT) Month. Visit [medicare.gov/coverage/pt-and-ot-and-speech-language-pathology.html](https://www.medicare.gov/coverage/pt-and-ot-and-speech-language-pathology.html) for more information about what's covered.

###

March 29th, 2017 National Medicare Education Program (NMEP) Meeting

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) -

Providing information and assistance to provider, patients and families regarding beneficiary complaints, discharge appeals and immediate advocacy

Health Care Fraud Trends - Common and emerging health care fraud trends including specialty topics such as Medical identity theft, criminal enterprises, and the use of data analytics to detect, investigate, and prevent fraud.

Medicare and You Handbook - Overview of the Medicare & You Handbook.

The link below will take you to the presentations, transcript, and audio recording of the meeting.
<https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/NationalMedicareEducationProgram.html>

###

From Coverage to Care: Step 2 Webinar

The Wednesday, April 12, 2017 webinar, which included presentations on From Coverage to Care: Step 2 from [A Roadmap to Better Care and a Healthier You](#), Tips for FFM Assistants on Working with Outside Organizations, and Internal Claims and Appeals and the External Review Processes Overview can be viewed here: <https://goto.webcasts.com/starthere.jsp?ei=1130234>.

The next webinar is tentatively scheduled for Friday May 12, 2017 at 2pm ET. Tentative topics include From Coverage to Care: Step 3 from [A Roadmap to Better Care and a Healthier You](#), an overview of the Market Stabilization final rule, and an update on round 3 of Medicare PDM.

###

CAPG Complimentary Educational Series 2017: Quality Payment Program Webinars with CMS

This Session: How to Select Measures and Maximize Quality Performance in MIPS

- **Date:** Friday, May 5, 2017
- **Time:** 3:00 to 4:30 PM ET / 12:00 – 1:30 PM
- **Registration link:** <http://eventcenter.commpartners.com/se/Rd/Rg.aspx?527230>

CAPG is pleased to present a complimentary new webinar series for physicians and physician groups implementing the Medicare Access and CHIP Reauthorization Act (MACRA) through the [Quality Payment Program \(QPP\)](#). Through a co-branding agreement with the [Centers for Medicare & Medicaid Services \(CMS\)](#), the sessions will combine CMS expertise on the regulation's content with CAPG members' knowledge of how clinicians are responding on the ground to these important changes.

In this session, CMS's Dr. David Nilasena will review MACRA's requirement for quality reporting, reporting mechanisms, and scoring methodology, and will answer questions on the specific quality component of the Quality Payment Program (QPP). CAPG members Dr. Susan Merrill and Dr. Matt Poffenroth will describe how they're selecting measures for optimal success, and will share the rationale behind their strategies and its implications for their organizations. Speakers are:

- David S. Nilasena, MD, Chief Medical Officer, CMS Region 6
- Susan Merrill, PhD, MPH, Director, Ambulatory Quality and Patient Safety, John Muir Physician Network
- Matt Poffenroth, MD, CEO and CMO, Signature Partners, Inova Health System

###

MIPS Group Reporting 101

- **Date:** Thursday, May 11, 2017
- **Time:** 1:00 – 2:30 PM ET
- **Registration link:** <https://engage.vevent.com/rt/cms/index.jsp?seid=773>

During the webinar, CMS will provide an overview of group reporting under MIPS and highlight requirements for participation, including:

- Individual vs. Group Reporting
- Group Reporting Requirements
- Performance Category Measures
- Data Submission Mechanisms
- Post-Data Submission
- Participation Milestones

###

Medicare Learning Network Publications & Multimedia

News & Announcements

- [2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply May 1 through 31](#)
- [IRF/LTCH/SNF QRP Data Due May 15](#)
- [Rural Community Hospital Demonstration: Submit Applications by May 17](#)
- [New Quality Payment Program Resources Available](#)
- [Revised CMS-588: Electronic Funds Transfer Authorization Agreement](#)
- [SNF QRP Quick Reference Guide Now Available](#)
- [Beneficiary Notice Initiative: New Email Address for Questions](#)
- [Accountable Health Communities Model: CMS Selects 32 Participants](#)
- [Mapping Medicare Disparities Tool: Identify Disparities in Chronic Disease](#)
- [Questions about Medicare Enrollment Revalidation?](#)
- [Administrative Simplification: New Fact Sheet and Infographic](#)

Provider Compliance

- [Billing for Ambulance Transports](#)
- [Psychiatry and Psychotherapy CMS Provider Minute Video 1679-P](#)

Medicare Learning Network Publications & Multimedia

- [Medicare Shared Savings Program Call: Audio Recording and Transcript — New](#)
- [Provider Compliance Products Fact Sheet — Revised](#)
- [Provider Compliance Tips for Spinal Orthoses Fact Sheet — Revised](#)
- [SNF Billing Reference Booklet — Revised](#)
- [April 2017 Catalog Available](#)
- [Quality Payment Program in 2017: Pick Your Pace Web-Based Training Course — New](#)
- [2017 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training Course — New](#)
- [Medicare Quarterly Provider Compliance Newsletter \[Volume 7, Issue 3\] Educational Tool — New](#)
- [IMPACT Act Call: Audio Recording and Transcript — New](#)
- [Educational Resources to Assist Chiropractors with Medicare Billing MLN Matters Article — Revised](#)
- [Home Health Prospective Payment System Booklet — Revised](#)

###

New Publications On-line

- [Exemptions from the Fee for Not Having Health Coverage](#)
- [Medicare Hospice Benefits](#)
- [Medicare and Home Health Care](#)

- [Medicare & Hospice Benefits: Getting Started](#)
- [Closing the Coverage Gap - Medicare Prescription Drugs are Becoming More Affordable](#)
- [A Quick Look at Medicare](#) - German
- [A Quick Look at Medicare](#) - Farsi
- [A Quick Look at Medicare](#) - Armenian
- [A Quick Look at Medicare](#) - Japanese
- [A Quick Look at Medicare](#) - Arabic
- [A Quick Look at Medicare](#) - Polish
- [A Quick Look at Medicare](#) - Portuguese
- [A Quick Look at Medicare](#) - Russian
- [A Quick Look at Medicare](#) - Chinese
- [A Quick Look at Medicare](#) - Tagalog
- [A Quick Look at Medicare](#) - Vietnamese
- [A Quick Look at Medicare](#) - Italian
- [A Quick Look at Medicare](#) - Haitian Creole
- [A Quick Look at Medicare](#) - French
- [A Quick Look at Medicare](#) - Korean

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