CMS Region 7 Updates – 08/18/2017

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ACA/Marketplace Updates

2018 Health Insurance Exchanges Issuer County Map

The Centers for Medicare and Medicaid Services today posted an update to the Health Insurance Exchanges Issuer County Map. This map is of projected issuer participation on the Health Insurance Exchanges in 2018 based on the known issuer public announcements through August 23, 2017. Participation is expected to fluctuate and does not represent actual Exchange application submissions.

This map currently shows that nationwide 1 county is projected to have no issuers, meaning that Americans in these counties could be without coverage on the Exchanges in 2018. It's also projected that 1,478 counties - over 45 percent of counties nationwide - could have only one issuer in 2018. This could represent more than 2.6 million Exchange participants with only one health insurance option, which means they will not have any choices.

###

2018 Assister Training Updates

We are pleased to invite all assisters to take the 2018 Assister Certification Training that went live August 4, 2017.

The training is hosted by the Marketplace Learning Management System (MLMS); the online web-based training platform for assisters providing application and enrollment assistance to consumers in Federally-Facilitated Marketplaces (FFMs), including State Partnership Marketplaces (SPMs), and certain State-based Marketplaces using the Federal platform (SBM-FPs). The training can be accessed through the CMS Enterprise Portal by logging in or registering as a new user at https://portal.cms.gov/wps/portal/unauthportal/registration. Existing users can login at: https://portal.cms.gov.

We hope that you were able to participate in the Wednesday, August 2 webinar at 2pm ET on the 2018 training and certification requirements. You can view the webinar slides here: https://marketplace.cms.gov/technical-assistance-resources/training-materials/2018-launch-ffm-assister-training.pdf.

You can find training presentations and additional resources, such as Frequently Asked Questions (FAQs), and MLMS Quick Reference Guides at the following link: https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html.

For additional assistance with questions on the MLMS assister training, please submit inquiries to MLMSHelpDesk@cms.hhs.gov. For assistance with CAC program questions, submit inquiries to CACQuestions@cms.hhs.gov. For assistance with Navigator program questions, submit inquiries to your CMS project officer.

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Assister Bulletin Released

CMS also released the 2017 Assister Certification Bulletin which outlines the Navigator and certified application counselor (CAC) certification and recertification requirements for the 2018 plan year, including the certification training curriculum for the Federally-facilitated Marketplace (FFM). In this bulletin, we refer to this updated training curriculum as the "2018 training." The 2018 training is available through the Marketplace Learning Management System (MLMS) and can be accessed through the CMS Enterprise Portal by logging in or registering as a new user at https://portal.cms.gov/wps/portal/unauthportal/registration.

Existing users can login at: https://portal.cms.gov. Click here to view the 2018 Assister Certification Bulletin.

###

Updates to Citizenship and Immigration Verification Services at the Federally-Facilitated Marketplace

Key Takeaway: Starting in August, the Federally-facilitated Marketplace (Marketplace)[1] began resolving more consumers' citizenship or immigration status electronically with the Department of Homeland Security (DHS), without requiring the consumer to provide additional documentation right away.

Overview

As part of determining eligibility for enrollment in a qualified health plan (QHP), the Marketplace attempts verification of certain application information provided by the consumer with trusted data sources.

If a consumer attests on his or her Marketplace application to being a naturalized or derived citizen of the United States, or attests to having a verifiable immigration status, the Marketplace attempts to verify the consumer's citizenship or immigration status through DHS via the Federal Data Services Hub (Hub). The DHS database that is used to electronically verify citizenship and immigration status is known as the Systematic Alien Verification for Entitlements (SAVE) program.

The SAVE program consists of three steps:

- Step 1 includes real-time verification of a consumer's citizenship or immigration status through the Hub with DHS while a consumer navigates through and submits his or her application for coverage through the Marketplace.
- Step 2 can take between three to five business days and includes additional verification of a consumer's attested citizenship or immigration status by DHS.
- Step 3 is a manual process started by DHS if a consumer's citizenship or immigration status cannot be verified through Step 2, and can take up to 20 business days.

Previously, if the Marketplace was unable to verify a consumer's citizenship or immigration status during the application process through SAVE Step 1, a Data Matching Issue (DMI) was created for follow-up and processing, at which point CMS reviewed consumers through a manual verification process.

Beginning in August 2017, the Marketplace will begin using enhanced functionality called SAVE Step 2 to more seamlessly verify citizenship or immigration status. This functionality allows the Marketplace to verify more consumers electronically through the Hub, and reduces the need for some consumers to provide documentation in order to resolve their citizenship or immigration status DMI. Note: all consumers with citizenship or immigration status DMIs will still have the option to submit documentation to resolve their DMI, if they choose.

New language in the Eligibility Determination Notice (EDN) will alert consumers that the Marketplace is continuing to attempt to verify their citizenship or immigration status electronically with trusted data sources. All notices will be mailed and/or posted to the Marketplace account of the household contact for the affected consumer(s) (depending on what the household contact selected as his or her communication preference). If the household contact has selected a preference for email communication, the Marketplace will send an email to inform him or her that a new notice is available for review in his or her account.

[1] References to the Federally-facilitated Marketplace refer throughout to the Federally-facilitated Marketplace and State-based Marketplaces using the federal eligibility and enrollment platform.

Q&A: How to help consumers with questions related to citizenship or immigration verification processes

Q1: How will consumers identify the different notices, and what does each notice say?

A1: The Marketplace has updated language in the EDN under the section titled "What should I do next?" for consumers whose applications will be processed through this enhanced SAVE Step 2 functionality.

If a U.S. Citizen or National receives a citizenship DMI:

- The EDN will now read: "*For each person listed here: We're still confirming your U.S. citizenship information. We'll send you another notice when this is complete, and we may ask you to upload or mail documents to help us confirm your information. If you already have documents to confirm your citizenship status, you may want to send them now to help with this process. If your citizenship information isn't confirmed by [date], your eligibility for Marketplace health coverage may end.*"
- If the consumer decides to take action to provide additional documentation, a list of acceptable documents that can be used to resolve the DMI are included in the notice.

If a consumer receives an immigration DMI:

- The EDN will now read: "*For each person listed here: We're still confirming your immigration information. We'll send you another notice when this is complete, and we may ask you to upload or mail documents to help us confirm your information. If you already have documents to confirm your immigration status, you may want to send them now to help with this process. If your immigration status isn't confirmed by [date], your eligibility for Marketplace health coverage may end.*"
- If the consumer decides to take action to provide additional documentation, a list of acceptable documents that can be used to resolve the DMI are included in the notice.

If a consumer receives an immigration DMI with a notice regarding status expiration:

- The EDN will now read: "*For each person listed here: According to our data, your immigration status is about to expire. Upload or mail documentation to confirm your most recent immigration status. If you don't send documents by [date], your eligibility for Marketplace health coverage may end.*"
- If the consumer decides to take action to provide additional documentation, a list of acceptable documents that can be used to resolve the DMI are included in the notice. If a consumer's attested citizenship or immigration status is verified successfully through SAVE Step 2, a **Resolution Notice** will be sent to the household contact for the impacted consumer. The headline of the notice states: "*The Health Insurance Marketplace has verified citizenship or immigration status information for [first name, last name of impacted consumer(s)]*." No further action is required of the consumer to verify this information. Note: this resolution is specific to immigration and/or citizenship status. The individual may still need to provide documentation to resolve another DMI type. Copies of the notice are available in English and Spanish, and language assistance services are available to consumers who need help in another language.

Q2: Why might consumers contact me after receiving a notice related to citizenship or immigration status verification, and how can I help them?

A2: Consumers whose citizenship or immigration attestations are processed through SAVE Step 2 may contact you for help understanding the notice and determining next steps. Here are some examples of ways you can help:

- **Help consumers understand the notice**. Explain that when they see language in their EDN that says the Marketplace is still confirming their eligibility, it's because the Marketplace is still trying to verify their information electronically. If a consumer's status cannot be verified through this electronic process, the consumer will need to submit additional documentation to verify his or her citizenship or immigration

status to establish eligibility for enrollment in a QHP. The Marketplace will send a follow-up notice to the household contact for the impacted consumer if he or she needs to send additional documents.

- **Help consumers who receive a citizenship or immigration status DMI** to resolve the issue within the 95-day timeframe by helping them submit additional documentation, as needed, to prove the impacted consumer's lawful presence (see instructions on HealthCare.gov: https://www.healthcare.gov/verify-information/send-more-info/). Explain that CMS is still trying to verify their citizenship or immigration status electronically, and will send another notice when that is complete. However, because CMS may still need consumers to upload or mail documents, the impacted consumer may want to send those documents now to expedite the process, though this is not required at this time.

Advise consumers who want updates on citizenship or immigration status verification to log into their Marketplace online account and review the "Application Details" page or to contact the Marketplace Call Center.

###

Phase 2: Pre-enrollment SEP Verification (SEPV) Process Overview

On June 23, 2017, CMS launched Phase 1 of the SEPV process to verify SEP eligibility for consumers newly enrolling in Marketplace coverage through loss of qualifying coverage and move Special Enrollment Period (SEP) types. Under the process, the Marketplace creates an **SEP Verification Issue, referred to as an SVI**, for *new* Marketplace applicants who submit an application and attest to information that qualifies them for an SEP that's subject to pre-enrollment verification. These consumers are required to submit documents to confirm their SEP eligibility before they can complete enrollment, make their first premium payment, and start using their Marketplace coverage.

- Click here to view slides from an assister webinar on the SEPV process.
- Click here to view a fact sheet on the SEPV process.

On August 23, 2017, CMS will start Phase 2 of SEPV for three additional SEP types:

- Marriage
- Gaining or becoming a dependent through an adoption, foster care placement, or a child support or other court order
- Medicaid/Children's Health Insurance Program (CHIP) denial after applying for Medicaid/CHIP during Open Enrollment.

What do consumers need to confirm?

To prove a marriage, consumers must submit documents to confirm the marriage happened up to 60 days before they applied for Marketplace coverage. These documents must include the names of the people who were married and the date of the marriage.

To prove an adoption, placement in foster care, child support or other court order, consumers must confirm that someone on the application was adopted, placed in foster care, or became a dependent due to a court order in the 60 days *before* they applied for Marketplace. These documents must be signed by a government or court official, showing who was adopted, placed in foster care, or became a dependent due to a court order and the date of the qualifying event.

To prove a denial of coverage through Medicaid or CHIP, consumers must return to their application or newly apply for coverage within the 60 days after their Medicaid or CHIP denial and submit documents to confirm who was determined ineligible for Medicaid/CHIP coverage and the date they were determined ineligible.

- The FFM will attempt to verify a denial of coverage through Medicaid/CHIP electronically by checking for an inbound account transfer and checking FFM internal application records. If this SEP is verified this way, no SVI will be created and enrollment can process without document submission.
- For those whose SEP cannot be verified electronically, consumers should upload or mail one or more documents as described above.

A list of acceptable documents consumers can submit to prove these SEP types will be available on HealthCare.gov in the coming weeks.

Resources on SEPV

Model Notices: Click here to view sample EDNs, PPS notices, and other consumer notices.

HealthCare.gov Content on Submitting Documents:

- Click here to view documents consumers can submit to prove a loss of qualifying coverage.
- Click here to view documents consumers can submit to prove a move.
- Click here to view instructions for submitting documents online or by mail.

Assister Resources:

- SEPV Overview: Assister Webinar Slides
- 5 Things Assisters, Agents, and Brokers Should Know About SVIs: Fact Sheet

Resources on SEPs:

- SEP Overview: Assister Webinar Slides
- Special Enrollment Periods Available to Consumers: Fact Sheet

Important Update Regarding SEPV Phase 2 on Healthcare.gov

As a reminder, Special Enrollment Period Pre-Enrollment Verification (SEPV) Phase 2 is scheduled to begin August 23rd, 2017. Consumers newly enrolling in Marketplace coverage through SEPs related to gaining/becoming a dependent due to marriage, adoption, foster care placement, or court order, and SEPs related to a Medicaid/CHIP denial will be requested to submit verification documents prior to proceeding to plan selection in his or her Marketplace application.

To reflect these new changes and requirements, Healthcare.gov is in the process of upgrading and making modifications to the existing application. Recently, consumers and assisters have seen new questions related to those SEPs appearing on the application. Even though these new questions appear, along with a note that the consumer may need to submit documents, their Eligibility Determination Notice will not include any statement to that effect until August 23rd. *Documents for these 3 SEPs will not be required for any enrollments prior to August 23rd.*

###

Guidance on Annual Eligibility Redeterminations and Re-Enrollments for Exchange Coverage for 2018

In July, the Centers for Medicare & Medicaid Services (CMS) issued guidance on annual eligibility redetermination and re-enrollment (ARR) outlining the policies the Federally-facilitated Marketplace (FFM) will operationalize for the upcoming Open Enrollment Period. These policies and procedures ensure that an enrollee may take no action and maintain coverage across benefit years and this guidance serves as a model for State-based Marketplaces to follow, if desired.

Click here for additional information on the guidance: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Redetermination-Exchange-2018.pdf

###

Role of Assisters after Open Enrollment

Assisters play a vital role after Open Enrollment ends. By staying in touch with consumers, assisters can help enrolled consumers get the most out of their health care coverage.

To contact consumers after you've provided enrollment assistance, you can use an opt-in consent form during the initial enrollment assistance session. This will allow you to follow-up with consumers to share important information about their coverage. For example, you can:

- Remind them when it's time to pay their first premium
- Help them make their first doctor's appointment
- Share information about preventative care
- Help them update their Marketplace application information, if needed
- Reevaluate their plan choice during a special enrollment period or during the annual Open Enrollment period

When scheduling appointments to enroll or renew your consumers' coverage, make sure they know what information they need to bring to make the process go as smoothly as possible.

Assisters can help enrolled consumers reevaluate their coverage options to ensure consumers choose the coverage that suits their needs. Use this resource with consumers to evaluate how satisfied they are with their current plan.

###

Back-to-School Outreach Opportunity: Address the Health Coverage Needs of Students & Families

During August and September, assisters are invited to take action to help students and families achieve their full potential for health through the year by organizing outreach and education events that coincide with the beginning of the school year. Back-to-School season is an important time to engage parents in conversations about addressing the health care coverage needs of children and families; moreover, it's also a great time to conduct outreach to students at college and university that are returning to campus and beginning to think about their choices and priorities for the upcoming school year. To launch timely and effective Back-to-School outreach and education, assisters can establish relationships and collaborate with school staff and organizations who work with students and families. Professionals within local school districts and community groups are well situated to identify children who are in need of health care coverage and provide their parents with the information and contacts to help them enroll in coverage. Similarly, many organizations on college and university campuses are able to leverage their position and social network to reach uninsured students, provide health coverage information, and make connections for those in need.

Assisters are encouraged to make the most of the unique timeframe of year, when students are returning to school, by planning targeted and collaborative outreach and education events. Consider teaming up with local school districts, colleges, universities, community organizations to help get out the word to students and families about the upcoming open enrollment period and the coverage options available to them. Remember, eligibility and enrollment in Medicaid and the Children's Health Insurance Program (CHIP) continues year-round.

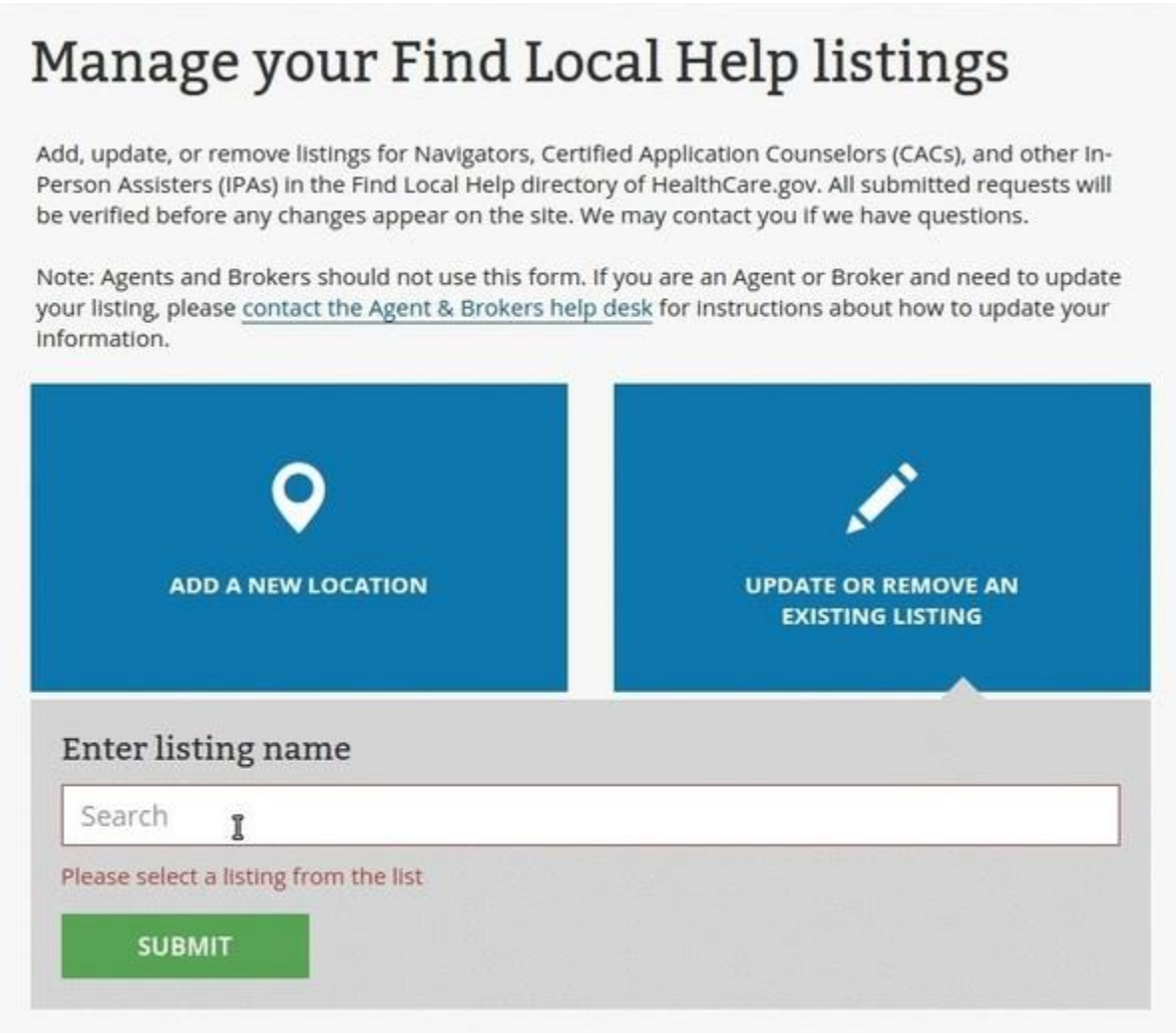
To help jump-start assister Back-to-School #GetCovered outreach, education, and enrollment efforts for children, students, and families, make use of the Healthcare.gov and Connecting Kids to Coverage National Campaign resources below:

- Review the Healthcare.gov resources targeted towards students and young adults, like Getting Covered if You're under 30, In School? Student Health Plans & Other Options, Why Bother with Health Insurance? and How to Get or Stay on a Parent's Plan.
- Use the Connecting Kids to Coverage National Campaign's School-Based Outreach and Enrollment Toolkit! It has everything your organization needs for effective planning and outreach. The Toolkit includes resources for partnering with schools, tips for connecting with members of the school community, like superintendents and counselors, and strategies for including enrollment into existing school activities. The Toolkit features ready-to-use materials like message guides, templates, resource links, and offers social media graphics for Facebook and Twitter.
- Checkout the Connecting Kids to A+ Health Coverage for Back-to-School Season webinar slides and transcript that explore how organizations can engage schools and other education-focused groups to help enroll children and families in health coverage. It also highlights best practices and provides tips to help make the Back-to-School enrollment season a success.
- Share Connecting Kids to Coverage National Campaign materials widely. There is an ever-growing Outreach Tool Library featuring resources to use in outreach and enrollment efforts, including materials in other languages.
- Spotlight details about your organization's efforts with the Connecting Kids to Coverage National Campaign via email at ConnectingKids@cms.hhs.gov or Twitter using #Enroll365, and #KidsEnroll in tweets.
- Sign up to receive the Connecting Kids to Coverage National Campaign Notes eNewsletter directly to your inbox. The eNewsletter is distributed throughout the year and provides updates on Campaign activities.

###

What's New With Find Local Help?

What's new with Find Local Help? The autocomplete dropdown has been updated on the upkeep tool. As you submit a request to update or delete your listing(s), you will now see up to 10 results in the scrollable autocomplete box. This functionality provides more options to choose when searching for a location or organization.



We have also updated Find Local Help by implementing a new vCard feature. The vCard provides an electronic business card for your organization. Now, you will see a new "Download Contact" button for each Find Local Help listing. When consumers select this green button, they can download your organization's contact information to their mobile or desktop application for easy and quick reference.

###

Links to Helpful Resources

- Marketplace Assister Training Resources and Webinar
- Technical Assistance Resources

- CMS Marketplace Applications & Forms
- CMS Outreach and Education Resources
- Marketplace.CMS.gov Page
- CMSzONE Community Online Resource Library Pilot for Marketplace Assisters
- Find Local Help

###

Marketplace Call Center and Shop Center Hours

Health Insurance Marketplace Call Center: 1-800-318-2596 (TTY: 1-855-889-4325). For customer service support, to start or finish an application, compare plans, enroll or ask a question. Available 24 hours a day, 7 days a week. Closed Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. CACs and Navigators should call their dedicated phone lines so the Call Center can better track the needs of assisters. The dedicated Assister Line can also help with password resets and can help with access to non-application SEPs. Contact your Navigator Project Officer (for Navigators) or your designated organization leadership (for CACs) for more information on the Assister Line.

Navigator Marketplace Call Center line: 1-855-868-4678

CAC Marketplace Call Center line: 1-855-879-2683

General consumer Call Center line: 1-800-318-2596 (TTY: 1-855-889-4325).

SHOP Call Center: For customer service support, including assisting employers and employees apply for and enroll in SHOP. 1-800-706-7893 (TTY: 711). Available M-F 9:00 am-7:00 pm EST. Closed New Year's Day, Martin Luther King Day, Memorial Day, July 3rd, Labor Day, Veterans Day, Thanksgiving and the day after, and Christmas.

###

Stay in Touch

To sign up for the CMS Weekly Assister Newsletter, please send a request to the Assister Listserv inbox (ASSISTERLISTSERV@cms.hhs.gov) write "Add to listserv" in the subject line, please include the email address that you would like to add in the body of your email. For requests to be removed from the listserv, please forward a copy of a webinar invite or newsletter received and write "Remove" in the subject line.

If you have specific questions or issues that you would like to see us highlight in our weekly webinar series or here in this newsletter please contact us.

- For **HHS Navigator grantees** - please get in touch with your Navigator Project Officer.
- For **CAC Designated Organizations in FFM or SPM states** - please send an email to CACQuestions@cms.hhs.gov.

Follow @HealthCaregov Twitter with the hashtag #ACAassisters for updates, reminders, and new publications for assisters.

We welcome questions, suggestions and comments, so please feel free to contact us!

Please note that the information presented in this Assister Newsletter is informal, technical assistance for assisters and is not intended as official CMS guidance.

###

New Health Insurance Marketplace Resources

The following publications are now available on the CMS Marketplace website, www.Marketplace.cms.gov:

Need Health Coverage
https://marketplace.cms.gov/outreach-and-education/need-health-coverage-postcard.pdf
https://marketplace.cms.gov/outreach-and-education/need-health-coverage-postcard-spanish.pdf

Key Dates
https://marketplace.cms.gov/outreach-and-education/key-dates-for-marketplace.pdf
https://marketplace.cms.gov/outreach-and-education/key-dates-in-the-marketplace-spanish.pdf

The Health Insurance Marketplace
https://marketplace.cms.gov/outreach-and-education/about-the-marketplace-english.pdf
https://marketplace.cms.gov/outreach-and-education/about-the-marketplace-spanish.pdf

Connecting Kids to Coverage Campaign: Back to School Resources

Back-to-School planning is underway! The Connecting Kids to Coverage National Campaign's School-Based Outreach and Enrollment Toolkit has everything your organization needs for effective planning and outreach. The Toolkit includes resources for partnering with schools, tips for connecting with members of the school community, like superintendents and counselors, and strategies for including enrollment into existing school activities. The Toolkit features ready-to-use materials like message guides, templates, resource links, and offers social media graphics for Facebook and Twitter. Visit InsureKidsNow.gov for additional Back-to-School resources.

We want to hear your success story! Have you collaborated with city leaders or other local government partners in Medicaid and CHIP outreach and enrollment work? We'd like to learn how your organization is connecting kids to coverage! And if you're using Campaign or NLC city outreach resources, let us know! Share details with the Campaign via email at ConnectingKids@cms.hhs.gov or Twitter using #Enroll365, and #KidsEnroll in tweets.

Stay Connected with the Campaign

- Share our materials widely. We have an ever-growing Outreach Tool Library featuring resources to use in outreach and enrollment efforts, including materials in other languages.
- Contact us to get more involved with the Campaign at ConnectingKids@cms.hhs.gov
- Follow the Campaign on Twitter. Don't forget to re-tweet or share our messages with your network or use our #Enroll365 and/or #KidsEnroll hashtags in your posts.

The Connecting Kids to Coverage National Campaign Notes eNewsletter is distributed throughout the year and provides updates on Campaign activities. You can sign up to receive this eNewsletter directly to your inbox.

###

Renew Your 2017 SHOP Coverage

Is your SHOP coverage up for renewal? Your SHOP coverage **does not** automatically renew each year. To avoid a coverage gap, you must **take action**.

You can renew your SHOP coverage in three ways:

- Online through HealthCare.gov
- Through a SHOP-registered agent or broker
- By phone through the SHOP Call Center

To avoid a gap in coverage, you should submit a renewal offer to your employees **by the 7th day of the month** in which your 2017 coverage expires. For example, if your coverage expires on September 30, you must submit a renewal offer to your employees by **Thursday, September 7.**

###

MACRA/Quality Payment Program (QPP) Updates

Visit the CMS Quality Measures Public Comment Page for More Information on the Call for Public Comment

The Office of the National Coordinator for Health Information Technology (ONC) has engaged Mathematica Policy Research to test two pediatric measures – one focused on vision screenings and the other on Attention Deficit Hyperactivity Disorder (ADHD) symptom improvement.

At this time, ONC is requesting feedback on the **Vision Screening and Referral in Children** measure. **Submit a formal comment by September 7, 2017.**

For More Information: Visit the CMS Quality Measures Public Comment Page for instructions on how to comment and measure-specific materials.

###

Explanation of Special Status Calculation – Correction

On July 24, the Centers for Medicare & Medicaid Services (CMS) distributed an email update with an explanation for its special status calculation for the Quality Payment Program. The message incorrectly stated that clinicians considered to have "special status" would be exempt from the Quality Payment Program.

Special status affects the number of total measures, activities, or entire categories that an individual clinician or group must report. **Individual clinicians or groups with special status are not exempt from the Quality Payment Program because of their special status determination.**

To determine if a clinician's participation should be considered special status under the Quality Payment Program, CMS retrieves and analyzes Medicare Part B claims data. Calculations are run to indicate a circumstance of the clinician's practice for which special rules would apply. These circumstances are applicable for clinicians in: Health Professional Shortage Area (HPSA), rural, non-patient facing, hospital-based, and small practices.

For more information, please visit the Quality Payment Program website.

###

Quality Payment Program Hardship Exception Application for the 2017 Transition Year Is Now Open

Clinicians Can Now Submit Quality Payment Program Hardship Exception Applications

The Quality Payment Program Hardship Exception Application for the 2017 transition year is now available on the Quality Payment Program website.

MIPS eligible clinicians and groups may qualify for a reweighting of their Advancing Care Information performance category score to 0% of the final score, and can submit a hardship exception application, for one of the following specified reasons:

- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of Certified EHR Technology (CEHRT)

There are some MIPS eligible clinicians who are considered Special Status, who will be automatically reweighted (or, exempted in the case of MIPS eligible clinicians participating in a MIPS APM) and do not need to submit a Quality Payment Program Hardship Exception Application.

About the Hardship Exception Application Process

In addition to submitting an application via the Quality Payment Program website, clinicians may also contact the Quality Payment Program Service Center and work with a representative to verbally submit an application.

To submit an application, you'll need:

- Your Taxpayer Identification Number (TIN) for group applications or National Provider Identifier (NPI) for individual applications;
- Contact information for the person working on behalf of the individual clinician or group, including first and last name, e-mail address, and telephone number; and
- Selection of hardship exception category (listed above) and supplemental information.

If you're applying for a hardship exception based on the Extreme and Uncontrollable Circumstance category, you must select one of the following and provide a start and end date of when the circumstance occurred:

- Disaster (e.g., a natural disaster in which the CEHRT was damaged or destroyed)
- Practice or hospital closure
- Severe financial distress (bankruptcy or debt restructuring)
- EHR certification/vendor issues (CEHRT issues)

Please note: Once an application is submitted, you will receive a confirmation email that your application was submitted and is pending, approved, or dismissed. Applications will be processed on a rolling basis.

For More Information

Contact the Quality Payment Service Center at 1-866-288-8292 or TTY: 1-877-715-6222 or QPP@cms.hhs.gov.

Visit the Quality Payment Program website.

Explanation of Special Status Calculation

The Centers for Medicare and Medicaid Services (CMS) has introduced new information on the Quality Payment Program website that indicates whether clinicians have "special status" and can therefore be considered exempt from the Quality Payment Program.

To determine if a clinicians' participation should be considered as special status under the Quality Payment Program, CMS retrieves and analyzes Medicare Part B claims data. A series of calculations are run to indicate a circumstance of the clinician's practice for which special rules under the Quality Payment Program will affect the number of total measures, activities or entire categories that an individual clinician or group must report. These circumstances are applicable for clinicians in: Health Professional Shortage Area (HPSA), Rural, Non-patient facing, Hospital Based, and Small Practices.

For more information, please visit the Quality Payment Program website.

Now Available: Quality Payment Program Presentations from Recent Webinars

View Recent Quality Payment Program Webinar Recordings Online

Were you unable to participate in a recent Quality Payment Program webinar?

There's good news: You can view webinar recordings, presentations, and transcripts on the CMS Quality Payment Program Events webpage.

Recent Quality Payment Program webinars include:

- Overview of MIPS for Small, Rural, and Underserved Practices – 7/12/17

- Quality Payment Program Year 2 Proposed Rule Listening Session – 7/5/17
- Proposed Rule for the Quality Payment Program Year Two - 6/26/17
- Quality Payment Program Participation Criteria Webinar – 5/22/17
- MIPS Group Participation – 5/11/17
- Listening Session: Cost Measure Development – 4/5/17
- MIPS Advancing Care Information Deep Dive Webinar – 4/4/17
- Virtual Groups in the Quality Payment Program – 3/16/17

CMS encourages you to stay up to date on the Quality Payment Program by visiting the website regularly and subscribing to the Quality Payment Program listserv. To subscribe, visit the Quality Payment Program website and select "Subscribe to Email Updates" in the footer.

For More Information

If you have questions on other topics related to the Quality Payment Program, please contact the Quality Payment Program Service Center at qpp@cms.hhs.gov or 1-866-288-8292.

###

Eligible Hospitals and Critical Access Hospitals: Submit Meaningful Use Data to the Hospital Quality Reporting System (HQR) via the QualityNet Secure Portal in 2018

The Centers for Medicare & Medicaid Services (CMS) is continuing efforts to reduce burden by easing reporting requirements and streamlining data submission methods for eligible hospitals and critical access hospitals participating in the Electronic Health Record (EHR) Incentive Programs.

What Does This Mean For You?

- **Medicare Eligible Hospitals:** Beginning January 2, 2018, eligible hospitals and critical access hospitals participating in the Medicare EHR Incentive Program will submit their 2017 meaningful use data to the QualityNet Secure Portal. The Medicare & Medicaid EHR Incentive Program Registration and Attestation System will not be available for Medicare hospitals after December 31, 2017. The goal of this change is to make it simpler for facilities to report data to CMS. Most hospitals are already familiar with using the QualityNet Secure Portal for secure communications and healthcare quality data exchange with CMS.
- **Medicaid Eligible Hospitals:** The Medicare & Medicaid Registration and Attestation System will still be available for Medicaid eligible hospitals. Medicaid-only hospitals should contact their state Medicaid agencies for specific information on how to attest.
- **Medicare and Medicaid Eligible Hospitals:** Hospitals attesting for both the Medicare and Medicaid EHR Incentive Programs as dually eligible hospitals will register and attest for the Medicare program in the HQR system. Dually eligible hospitals should contact their state Medicaid agencies to submit Medicaid attestations. Dually eligible hospitals new to the EHR Incentive Programs must register in the EHR Incentive Program Registration & Attestation system and register to use the QualityNet Secure Portal.

Stay Up To Date

As CMS prepares for this transition, stay up to date by:

- Reviewing relevant information on the EHR Incentive Programs website
- Following us on Twitter
- Signing up for the EHR Incentive Programs listserv

CMS will distribute more information on this transition as it becomes available. In the meantime, don't forget to review the EHR Incentive Programs requirements to ensure you are ready to attest in 2018.

For questions about this transition, please contact the EHR Inquiries Mailbox at EHRinquiries@cms.hhs.gov.

###

CMS Proposes Changes to The Comprehensive Care for Joint Replacement Model, Cancellation of the Mandatory Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model

Proposed rule to offer greater flexibility and choice for hospitals in orthopedic care for Medicare beneficiaries

The Centers for Medicare & Medicaid Services (CMS) announced a proposed rule to reduce the number of mandatory geographic areas participating in the Center for Medicare and Medicaid Innovation's (Innovation Center) Comprehensive Care for Joint Replacement (CJR) model from 67 to 34. In addition, CMS proposes to allow CJR participants in the 33 remaining areas to participate on a voluntary basis. In this rule, CMS also proposes to make participation in the CJR model voluntary for all low volume and rural hospitals in all of the CJR geographic areas.

CMS also is proposing through this rule to cancel the Episode Payment Models (EPMs) and the Cardiac Rehabilitation (CR) incentive payment model, which were scheduled to begin on January 1, 2018. Eliminating these models would give CMS greater flexibility to design and test innovations that will improve quality and care coordination across the in-patient and post-acute-care spectrum.

"Changing the scope of these models allows CMS to test and evaluate improvements in care processes that will improve quality, reduce costs, and ease burdens on hospitals," said CMS Administrator Seema Verma. "Stakeholders have asked for more input on the design of these models. These changes make this possible and give CMS maximum flexibility to test other episode-based models that will bring about innovation and provide better care for Medicare beneficiaries."

Moving forward, CMS expects to increase opportunities for providers to participate in voluntary initiatives rather than large mandatory episode payment model efforts. The changes in the proposed rule would allow the agency to engage providers in future voluntary efforts, including additional voluntary episode-based payment models.

The EPMs and the CR incentive models were designed as mandatory payment models and implemented via notice and comment rulemaking to test the effects of bundling cardiac and orthopedic care beginning in 2018. They were established by the Innovation Center under the authority of section 1115A of the Social Security Act (the Act).

For more information on the Comprehensive Care for Joint Replacement Model, please visit: https://innovation.cms.gov/initiatives/cjr.

For more information on the EPM and CR models proposed for rescission, please visit: https://innovation.cms.gov/initiatives/epm

The proposed rule (CMS-5524-P) can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection. Public comments are due by October 16 at 11:59 pm EST.

###

Visit the EHR Incentive Programs Website for Information about 2017 Program Requirements

The Centers for Medicare & Medicaid Services (CMS) would like to remind eligible professionals (EPs) and eligible hospitals that the **Medicaid EHR Incentive Program**, which is administered voluntarily by states and territories, will continue through 2021.

To participate in the program in 2017, EPs and eligible hospitals must attest to:

- Modified Stage 2 objectives and measures, or
- Stage 3 objectives and measures

To learn more, visit the 2017 program requirements page on the EHR Incentive Programs website. For state-specific information and resources, review the Medicaid State Information page.

Incentive Payment Information

- There are no payment adjustments in the Medicaid EHR Incentive Program.
- EPs and eligible hospitals who meet program requirements can continue to attest to their state Medicaid agencies to receive yearly incentive payments.
- The incentive payment is a fixed amount for each year of participation.
- EPs and eligible hospitals can receive incentive payments for six years nonconsecutively. EPs and eligible hospitals who began the program in 2016 must participate consecutively to receive the full payment amount over six years.
- Eligible hospitals that are eligible to participate in the Medicare and Medicaid EHR Incentive Programs may attest under Medicare to avoid a payment adjustment.

Please note: 2016 was the last year EPs and eligible hospitals could begin participation in the Medicaid EHR Incentive Program.

Medicaid EHR Incentive Program and the Merit-based Incentive Payment System (MIPS)

MIPS does not replace the Medicaid EHR Incentive Program. If a provider plans to participate in the Medicaid EHR Incentive Program through their state and they are also a Medicare Part B clinician who is eligible for MIPS, they will also need to participate in the MIPS program to avoid a negative MIPS payment adjustment.

For More Information

- Visit the EHR Incentive Program website
- Email your question to EHRInquiries@cms.hhs.gov

To learn more about MIPS, visit qpp.cms.gov

###

2017 Medicare Advantage & Prescription Drug Plan Fall Webcast & Conference Registration (In-Person Registration Closing for Foreign Nationals)

The Center for Medicare will convene a one day event to provide new information for staff-level operations, mid-level management and senior executives partnering organizations.

Dates and Times:

September 7, 2017
9:30am - 4:30pm EDT

Location: CMS Grand Auditorium (this event is open to all CMS employees)

Please Note: In order to comply with CMS' conference policies, only Central Office employees are allowed to attend this event in person, and Regional Office employees must view the event via webcast. All other CMS staff at various locations may register and view the webcast live.

Session topics include:

- Parts C&D Past Performance Analysis
- Encounter Data
- Leadership Chat & Roundtable
- The Medicare Beneficiary Ombudsman and Medicare Plans: Working Together
- Appeals, Grievances, and Complaints: Identification and Processing

Registration Information

In-Person Registration Information:

In-person registration is only for CMS Central Office Employees. Registration for Foreign Nationals closed on **Friday, August, 11th 2017 at 6pm EDT.**

- **In-Person Registration Link:** CMS 2017 MA & PDP Fall Conference (In-person)

Webcast Registration Information:

- **Webcast Registration Link**: CMS 2017 MA & PDP Fall Conference (Webcast)

Continuing Education Credits:

This event will be evaluated for continuing education credits. To learn more about CMS' accreditation, please click here CMS Accreditation Statements.

Interpreting and captioning services will be provided. Prior supervisory approval to participate is required.

Issues with Registration:

This event does not require a password. However, if you previously registered and/or attended a CMS webinar training or webcast event using CMS' Adobe Connect, you may be prompted to enter a password associated with your email address.

Adobe Connect Password Reset Issues:

If you have forgotten your CMS Adobe Connect password, please email webinar@cms.hhs.gov and CTEO@cms.hhs.gov for assistance.

Changes/Cancellations:

Important Message: If you registered to attend this year's event in-person and you are unable to attend, we would appreciate being informed of these changes as quickly as possible so that the seat may be given to another participant. Please email us at CTEO@cms.hhs.gov and call us at 410-786-3207 regarding this change.

Additional Conference Details:

If you have additional questions regarding this conference, please contact CMS via email at CTEO@cms.hhs.gov.

To learn more about this event, past events and future events, please visit our website here.

###

Final Rule Supports Transparency, Flexibility, Program Simplification and Innovation in the Medicare Program

The Centers for Medicare & Medicaid Services (CMS) issued the fiscal year 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule, which updates 2018 Medicare payment and policies when patients are discharged from hospitals. The final rule relieves regulatory burdens for providers, supports the patient-doctor relationship in healthcare, and promotes transparency, flexibility, and innovation in the delivery of care for Medicare patients.

"This final rule will help provide flexibility for acute and long-term care hospitals as they care for Medicare's sickest patients," said CMS Administrator Seema Verma. "Burden reduction and payment rate increases for acute care hospitals and long-term care hospitals will help ensure those suffering from severe injuries and illnesses have access to the care they need."

In the final rule, CMS is increasing the amount of uncompensated care payments made to acute care hospitals by $800 million to approximately $6.8 billion for fiscal year 2018.

Uncompensated care represents healthcare services provided by hospitals or providers for which they don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care. CMS is also providing further clarification about discounts given to uninsured patients who meet the hospital's charity care policy.

In relieving providers of administrative burdens and encouraging patient choice, CMS is finalizing a one-year regulatory moratorium on the payment reduction threshold for patient admissions in long-term care hospitals. CMS continues to evaluate this policy. CMS is also finalizing provisions that reduce clinical quality measure reporting requirements for hospitals that have implemented electronic health records.

Due to the combination of payment rate increases and other policies and payment adjustments, particularly in changes in uncompensated care payments, acute care hospitals will see a total increase in Medicare spending on inpatient hospital payments of $2.4 billion in fiscal year 2018. Based in part on the changes

included in the final rule, overall payments to long-term care hospitals will decrease by $110 million in fiscal year 2018.

In addition to the payment and policy updates for Medicare hospital admissions, the final rule addresses changes to how the public is notified of Medicare terminations of certain providers and implements the statutory extension of the Rural Community Hospital Demonstration.

CMS also issued a notice with comment period updating 2018 Medicare payment policies and rates for inpatient psychiatric facilities. CMS estimates that Medicare payments to inpatient psychiatric facilities will increase by $45 million, or nearly one percent, in fiscal year 2018.

For a fact sheet on the fiscal year 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html

For a fact sheet on the fiscal year 2018 Medicare Inpatient Psychiatric Prospective Payment System notice with comment period, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02-2.html

The fiscal year 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule (CMS-1677-F) and the fiscal year 2018 Medicare Inpatient Psychiatric Prospective Payment System notice with comment period (CMS-1673-NC) can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection.

###

Medicare finalizes fiscal year 2018 payment & policy changes for skilled nursing facilities

Overview

On July 31, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a final rule [CMS-1679-F] outlining Fiscal Year (FY) 2018 Medicare payment rates and quality programs for skilled nursing facilities (SNFs).

Policies in the final rule continue to build on CMS' commitment to shift Medicare payments from volume to value, with continued implementation of the SNF Value-based Purchasing (VBP) program.

This fact sheet discusses major provisions of the final rule, including policies related to the SNF Value-Based Purchasing Program and the SNF Quality Reporting Program. The final rule also finalizes an updated performance period for the National Healthcare Safety Network (NHSN) Healthcare Personnel (HCP) Influenza Vaccination Reporting Measure included in the End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) for Payment Year 2020 and other key elements. The major FY 2018 policies and other issues discussed in the final rule are summarized below.

Additionally, in the final rule CMS clarifies definitions and provisions related to the investigation of complaints and team composition and aligns regulatory provisions for the investigation of complaints with sections 1819 and 1919 of the Act. CMS has finalized this clarification. The final rule can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection

Changes to Payment Rates under the SNF Prospective Payment System (PPS)

Based on changes contained within this final rule, CMS projects aggregate payments to SNFs will increase in FY 2018 by $370 million, or 1.0 percent, from payments in FY 2017. This estimated increase is attributable to a 1.0 percent market basket increase required by section 411(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

SNF Quality Reporting Program (QRP)

Background: Under the SNF QRP, SNFs that fail to submit the required quality data to CMS will be subject to a 2 percentage point reduction to the otherwise applicable annual market basket percentage update with respect to that fiscal year.

Finalized Changes: In this FY 2018 final rule, CMS is finalizing its replacement of the current pressure ulcer measure with an updated version of that measure and adopting four new measures that address functional status beginning with the FY 2020 program year. The new quality measures being finalized are:

1. *Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury*
2. Four outcome-based functional measures on resident functional status:
    1. *Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)*
    2. *Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)*
    3. *Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)*
    4. *Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)*

Further, CMS is finalizing that it will begin publically reporting six new measures for display by fall 2018.

1. In addition, CMS is finalizing that beginning with the FY 2019 SNF QRP, the data SNFs report on the measure Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) meet the definition of standardized resident assessment data and that beginning with the FY 2020 SNF QRP, the data SNFs report on the measures: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631); and Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury meet the definition of standardized resident assessment data. However, in response to the comments received for the FY 2020 program year, CMS is not finalizing the additional proposed standardized data elements.

SNF Value-Based Purchasing Program (VBP)

Background: The SNF VBP Program has adopted scoring and operational policies for its first year (FY 2019) and has specified measures and program features as required by statute. The FY 2018 SNF PPS final rule includes additional Program proposals, including an exchange function approach to implement value-based incentive payment adjustments beginning October 1, 2018.

Scoring & Operational Updates: The SNF VBP Program's scoring and operational policies for its first year (FY 2019) include:

- The Program will include one readmission measure for each year.
- The Secretary will reduce the adjusted Federal per diem rate applicable to each SNF in a fiscal year by 2 percent to fund the value-based incentive payments for that fiscal year
- The total amount of value-based incentive payments that can be made to SNFs' in a fiscal year will be 60 percent of the total amount withheld from SNFs' Medicare payments for that fiscal year, as estimated by the Secretary. The Program will pay SNFs ranked in the lowest 40 percent less than the amount they would otherwise be paid in the absence of the SNF VBP.
- Both public and confidential facility performance reporting will be conducted.

In addition to the logistic exchange function CMS is finalizing in the final rule, the SNF VBP Program policies in the FY 2018 final rule include performance and baseline periods for the FY 2020 Program year, updated values for performance standards for FY 2020, additional details for the Review and Correction process for SNFs' performance information to be made public on *Nursing Home Compare,* and a revision to the previously-adopted rounding policy for SNF performance scores.

End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)

Background: Section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended the Social Security Act to require CMS to establish an ESRD QIP that selects measures, establishes performance standards, specifies a performance period for each payment year (PY), assesses the total performance of each facility, applies an appropriate payment reduction to each facility that does not meet a minimum TPS, and publicly reports the results. The ESRD QIP is intended to promote high-quality care by dialysis facilities treating beneficiaries with ESRD. This program changes the way CMS pays for the treatment of ESRD patients by linking a portion of payment directly to facilities' performance on quality measures. The ESRD QIP will reduce payments by up to two percent to ESRD facilities that do not meet or exceed a minimum total performance score (TPS).

Updated PY 2020 Performance Period for the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) National Healthcare Safety Network (NHSN) Healthcare Personnel (HCP) Influenza Vaccination Reporting Measure

In the Calendar Year (CY) 2017 ESRD Prospective Payment System (PPS) final rule, CMS inadvertently finalized the same performance period for the NHSN Healthcare Personnel Influenza Vaccination Reporting Measure for PY 2020 that it previously finalized for that measure for PY 2019. In the FY 2018 SNF PPS proposed rule, CMS proposed to correct that performance period such that it will align with the schedule established in earlier payment years. Based on the comments received, the final rule finalizes the updated performance period for the NHSN Healthcare Personnel Influenza Vaccination Reporting Measure for PY 2020 as proposed: The performance period for that measure is October 1, 2017, through March 31, 2018, for the Payment Year (PY) 2020 ESRD QIP program.

Survey Team Composition

In the proposed rule, CMS explained the need to make technical changes to specific provisions of 42 C.F.R. part 488 to more clearly reflect the authorizing statutory requirements found in Sections 1819 and 1919 of the Social Security Act, to clarify the regulatory requirements for team composition for surveys conducted for investigating a complaint, and to better align regulatory provisions for investigation of complaints with the statutory requirements found in sections 1819 and 1919 of the Act.

There has been recent administrative litigation as to which regulatory provision, that is, §488.314 or §488.332, applies to the survey team composition related to the investigation of complaints. Thus, we are finalizing the regulatory changes as proposed to clarify that only surveys conducted under sections 1819(g)(2) and 1919(g)(2) of the Act are subject to the requirement at §488.314 that a survey team consist of an interdisciplinary team that must include a registered nurse. And that complaint surveys and surveys related to on-site monitoring, including revisit surveys, are subject to the requirements of sections 1819(g)(4) and 1919(g)(4) of the Act and §488.332, which allow the state survey agency to use a specialized investigative team that may include appropriate healthcare professionals but need not include a registered nurse. This clarification is also reflected in revisions to the definition of complaint survey in §488.30(a), the definition of abbreviated standard survey in §488.301, and the requirements for the investigation of complaints in §488.308.

For more information…

The final rule displayed on July 31, 2017, at the *Federal Register's* Public Inspection Desk and will be available under "Special Filings," at http://www.federalregister.gov/inspection.aspx

Additional information is available at:

- SNF PPS: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html
- SNF QRP: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Proposed-Specifications-for-SNF-QRP-Quality-Measures-and-Standardized-Data-Elements-Effective-10-1-18.pdf
- SNF VBP: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html

###

2018 Medicare Part D Benchmark

Today, the Centers for Medicare & Medicaid Services (CMS) released the 2018 Medicare Part D Benchmark. Medicare announced that the average basic premium for a Medicare Part D prescription drug plan in 2018 is projected to decline to an estimated $33.50 per month. This represents a decrease of approximately $1.20 below the actual average premium of $34.70 in 2017.

The 2018 regional rates and benchmarks are now live on CMS.gov: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data-Items/2018Rates.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Click here to view today's announcement on the Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2018.pdf

###

Final Fiscal Year 2018 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities (CMS-1671-F)

Overview

On July 31, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a final rule outlining fiscal year (FY) 2018 Medicare payment policies and rates for the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) and the IRF Quality Reporting Program (IRF QRP). The FY 2018 final policies are summarized below.

Updates to IRF payment rates

Update to the payment rates under the IRF PPS. For FY 2018, CMS is finalizing an update to the IRF PPS payments to reflect a 1.0 percent increase factor, in accordance with section 1886(j)(3)(C)(iii) of the Social Security Act, as added by section 411(b) of the Medicare Access and CHIP Reauthorization Act of 2015. An additional approximate 0.1 percent decrease to aggregate payments due to updating the outlier threshold results in an overall estimated update for FY 2018 of approximately 0.9 percent (or $75 million), relative to payments in FY 2017.

No changes to the facility-level adjustments. For FY 2018, CMS will continue to maintain the facility-level adjustment factors at current levels as we continue to monitor the most current IRF claims data available to assess the effects of the FY 2014 changes.

Rural Adjustment Transition. FY 2018 is the third and final year of the phase-out of the 14.9 percent rural adjustment for the 20 IRF providers that were designated as rural in FY 2015 and changed to urban under the new Office of Management and Budget (OMB) delineations in FY 2016. Thus, we will no longer apply a rural adjustment for these IRFs.

Removal of 25 Percent Payment Penalty for Late Transmissions of the IRF-PAI

Under the IRF PPS, we currently apply a 25 percent payment penalty to IRF patient assessment instrument (IRF-PAI) submissions that are not timely transmitted to our data repository. We are finalizing the removal of the 25 percent payment penalty.

Refinements to the 60 Percent Rule Presumptive Methodology

On October 1, 2015, Medicare transitioned from ICD-9-CM to ICD-10-CM. In the FY 2014 IRF PPS final rule (78 FR 47860) and the FY 2015 IRF PPS final rule (80 FR 45872), we stated that after the adoption of the ICD-10-CM medical code set, we would review the presumptive methodology lists in ICD-10-CM (once we had enough ICD-10-CM data available) and make any necessary changes. Over the past year, we have performed a comprehensive analysis of the lists with our clinicians and input from industry stakeholders and are finalizing necessary refinements to the lists to ensure that they continue to reflect the list of 60 percent rule qualifying conditions in 42 CFR §412.29(b)(2). For FY 2018, we are finalizing the following refinements to the ICD-10-CM lists used in determining IRFs' presumptive compliance to ensure that these lists reflect as accurately as possible the types of patients that should count presumptively toward the 60 percent rule by:

- Counting certain ICD-10-CM diagnosis codes for patients with traumatic brain injury and hip fracture conditions; and
- Revising the presumptive methodology list for major multiple trauma by counting IRF cases that contain two or more of the ICD-10-CM codes from three major multiple trauma lists in the specified combinations.

Based on stakeholder comments, we are not finalizing our proposed removal of certain ICD-10-CM codes from the presumptive methodology at this time, as we will continue to monitor and consider their appropriateness for inclusion on the presumptive methodology lists for future policy development and rulemaking.

Technical IRF Process Revisions

We are finalizing the following technical process revisions:

- Removal of Voluntary Item for Swallowing Status from IRF-PAI—We are finalizing the removal of a voluntary item for swallowing status (Item #27) from the IRF-PAI as it is duplicative with a recently added item in the Quality Indicators section.

- Sub-regulatory Process for Certain Updates to Presumptive Methodology Diagnosis Code Lists —We are finalizing a formal process to distinguish between non-substantive updates to the ICD-10-CM codes on the lists used to determine IRFs' presumptive compliance with the 60 percent rule that would be applied through a sub-regulatory process and substantive revisions to the ICD-10-CM codes on the lists that would only be proposed and finalized through notice and comment rulemaking. The sub-regulatory process would be used to update the ICD-10-CM codes on the presumptive methodology lists to ensure that they reflect the most current ICD-10 medical code data sets, which are typically updated effective October 1 of each year.

- Use of IRF-PAI Data to Determine Patient Body Mass Index (BMI) Greater Than 50 for Cases of Lower Extremity Single Joint Replacement—We are finalizing the use of the height/weight items (items #25A and 26A) on the IRF-PAI to calculate patients' BMI and the use of this information to determine and presumptively count lower-extremity joint replacement patients with a BMI greater than 50 toward an IRF's presumptive compliance percentage, in accordance with the regulations at 412.29(b)(2)(xiii)(B).

IRF Quality Reporting Program (QRP)

Under the IRF QRP, the applicable annual payment update for any IRF that does not submit the required data to CMS is reduced by 2 percentage points. In this FY 2018 IRF PPS Final Rule, CMS is finalizing the replacement of the current pressure ulcer measure with an updated version of that measure, as well as the removal of the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs (NQF #2502). CMS is also finalizing the public display of six additional quality measures on the IRF Compare website in calendar year 2018.

In addition to the proposals related to quality measures and public reporting, CMS is finalizing that the data IRFs submit on the measure Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) meet the definition of standardized patient assessment data for the FY 2019 IRF QRP. For the FY 2020 IRF QRP, CMS is finalizing that the data IRFs submit on the measures Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses

Function (NQF #2631) and Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury meet the definition of standardized patient assessment data. However, in response to the comments received for the FY 2020 program year, CMS is not finalizing the proposed additional standardized data elements.

Lastly, CMS is finalizing its proposals with respect to the applicability of current procedural requirements, such as the mechanism for reporting and reporting schedules, to the standardized patient assessment data.

The final IRF PPS rule can be downloaded from the *Federal Register* at: http://www.federalregister.gov/public-inspection

###

CMS finalizes updates to the wage index and payment rates for the Medicare Hospice Benefit and hospice quality reporting requirements for FY 2018

The Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1675-F) that updates fiscal year (FY) 2018 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries, and also updates the hospice quality reporting requirements.

Summary

This final rule will update the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2018. It also makes changes to the Hospice Quality Reporting Program (HQRP) that would continue to ensure high quality, accessible care, without added burden.

Background

This rule finalizes updates to the hospice payment rates for fiscal year (FY) 2018, as required under section 1814(i) of the Social Security Act (the Act). This final rule also specifies public reporting measures derived from the CAHPS® Hospice Survey, and provides an update on the Hospice QRP consistent with the requirements of section 1814(i)(5) of the Act, as added by section 3004(c) of the Affordable Care Act. In accordance with section 1814(i)(5)(A) of the Act, hospices that fail to meet quality reporting requirements receive a 2.0 annual percentage point reduction to their payments.

Final Rule Details

Routine Annual Rate Setting Changes

Section 411(d) of the Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114-10) (MACRA) amends section 1814(i) of the Social Security Act to set the market basket percentage increase at 1 percent for hospices in FY 2018. As such, hospices will generally see a 1.0 percent ($180 million aggregate) increase in their payments for FY 2018.

The hospice payment system includes a statutory aggregate cap. The aggregate cap limits the overall payments made to a hospice annually. As mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113-185) (IMPACT Act), the cap amount for accounting years that end after September 30, 2016, and before October 1, 2025, must be updated by the hospice payment update percentage, rather than the Consumer Price Index (CPI). Therefore, the cap amount for FY 2018 will be $28,689.04 (2017 cap amount of $28,404.99 increased by 1 percent).

Hospice Quality Reporting Program

The rule finalizes eight measures from CAHPS Hospice Survey data already submitted by hospices. Further, the rule finalizes the extension or exception for quality reporting purposes from 30 calendar days to 90 calendar

days after the date that an extraordinary circumstance occurred. The rule describes plans to publically display quality measure data via Hospice Compare in August 2017. Additionally, this rule outlines policies and procedures associated with the public reporting of the quality measures used in the hospice program. The final rule also discusses the public comments received on two claim-based measures under consideration and the Hospice Evaluation & Assessment Reporting Tool (HEART), a patient assessment tool.

Hospice CAHPS® Experience of Care Survey

The Hospice CAHPS® Survey is a component of the Hospice Quality Reporting Program. This final rule sets out requirements for the Hospice CAHPS® Survey for the FY 2020, FY 2021, and FY 2022 annual payment updates. In addition, the rule adopts two global CAHPS® Hospice Survey measures and six composite CAHPS® Hospice Survey-based measures, which would be derived from data submitted on the survey. The rule also finalizes how these measures will be calculated based on the survey data. More information about the survey can be obtained at the survey website, www.hospicecahpssurvey.org.

Hospice CAHPS® is important for the hospice community because the results of the survey allow comparisons among hospices nationally. Once it is publically reported, CMS believes the data will help beneficiaries and their families select a hospice program. CMS also believes public reporting of survey results will encourage hospices to improve quality.

Hospice Quality Reporting Program Submission Exemption and Extension Requirements for the FY 2019 Payment Determination and Subsequent Years

For FY 2019 payment determination and subsequent years, CMS finalized that it will extend the period of time a hospice may have to submit a request for an extension or exception for quality reporting purposes from 30 calendar days to 90 calendar days after the date that an extraordinary circumstance occurred. This change will align the HQRP with the other post-acute care quality reporting programs, as well as the Hospital Inpatient Quality Reporting Program, and will give additional time for providers to focus on operations related to patient care should a situation arise, such as an unforeseen environmental emergency.

Public Reporting

CMS will begin public reporting hospice quality reporting program (HQRP) data via a Hospice Compare Site in August 2017 to help customers make informed choices. While HQRP includes both the Hospice Item Set (HIS) and Hospice CAHPS® Survey data, this new website will initially display only HIS data. The public display of the Hospice CAHPS® Survey data will be added in winter 2018. In this final rule, CMS has also finalized policies and procedures associated with the public reporting of the quality measures used in the Hospice Program, including release of the aggregate quality data file and the Provider Preview Reports.

Quality Measure Concepts Under Consideration for Future Years

Although CMS did not add new measures based on the Hospice Item Set in this final rule, we discussed and received public feedback on two measure concepts under consideration for future years. Those measure concepts are: 1) potentially avoidable hospice care transitions, and 2) access to levels of hospice care. Both measure concepts would be claims-based measures. These two measure concepts are under development. We discussed the comments received and will carefully consider them for any future rulemaking proposals. This includes details regarding measure definitions, specifications, and timeline for implementation, all of which would be communicated in future rulemaking.

New Data Collection Mechanisms Under Consideration: Hospice Evaluation & Assessment Reporting Tool (HEART)

CMS discussed enhancing the current Hospice Item Set data collection instrument to be more in line with other post-acute care settings. CMS received public feedback on considering this revised data collection instrument, HEART, which would be a patient assessment tool, rather than the current chart abstraction

tool. We discussed the comments received and will carefully consider them for any future rulemaking proposals.

The final rule went on display on August 1 at the *Federal Register's* Public Inspection Desk and will be available under "Special Filings," at http://www.federalregister.gov/inspection.aspx.

For further information, see http://www.cms.gov/Center/Provider-Type/Hospice-Center.html.

###

Medicare Issues Projected Drug Premiums for 2018

The Centers for Medicare & Medicaid Services (CMS) announced that the average basic premium for a Medicare Part D prescription drug plan in 2018 is projected to decline to an estimated $33.50 per month. This represents a decrease of approximately $1.20 below the actual average premium of $34.70 in 2017.

"We are committed to making prescription drug plan premiums affordable so that seniors and people with disabilities in Medicare can access the prescription drugs that they need," said CMS Administrator Seema Verma. "This projection is a step forward in fulfilling the Trump Administration's promise to lower the cost of prescription drug coverage, particularly for Medicare beneficiaries."

The decline in the average premium comes despite the fact that spending for the Part D program continues to increase faster than spending for other parts of Medicare, largely driven by spending on high-cost specialty drugs. As the recent 2017 Medicare Trustees reported noted, growth in Medicare spending on prescription drugs continues to exceed growth in other Medicare spending and in overall U.S. healthcare spending.

The projection for the average premium for 2018 is based on bids submitted by drug plans for basic drug coverage for the 2018 benefit year and calculated by the independent CMS Office of the Actuary.

The upcoming annual Medicare open enrollment period begins on October 15, 2017, and ends on December 7, 2017. During this time, Medicare beneficiaries can choose health and drug plans for 2018 by comparing their current coverage and plan quality ratings to other plan offerings or choose to remain in traditional Medicare. CMS anticipates releasing the premiums and costs for Medicare health and drug plans for the 2018 calendar year in mid-September.

To view the 2018 Part D base beneficiary premium, the Part D national average monthly bid amount, the Part D regional low-income premium subsidy amounts, the *de minimis* amount, the Part D income-related monthly adjustment amounts, the Medicare Advantage employer group waiver plan regional payment rates, and the Medicare Advantage regional PPO benchmarks, visit: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html and select "2018."

###

CMS finalizes 2018 payment and policy updates for Medicare hospital admissions

Final rule supports transparency, flexibility, program simplification and innovation in the Medicare program

Today, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule, which updates 2018 Medicare payment and policies when patients are discharged from hospitals. The final rule relieves regulatory burdens for providers, supports the patient-doctor relationship in healthcare, and promotes transparency, flexibility, and innovation in the delivery of care for Medicare patients.

"This final rule will help provide flexibility for acute and long-term care hospitals as they care for Medicare's sickest patients," said CMS Administrator Seema Verma. "Burden reduction and payment rate increases for

acute care hospitals and long-term care hospitals will help ensure those suffering from severe injuries and illnesses have access to the care they need."

In the final rule, CMS is increasing the amount of uncompensated care payments made to acute care hospitals by $800 million to approximately $6.8 billion for fiscal year 2018. Uncompensated care represents healthcare services provided by hospitals or providers for which they don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care. CMS is also providing further clarification about discounts given to uninsured patients who meet the hospital's charity care policy.

In relieving providers of administrative burdens and encouraging patient choice, CMS is finalizing a one-year regulatory moratorium on the payment reduction threshold for patient admissions in long-term care hospitals. CMS continues to evaluate this policy. CMS is also finalizing provisions that reduce clinical quality measure reporting requirements for hospitals that have implemented electronic health records.

Due to the combination of payment rate increases and other policies and payment adjustments, particularly in changes in uncompensated care payments, acute care hospitals will see a total increase in Medicare spending on inpatient hospital payments of $2.4 billion in fiscal year 2018. Based in part on the changes included in the final rule, overall payments to long-term care hospitals will decrease by $110 million in fiscal year 2018.

In addition to the payment and policy updates for Medicare hospital admissions, the final rule addresses changes to how the public is notified of Medicare terminations of certain providers and implements the statutory extension of the Rural Community Hospital Demonstration.

CMS also today issued a notice with comment period updating 2018 Medicare payment policies and rates for inpatient psychiatric facilities. CMS estimates that Medicare payments to inpatient psychiatric facilities will increase by $45 million, or nearly one percent, in fiscal year 2018.

For a fact sheet on the fiscal year 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html

For a fact sheet on the fiscal year 2018 Medicare Inpatient Psychiatric Prospective Payment System notice with comment period, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02-2.html

The fiscal year 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule (CMS-1677-F) and the fiscal year 2018 Medicare Inpatient Psychiatric Prospective Payment System notice with comment period (CMS-1673-NC) can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection

###

CMS Approves Florida Medicaid Demonstration Under New Era of State Flexibility

The Centers for Medicare & Medicaid Services (CMS) approved a five-year extension of Florida's Managed Medical Assistance (MMA) section 1115 demonstration that allows the state to operate a capitated Medicaid managed care program and a low-income pool (LIP) to provide continuing support for the safety net providers that furnish charity care to the uninsured.

"This program gives Florida the ability to care for its most vulnerable and at-risk citizens. Its renewal also provides flexibility to use the funds in a way that meets the unique needs of the State while reducing burden by eliminating duplicative reporting and documentation requirements," said CMS Administrator Seema Verma. "This extension has a positive and direct impact on people's lives and their ability to access care. Florida's program offers an innovative and realistic pathway to tackling some of Medicaid's biggest challenges."

This demonstration equips the state with new tools to help it meet the following goals:

- Provides necessary financial support to public teaching hospitals, children's hospitals, and other hospitals for the care they furnish to low-income uninsured Floridians; and

- Strengthens the breadth of access to and quality of providers participating in Florida's managed care program, including care provided by many Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC).

This agreement is the first demonstration approved through CMS's new approach to state reporting activities. The agency will monitor progress toward state-selected benchmarks and work with the state to design a meaningful program evaluation. These changes are consistent with CMS's commitment to lessen or remove inappropriately burdensome and/or duplicative state reporting activities.

Today's announcement further builds on a joint commitment from Health and Human Services Secretary Tom Price, M.D. and CMS Administrator Seema Verma to partner with states in improving the Medicaid program and the lives of those it serves. In the March 14, 2017 letter to governors, Secretary Price and Administrator Verma expressed a commitment "to empower all states to advance the next wave of innovative solutions to Medicaid's challenges—solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner."

For more information regarding the five-year extension of the Managed Medical Assistance (MMA) section 1115 demonstration in Florida please visit: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

###

Visit the New Hospice Compare Website for Important Information Relevant to Quality Hospice Care

As part of our continuing commitment to greater data transparency, the Centers for Medicare & Medicaid Services (CMS) unveiled the new Hospice Compare website. The site displays information in a ready to use format and provides a snapshot of the quality of care each hospice facility provides to its patients. CMS works diligently to make healthcare quality information more transparent and understandable for consumers and is committed to helping individuals make informed healthcare decisions for themselves and their families based on objective measures of quality.

The Hospice Compare site allows patients, family members, caregivers, and healthcare providers to compare hospice providers based on important quality metrics, such as the percentage of patients that were screened for pain or difficult or uncomfortable breathing, or whether patients' preferences are being met. Currently, the data on Hospice Compare is based on information submitted by approximately 3,876 hospices.

The Hospice Compare website will reflect current industry best practices for consumer-facing websites and will be optimized for mobile use.

For More Information

Please visit https://www.medicare.gov/hospicecompare/ and the Hospice Quality Public Reporting webpage.

###

Termination Notices Available via the Survey & Certification Website

The Centers for Medicare & Medicaid Services (CMS) eliminated the specific requirement for publishing public notice of Medicare provider agreement terminations in local newspapers for Ambulatory Surgical Centers (ASCs), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Organ Procurement Organizations (OPOs).To ensure public awareness of Medicare-certified provider, supplier, and laboratory involuntary terminations for failure to meet health and safety requirements, CMS will post the required public

notice of termination on a CMS website, accessible through a link on Medicare.gov. Posting these notices online allows for greater reach and exposure for these public notices.

For more information click here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-17-42.html?DLPage=1&DLEntries=10&DLFilter=17-42&DLSort=3&DLSortDir=descending

###

CMS Administrator: EpiPen Agreement Protects Medicaid Integrity, Saves Hundreds of Millions of Dollars

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce an agreement with Mylan regarding the classification of EpiPen. Per the agreement, Mylan will reclassify EpiPen as a brand name drug consistent with the Medicaid statute and regulations. In addition, Mylan has agreed to use the correct reference price of the 3rd quarter of 1990 for the purpose of calculating inflationary payment rebates under the Medicaid Drug Rebate (MDR) program, saving the Medicaid program hundreds of millions of dollars. These changes will be effective retroactive to April 1, 2017.

"Mylan's agreement with CMS to correctly classify EpiPen is a huge win for Medicaid beneficiaries and American taxpayers," said CMS Administrator Seema Verma. "Medicaid will no longer be overcharged for EpiPen, protecting access for Medicaid beneficiaries who rely on this lifesaving drug while saving hundreds of millions of dollars. This announcement puts drug manufacturers on notice that CMS remains vigilant in our duty to protect the integrity of the Medicaid program."

###

Upcoming Webinars and Events and Other Updates

2017 Medicare National Training Program (NTP) Workshops

The Centers for Medicare & Medicaid Services (CMS) Kansas City Regional Office invites you to attend the **2017 Medicare National Training Program (NTP) Workshops**.

This year we are pleased to offer the Workshop in 4 different locations. The same agenda and information will be provided at all Workshops.

When and Where

Kansas City, MO – SOLD OUT
Wednesday, August 9, 2017 12:30PM – 5:00PM to Thursday, August 10, 2017 8:00AM – 4:30PM
Register: https://www.eventbrite.com/e/medicare-national-training-program-ntp-workshop-kansas-city-tickets-35821672587

St. Louis, MO Area– SOLD OUT
Monday, August 14, 2017 12:30PM – 5:00PM to Tuesday, August 15, 2017 8:00AM – 4:30PM
Register: https://www.eventbrite.com/e/medicare-national-training-program-ntp-workshop-st-louis-area-registration-35433070267

Lincoln, NE– SOLD OUT
Thursday, August 24, 2017 12:30PM – 5:00PM to Friday, August 25, 2017 8:00AM – 4:30PM
Register: https://www.eventbrite.com/e/medicare-national-training-program-ntp-workshop-lincoln-tickets-35823187117

Des Moines, IA – 9 SEATS LEFT
Tuesday, August 29, 2017 12:30PM – 5:00PM to Wednesday, August 30, 2017 8:00AM – 4:30PM

Register: https://www.eventbrite.com/e/medicare-national-training-program-ntp-workshop-des-moines-tickets-35823465951

Topics to be covered are:

- Medicare 101 - Explains the Medicare Program including what it is, coverage and costs, coverage choices, enrollment, coordination of benefits, and how to fight fraud and abuse.
- Medicare Supplement Insurance (Medigap) Policies - Explains how Medigap policies work with Medicare, what Medigap policies cover, how they are structured, and when to buy a Medigap policy.
- Medicare Advantage - Explains Medicare health plan options other than Original Medicare.
- Medicare Prescription Drug Coverage - Provides an overview of Medicare prescription drug coverage under Part A (Hospital insurance), Part B (Medical Insurance), and Part D (Prescription Drug Coverage).
- Medicare and Other Programs for People With Disabilities/SSA - Explains Medicare, Social Security benefits and other programs for people with disabilities.

- Medicare and Medicaid Fraud and Abuse Prevention - Explains Medicare and Medicaid fraud and abuse prevention, detection, reporting, recovery and the Office of the Inspector General's role in fighting healthcare fraud including showcasing resolved fraudulent Medicare and Medicaid cases.

- CMS' Approach to Combating the Opioid Epidemic - Explains CMS' goals, scope and focus on the misuse of opioids.
- Medicaid and the Children's Health Insurance Program - Describes eligibility, benefits, and administration of Medicaid; Define eligibility, benefits, and administration of the Children's Health Insurance Program (CHIP).
- Casework - Hands-on experience working through case scenarios pertaining to Medicare Parts C & D.
- Current Topics - Explains new policies, innovations, and legislation.
- CMS Program Resources - Outlines key websites, associated resources, and tools for the programs administered by CMS—Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace.
- Opportunities to network with CMS staff and subject matter experts and other organizations working with the Medicare/Medicaid population.

As always, there will be no charge to you for the training; however, CMS will not be able to provide food or drinks.

We will be providing materials electronically to attendees prior to the Workshop. Attendees will be responsible for bringing any hard copies of materials they would like, or have access to them electronically on their own personal device. Please make sure your email address in your registration is correct.

In addition, if you register for a Workshop and then later determine you are unable to attend, please access Eventbrite and cancel your ticket so others can attend. Those who register and do not attend may be placed on a wait list for future CMS events.

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

###

HHS Live-Stream- National Recovery Month Event

Recovery, Prevention, & Hope: National Experts Equip Faith and Community Leaders on Opioids and Addictions

On September 27, live from Washington D.C., the U.S. Department of Health and Human Services will convene national speakers to talk directly to faith and community leaders about the opioid epidemic and other addictions to raise awareness, encourage compassion, reinforce the role of community and families in long-term recovery and prevention, and make a call to action.

Please save the date and consider hosting a post-broadcast discussion in your community with local experts and discuss approaches for fostering healing and aligning community-wide efforts to renew wholeness in your community. To help with those discussions, the HHS Partnership Center will introduce a new "Practical Toolkit" for congregations and communities to act as a discussion guide.

Save the date, gather your community and stay tuned for details! If you need help hosting an event, contact Heidi.Christensen@hhs.gov

###

CMS Fraud Prevention Initiative

CMS is readying a fraud prevention initiative that will remove Social Security numbers from Medicare cards to help combat identity theft and safeguard taxpayer dollars. CMS will begin mailing new Medicare cards in April 2018 and complete this mailing by April 2019. To help you find information quickly, we've designed a new page at CMS.gov/newcard with all the latest updates. Visit us and bookmark the page so you can get the newest details as they are released. And check out the messaging guidelines to find out how we'll be talking to people

with Medicare about this change. There's also an area just for partners and employers which includes a new Medicare card overview PowerPoint.

Webinar: New Medicare Cards

Register Now

September 12, 2017 2:00 - 3:30 ET

This webinar will provide an overview about the new Medicare card including:

- Why there will be a new card
- What to expect during the transition period
- How CMS is reaching out to providers and people with Medicare including a timeline for the new cards and key points to remember

To join the webinar, visit goto.webcasts.com/starthere.jsp?ei=1156802&tp_key=5351ea445f

###

Newly Posted Training Materials

- Job Aid revised: 2017 Comparison of the Parts A, B, C, and D Appeal Processes (Part A and Part B Fee-for-Service)
- Module 2: Medicare Rights and Protections – Spanish
- Module 3: Medigap – Spanish
- Module 5: Coordination of Benefits – Spanish
- Module 7: Medicare Preventive Services – Spanish
- Module 8: CMS Program Resources – Spanish
- Module 11: Medicare Advantage Plans – Spanish
- Module 13: Medicare and Other Programs for People with Disabilities Medicare and the Marketplace - English and Spanish

###

Medicare Learning Network Publications & Multimedia

News & Announcements

- Antipsychotic Drug use in Nursing Homes: Trend Update
- Beneficiary Notices: Large Print Forms Available
- Chronic Care Management: New Connected Care Videos
- CMS Releases Hospice Compare Website to Improve Consumer Experiences, Empower Patients
- CMS Releases Updated Data on Medicare Hospice Utilization and Payment
- CMS Updates Medicare Payment Rates, Quality Reporting Requirements
- EHR Incentive Program Hardship Exception Application Due by October 1
- Home Health Quality Reporting Program: OASIS-C2 2018 Guidance Manual Available
- Hospice Benefit: FY 2018 Updates to the Wage Index and Payment Rates
- Hospitals: Submit Meaningful Use Data to the HQR via the QualityNet Secure Portal in 2018
- IRFs: Final FY 2018 Payment and Policy Changes
- Medicare Fee-For-Service Beneficiary Selection of a Primary Clinician
- New Medicare Card: Webpage Updates
- Proposed Changes to Comprehensive Care for Joint Replacement Model, Cancellation of Other Models
- Quality Payment Program Hardship Exception Application for 2017 Transition Year Open
- Quality Payment Program: Explanation of Special Status Calculation — Correction

- SNF Quality Reporting Program Web-based Training Module Available
- SNFs: Final FY 2018 Payment and Policy Changes
- Vaccines are Not Just for Kids

Provider Compliance

- Reporting Changes in Ownership
- Inpatient Skilled Nursing Facility Denials
- Home Health Care: Proper Certification Required

Claims, Pricers & Codes

- ICD-10 GEMS for 2018 Available
- 2018 ICD-10-CM Coding Guidelines and Conversion Table Available
- Part B Billing for Certain New Biosimilar Biological Products before the Modifier is Implemented

Upcoming Events

- CMS National Provider Enrollment Conference — September 6 and 7
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7
- Comparative Billing Report on IPPE/AWV Webinar — September 13

Medicare Learning Network Publications & Multimedia

- August 2017 Catalog Available
- Quality Payment Program 2017: MIPS Quality Performance Category Web-Based Training Course — New
- Long-Term Care Call: Audio Recording and Transcript — New
- ESRD Listening Session: Audio Recording and Transcript — New
- Medicare Secondary Payer Web-Based Training Course — Revised
- Medicare Secondary Payer Booklet — Revised
- Medicare Part B Immunization Billing Educational Tool — Revised
- The ABCs of the Annual Wellness Visit Educational Tool — Reminder
- Care Management Listening Session: Audio Recording and Transcript — New
- Medicare Parts A & B Appeals Process Booklet— Revised
- DMEPOS Information for Pharmacies Fact Sheet – Revised
- DMEPOS Accreditation Fact Sheet – Revised

###

New Publications

- Medicare Drug Coverage under Medicare Part A, Part B, Part C & Part D
- Medicare Coverage of Cancer Treatment Services
- How Medicare Prescription Drug Coverage Works with a Medicare Advantage Plan or Medicare Cost Plan – Spanish
- What To Do If You No Longer Automatically Qualify For Extra Help With Medicare Prescription Drug Coverage Costs – Spanish
- What are Long-Term Care Hospitals? - Spanish
- Medicare's Coverage of Dialysis and Kidney Transplant Benefits: Getting Started – Spanish
- Medicare Coverage of Kidney Dialysis and Kidney Transplant Services
- Medicare for Children with End-stage Renal Disease – Spanish
- Coordination of Benefits: Getting Started – Spanish
- Get Covered: A one-page guide to the Health Insurance Marketplace – Spanish

- Get Covered: A one-page guide to the Health Insurance Marketplace
- Special Enrollment Periods Available to Consumers
- Marketplace Pre-Application Worksheet
- College Marketplace Brochure
- Appealing eligibility decisions in the Marketplace
- Medicare & Your Mental Health Benefits
- Already have Marketplace coverage? You should still compare plans every year
- Already have Marketplace coverage? You should still compare plans every year - Spanish
- 4 Ways to Help Lower your Medicare Prescription Drug Costs - Spanish
- Information Partners Can Use on: Reassignment - Spanish

###

Immunization Awareness Month

The importance of immunizations and health is a year 'round topic, but August, especially, is a good time to promote awareness. The National Immunization Awareness Month Toolkit, available from the Office of Disease Prevention and Health Promotion, includes plans for taking action, such as: articles to share, sample tweets, suggested newsletter items, ideas for community events, and a badge to add to your web page. By raising awareness about the importance of vaccines, we can all work together to help prevent serious illnesses and diseases.

###

Clergy Toolkit for PTSD

This toolkit -- developed by the National Center for PTSD in consultation with leaders of the Department of Veterans Affairs National Chaplain Center and Mental Health and Chaplaincy Program -- was created for clergy who work with veterans and service members who have or are at risk for developing post traumatic stress disorder. The purpose of the Clergy Toolkit is to provide practical information and tools to support clergy members both within and outside of the VA who serve these and other trauma survivors. Much of what is contained here is also helpful to clergy members supporting non-military trauma survivors.

###

SAVE the DATE: Recognizing World Suicide Prevention Day on September 10!

The Partnership Center
Center for Faith-based and Neighborhood Partnerships
U.S. Department of Health and Human Services

In recognition of World Suicide Prevention Day (Sept. 10) and National Suicide Prevention Month (Sept.) the Faith Communities Task Force of the National Action for Suicide Prevention (Action Alliance) in collaboration with leaders in faith, business, government, healthcare, and social justice, invite you to participate in National Day of Prayer for Faith, Hope, & Life (www.faith-hope-life.org).

We encourage you to join during the weekend (9/8-9/10) leading up to World Suicide Prevention Day to recognize those whose lives have been touched by suicide.

It is the goal to reach as many people as possible with the invitation to come together collectively to call for Faith, Hope, and Life. Please share the National Day of Prayer Save the Date widely within your faith community and other networks.
Thank you in advance for your willingness to shine light on this important issue and to pray for those who are struggling.
HHS Partnership Center

###

IMPACT Act: Medicare Spending Per Beneficiary Measures Call

Wednesday, September 6, 2017, from 1:30 to 3 pm ET

During this call, CMS and measure developers present information on the adopted Medicare Spending per Beneficiary Post-Acute Care (PAC) resource use measures, focusing on the components of each measure, as well as public reporting. A question and answer session follows the presentation.

The Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) requires the development of resource use measures for PAC providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

Target Audience: PAC providers, health care industry professionals, clinicians, researchers, health IT vendors, and other interested stakeholders.

You may email questions in advance of the call to PACQualityInitiative@cms.hhs.gov. Questions received in advance of the call may be addressed during the call or used for other materials following the call.

###

Call for Membership Applications for the Heartland Regional Health Equity Council - Application Deadline: September 4, 2017

The National Partnership for Action to End Health Disparities (NPA) was established to mobilize a nationwide, comprehensive, community-driven and sustained approach to combat health disparities in order to move the nation toward achieving health equity. Regional Health Equity Councils (RHECs) were formed within the 10 federal regions to bring together leaders and stakeholders committed to improving health equity and addressing health disparities.

The Region VII RHEC (Heartland RHEC) plays a critical role in coordinating and enhancing state and local efforts to address health disparities and the social determinants of health at the regional level. Region VII encompasses the following states: Iowa, Kansas, Missouri and Nebraska. More information about the Council can be found at: http://region7.npa-rhec.org/.

How to Apply to Be a Heartland RHEC Member:
We are currently accepting applications from qualified individuals interested in becoming members of the Heartland RHEC from the four states in Region VII. Individuals interested in serving on the Council may submit an application online using the following link: http://region7.npa-rhec.org/membership

The Heartland RHEC is a volunteer, not-for-profit association of 25 members that brings together leaders from diverse backgrounds including healthcare providers, healthcare-focused organizations, academia, public health agencies, economic development, faith-based organizations, grassroots organizations, other nonprofit organizations and the business sector to reinforce the need for multi-sector linkages as a key strategy for ending

health disparities in America.

###

Grant Writing & Capacity Building Workshop - 8/29-30/2017

Link to Register: http://www.ksutab.org/education/workshops

FEDERAL GRANT WRITING WORKSHOP

The U.S. EPA Region 7 Brownfields and Environmental Justice programs along with the Technical Assistance to Brownfields (TAB) Program at Kansas State University and the States of Iowa, Kansas, Missouri and Nebraska Brownfields Programs are co-hosting a two-day* grant writing workshop. The workshop is designed to offer tools and tips for grant writing and successful execution of funded grants.

*** ONE-ON-ONE TECHNICAL ASSISTANCE MAY BE SCHEDULED FOR AUGUST 31, 2017.** For an appointment, please email Maggie Weiser, mjweiser@ksu.edu and include your name, organization and type of grant proposal you are seeking assistance for.

TARGET AUDIENCE

- Local and regional government officials, not-for-profit economic and community development organizations, and any other entity interested in applying for federal grants to assist with the assessment, cleanup, or redevelopment of their community.
- Environmental Justice grantees/award recipients.

ADDITIONAL INFORMATION

For additional information, please contact:

Maggie Weiser 785-532-0782
Kansas State University TAB Program

Jennifer Morris 913-551-7341
U.S. EPA Region 7 Brownfields Program

Althea Moses 913-551-7649
U.S. EPA Region 7 Environmental Justice Program

Gary Richards 785-291-3246
Kansas Brownfields Program

Catherine Jones 573-526-4725
Missouri Brownfields Voluntary Cleanup Program

Mel Pins 515-725-8344
Iowa Brownfield Redevelopment Program

Taryn Serwatowski 402-471-6411
Nebraska Brownfields Voluntary Cleanup Program

REGISTRATION

Registration is free of charge, but is required. Please visit the workshop webpage at: http://www.ksutab.org/education/workshops to register and view the workshop agenda. Please contact Sheree Walsh, chsr@ksu.edu if you need help with your registration.

****Please share this information with your colleagues, clients, listservs and anyone you think would benefit from attending this workshop.****

This workshop made possible with funding provided by the U.S. EPA.

TAB
KANSAS STATE UNIVERSITY

Office of Minority Health Health Resources

View as webpage

OMH
U.S. Department of Health and Human Services
Office of Minority Health

August 2017

The Office of Minority Health (OMH) invites you to help us share resources with American Indian and Alaska Native communities to promote the 2017 Behavioral Risk Factor Surveillance System Oversampling Study (BRFSS). This phone survey aims to increase understanding of health-related risk behaviors, chronic health conditions, access to care and use of preventive services in American Indian/Alaska Native (AI/AN) populations. Click here to download and share outreach materials related to this initiative.

In This Issue:

- Health Insurance
- Hispanic/Latino Health
- Maternal and Child Health
- Substance Use
- Vaccines
- Workforce Development
- @ The Knowledge Center - Recommended Reading

Funding

Federal Grants

- HHS/Indian Health Service (IHS): Domestic Violence Prevention Initiative Grant. The primary purpose of this grant program is to build Tribal, Urban Indian Organizations, and Federal capacity to provide coordinated community responses to AI/AN victims of domestic and sexual violence. Deadline is August 31, 2017. Learn more.
- HHS/Indian Health Service (IHS): Behavioral Health Integration Initiative (BH2I). The purpose of BH2I is to improve the physical and mental health status of AI/ANs with behavioral health issues by developing an integrative, coordinated system of care between behavioral health and primary care providers. Deadline is September 16, 2017. Learn more.
- HHS/National Institutes of Health (NIH), National Heart, Lung, and Blood Institute (NHLBI): Increasing Use of Cardiovascular and Pulmonary Rehabilitation in Traditional and Community Settings (R61/R33) Exploratory/Developmental Phased Award. Deadline for Letter of Intent (LOI) is September 19, 2017. Learn more.
- HHS/National Institutes of Health (NIH), National Human Genome Research Institute (NHGRI) and others: Ethical, Legal, and Social Implications of Genomics (R01) Research Project Grant Program. Deadline is October 5, 2017. Learn more.
- HHS/NIH: Addressing Health Disparities through Effective Interventions among Immigrant Populations (R01) Research Project Grant. Deadline is October 5, 2017. Learn more.

Non-Federal Grants

- Futures Without Violence/Quality Improvement Center on Domestic Violence in Child Welfare (QIC-DVCW): Research and Capacity Building Project. QIC-DVCW will work with up to four projects across the country to develop, implement and evaluate practices, policy and programming to promote the safety and well-being of adult and child domestic violence survivors, accountability and meaningful support for change for people using violence and coercion with a partner, and permanency for children. Deadline is September 29, 2017. Learn more | A Technical Assistance webinar will be held September 1, 2017, 2:00 pm ET. Register.
- DentaQuest Foundation: Community Response Fund. Supports small, one-time grants that address access to oral health care. Applications accepted on an ongoing basis. Learn more.

Scholarships / Fellowships / Internships / Mentoring

- United Negro College Fund (UNCF): 2017 UNCF Historically Black Colleges and Universities (HBCU) Innovation Summit. Applications are open to HBCU students majoring in health information systems and health information technology. Event to be held in San Mateo, CA. Deadline is September 4, 2017. Learn more.

American Indian/Alaska Native Health

Events

- HHS/NIH, National Network of Libraries of Medicine (NNLM): Webinar. *American Indian Health Information Resources*. This program will introduce a variety of governmental and non-governmental

Internet resources that have health information for AI/AN populations. August 24, 2017, 2:00 pm ET. Register.

Black and African American Health

Events

- AEIMforward Tech Services and partner organizations: Registration open for the 5th Annual United States Conference on African Immigrant and Refugee Health (USCAIH), *Advancing the Health of African Immigrants through Research, Advocacy and Community Engagement*. October 5-8, 2017 in Washington, DC. Learn more.

Cardiovascular Health

Continuing Education

- Association of Black Cardiologists and the National Association for Continuing Education: Conversations in Cardiology virtual live conference. *Diabetes and Cardiovascular Disease, Dyslipidemia, and Congestive Heart Failure*. This free live course offers 3.5 AMA PRA Category Credits and 3.5 AANP Contact hours. September 23, 2017, 10:00 am ET. Register.

Clinical Trials

- HHS/NIH, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK): Therapeutic Targets in African-American Youth With Type 2 Diabetes. NIH researchers seek African American youth, ages 12-21, diagnosed with type 2 diabetes less than 3 years ago, for a study to test whether using liraglutide and metformin in combination will be better than using metformin alone in treating African-American youth with type 2 diabetes. Study to be conducted at the NIH Clinical Center in Bethesda, MD. Learn more.
- HHS/NIH, National Institute of Allergy and Infectious Diseases (NIAID): Sanaria PfSPZ Challenge with Pyrimethamine Chemoprophylaxis (PfSPZ-CVac Approach): Trial to Determine Safety and Development of Protective Efficacy after Exposure to Only Pre-erythrocytic Stages of Plasmodium Falciparum. NIH researchers seek healthy volunteers, ages 18-50, to test a potential new malaria vaccine. Study to be conducted at the NIH Clinical Center in Bethesda, MD. Learn more.

Cultural Competence and CLAS

Events

- The Cross Cultural Health Care Program: Training. *Equity and Inclusion Cultural Competency Training of Trainers* (TOT) *Institute*. This TOT will build internal training capacity, meet mandates for culturally and linguistically appropriate services, and provide best practices on equity and inclusion. October 2-6, 2017 in Seattle, WA. For further information and to register, please contact Aselefech Evans.

Diabetes

Events

- HHS/OMH, in partnership with the Centers for Disease Control and Prevention (CDC): Webinar. *The Important Role of Faith-based Organizations in Fighting Diabetes*. Speakers from the CDC and Sheilah Easterling-Smith of Methodist Le Bonheur Healthcare will discuss how faith-based organizations can help address diabetes, and will highlight the CDC National Diabetes Education Program (NDEP)'s Faith Leaders Toolkit. August 31, 2017, 11:00 am ET. Register

Health Insurance

Events

- HHS/CMS: Training. *2017 Partner Train the Trainer Workshops*. Participants will learn about Medicare Parts A, B, C & D, program specifics, and current topics and updates for other CMS initiatives/programs. Workshops will be held by the CMS Region VI Dallas Regional Office on **August 23-24** in Houston, TX, and **August 28-29** in Oklahoma City, OK.

Hispanic/Latino Health

Events

- University of Texas (UT) Health Cancer Center and the Institute for Health Promotion Research at UT Health San Antonio: Call for abstracts for the inaugural *Advancing the Science of Cancer in Latinos* conference. Event to be held in San Antonio, TX. Deadline for abstracts submission is November 1, 2017. Learn more.

Online Survey

- NHCOA: Request for responses to the *Hispanic Caregivers Survey/Encuesta de Cuidadores Hispanos*. NHCOA invites Hispanic caregivers to participate in this brief survey and share their insights and recommendations so that the needs of Hispanic caregivers and their families can be shared at the national level. Complete the survey in English | Complete la encuesta en español.

Maternal and Child Health

Resources

- HHS/Office on Women's Health (OWH): New breastfeeding health promotion campaign. As part of National Breastfeeding Month, OWH is promoting its *#First31 Series* to help expecting and new moms prepare for and navigate their "first 31 days" of breastfeeding. Each day, OWH will share a promotional graphic and resource via social media. Follow and share the series using OWH's Twitter page, the #First31 hashtag or the OWH Facebook page.

Mental Health

Resources

- HHS/Substance Abuse and Mental Health Services Administration (SAMHSA): New fact sheet. *Tips for Survivors: Coping with Grief after a Disaster or Traumatic Event*. This tip sheet contains information about grief, the grieving process, and what happens when the process is interrupted and complicated or traumatic grief occurs. Learn more | Download full fact sheet (PDF).

Vaccines

Events

- HHS/Food and Drug Administration Office of Minority Health (FDA-OMH): Webinar. *An Examination of the Role of Advertising and Promotion in Adult Immunization Disparities*. As part of National Immunization Awareness Month, join researchers from FDA and Howard University as they discuss barriers that may hinder receipt of vaccines and strategies that may aid in encouraging the receipt of vaccines among minority populations. August 23, 2017, 11:00 am ET. Register.

Workforce Development

Events

- HHS/NIH, Office of Equity Diversity and Inclusion (EDI): Be Inspired series. *Tools for Maximizing Your Success*. Speaker Carla Harris, Vice Chairman of Morgan Stanley and Global Wealth Management and Senior Client Advisor, will address workplace issues such as understanding the difference between advisors, mentors, and sponsors, facing fears, becoming a more confident leader, and what it means to have performance and relationship currency. September 7, 2017, 10:00 am ET at Building 10 of the NIH Campus Lipsett Auditorium in Bethesda, MD. Join in person or watch live via NIH VideoCasting.

@ The Knowledge Center - Recommended Reading

- *Advancing the Right to Health*, issued by the World Health Organization in 2017, is an extensive report that raises awareness on how legislative actions can improve public health. Subtitled *The Vital Role of Law*, it uses case studies from several countries, including the United States, to demonstrate the influence of law on public health outcomes. The report also addresses several priorities to consider in the development of public health laws. To view this title and find additional information, search our online catalog.
- This week, we are highlighting *Free to Breastfeed*, subtitled *Voices of Black Mothers* and written by Jeanine Valrie Logan and Anayah Sangodele-Ayoka. This publication provides advice and encourages African American women and others of African heritage to breastfeed. The book includes testimonials, pictures, and a resource guide. To view this title and find additional information, search our online catalog.

###

Funding Opportunities

NACCHO Health Impact Assessment Grants: ***Due September 15*** - The Health Impact Project, a collaboration of RWJF and Pew Charitable Trusts, announced a new funding opportunity, which will award at least four, two-year grants of up to $100,000 to advance Health Impact Assessments implementation.

AHRQ Implementation & Evaluation of Health IT Strategies: ***Due September 25*** - AHRQ is funding projects that stimulate innovative and collaborative research by utilizing new health IT strategies for collecting and using patient-reported outcome measures in primary care and other ambulatory care settings.

###

Upcoming Events

Conference Presentations

- **APPAM Annual Research Conference**: ***November 2 - 4 in Chicago, IL*** - DASH grantee NYC Department of Health and Mental Hygiene is presenting about how they are using neighborhood tabulation areas to enhance their community health analysis, monitoring, and planning.

- **APHA Annual Meeting**: ***November 4 - 8 in Atlanta, GA*** - During an *All In* session, four local health departments will discuss how they are accessing, analyzing and leveraging big data to address public health priorities.

Webinars

All In* Webinar: Building Patient-Centered Care Coordination Data Systems**: ***August 30 @ 2:00 pm ET - Attend the second in a series of project showcase webinars where local projects will share insights and lessons learned about integrating multi-sector data for community health improvement.

###

Rural Health Grants Webinar Series: "Understanding the How, the Where, the Resources

The Health Resources and Services Administration, Office of Regional Operations–Kansas City, invites you to a **Rural Health Grants Webinar Series**: "**Understanding the How, the Where, the Resources"**. The goal of this free webinar series is to educate potential applicants about HRSA programs and resources, the federal grant application process, federal and state funding opportunities, as well as important tips, resources, and training opportunities to drive a successful grant application.

Session #4: **Vision, Design and Capacity Grant Writing Trainings / Office of Minority Health Resource Center**
Monday, August 28th / 10am - 11am CT

Session #5: **Creating a Competitive Proposal**
Tuesday, September 19th / 9:30am - 11am CT

NEW SESSION
Session #6: **How to Work with Foundations**
Monday, September 25th / 10:00am – 11:30am CT

To register for any of the sessions - If you have any questions or need additional information, please contact Richard Overcast at 816-426-5227 or at ROvercast@hrsa.gov.

###

FIHET Equity in All Policies Webinar Series: Advancing Health Equity in Tribal Communities through Public Health Accreditation

You are invited to a webinar hosted by the Federal Interagency Health Equity Team

DATE AND TIME: August 24, 2017, 3:00 – 4:00 p.m. EDT
Tribal communities bear a disproportionate burden of social, economic, and/or environmental disadvantage relative to other racially or ethnically defined population groups. Therefore, ensuring that all American Indians and Alaska Natives (AI/ANs) achieve the highest level of health possible will require broad-spectrum action that goes beyond addressing individual determinants and disease management to include action to address such disadvantages.
This webinar will highlight the work that has been done at the national level as well as within a tribal community to advance health equity and improve health outcomes for AI/ANs.
Presenters will: Provide a background on the landscape of public health in Indian Country; Discuss the findings of an environmental scan on the state of public health accreditation and health equity within tribal communities; and Share one tribe's approach to using public health accreditation activities to achieve health equity within its community.

Karrie Joseph, MPH, CHES, Public Health Programs Manager, NIHB, **Carrie Sampson** (Umatilla, WallaWalla, Cayuse), Assistant Administrator, Yellowhawk Tribal Health Center
Register Here **Click** Here **for Full Abstract and Speaker Biographies.**

###

Taking Action for a Healthier Missouri Now!

Presented by Missouri Public Health Association, Missouri Association of Local Public Health Agencies, Missouri Institute for Community Health, and Missouri Department of Health and Senior Services

Date: September 25 - 27, 2017
Where: Stoney Creek Inn, Columbia, MO

Information regarding registration can be found here: http://www.mopha.org/viewevent.php?id=1226

###

Registration Open for the 15th Annual Missouri Health Policy Summit

October 26-27, 2017 Hilton Garden Conference, Columbia, MO
How we produce and consume food has a bigger impact on American's well-being than any other human activity. The food industry is the largest sector of our economy and food touches everything from our health to the environment, climate change, economic inequality and the federal budget. The time is ripe to revisit our food system and identify ways to change our policies to improve health.
On another track, the New Administration and the 115th US Congress is planning and implementing changes in the priorities for national health policies.
This is a unique time in history to examine the intersection between these two policy arenas. This presents opportunities for wins in both policy arenas that assures access to healthful food, appropriate food marketing, chronic disease prevention, and reduced health care costs and premature deaths.

Summit Objectives:
Identify food and health policy intersections and opportunities for gains in both arenas to improve Missouri's economy and public health.
Examine the impact of local, state and federal food policy and environmental change on health, including Local projects and programs with demonstrated success in Missouri; Private sector actions making a difference in public health; State-level policy initiatives; and The Farm Bill, federal food policy and public health. Review the major shifts in food and nutrition patterns and the impact these have had on Missouri's rates of preventable, chronic disease. Share the most current information on health reform in 2017 and implications for Missouri.

###

2017 Mental Health Conference

October 3, 2017
Holiday Inn Airport
6111 Fleur Drive
Des Moines, IA 50321

The 2017 Mental Health Conference is designed for professionals, clinicians, administrators, educators, consumers, family members, advocates, and other providers.
Conference Audience and Objectives:

- Provide an educational opportunity to hear professionals and experts share the most recent trends and issues, treatment methods, and research relating to mental health, mental illness, and co-occurring disorders.
- Provide a forum to stimulate discussion, exchange ideas, and strengthen the support and information network around the state.
- Generate public interest in issues relating to mental health and co-occurring disorders.

###

Iowa One Health Conference

The upcoming second annual 2017 Iowa One Health Conference will bring together a multidisciplinary cast of students and professionals in relevant fields to learn and discuss how the concept of One Health can help drive positive change in the health of humans, animals, and the environment.
Planning for IOHC 2017 is currently underway. Stay tuned on Facebook and Twitter for updates!

Event	2nd Annual 2017 Iowa One Health Conference
Date	Saturday, October 14th, 2017
Time	9:00AM – 5:00 PM
Location	University of Iowa College of Public Health Building
Cost	TBD

2017 conference registration: to be announced.

For poster presenters, click here.
For travel information, click here.

To find out more about the Inaugural 2016 Iowa One Health Conference, click here.

###

2017 Rural Health Conference

September 20 – 21, 2017 - Younes Conference Center - Kearney, NE

Nebraska Rural Health Conference bring together residents of rural Nebraska communities, rural health professionals of all specialties representatives of state, local, and national governments, and the full range of private sector rural health organizations.

For more information: http://nebraskaruralhealth.org/events/2017

###

Nebraska Public Health Association Conference

September 22, 2017 - Embassy Suites in Lincoln, NE
Call for presentations and posters at http://publichealthne.org/

###

2017 Tobacco-Free College Program for Community Colleges and Minority-Serving Institutions

In the fight to curb tobacco use in the U.S., college campuses have emerged as a critical battleground.

That's because virtually all smokers—99 percent—start smoking before turning 26 years old. Community colleges and minority-serving academic institutions are especially important because they tend to serve students who are at greater risk for tobacco use, including low-income and first-generation students.

To keep the momentum going, Truth Initiative is launching its new Tobacco-Free College Program, which offers **17-month grants of up to $20,000 to community colleges and minority-serving institutions** to adopt a 100 percent tobacco-free college policy. Grantees receive guidance through webinars, learning communities and one-on-one consultations throughout the grant period.

Please visit the Truth Initiative website to view the grant guidelines, application information, and registration for an informational webinar.

The deadline for applications is Wednesday, October 11, 2017.

For more information, please contact Kristen Tertzakian at ktertzakian@truthinitiative.org or 202-454-5788.

###

LACTATION SUPPORT MINI-GRANT FOR BUSINESSES

The Missouri Breastfeeding Friendly Worksite Program is a state-wide initiative to increase employer support for breastfeeding mothers. The Missouri Department of Health and Senior Services (DHSS) is offering up to $500 to a limited number of Missouri employers to create or improve their lactation support policies and programs. For example, funds may be used on locks on doors, privacy screens/partitions, comfortable chair, table or other flat surface to hold a breast pump, or signs. To be eligible to receive a mini-grant, the employer must submit their breastfeeding support policy which must be in compliance with the breastfeeding support requirements from the Fair Labor Standards Act (FLSA). Applications can be found here. To apply, please complete the application and budget, and submit by September 1 to marcia.davis@health.mo.gov. Please call 573-522-2820 with any questions.

###

NIH Grants - How to Apply Video Tutorials

New to the NIH grant process? Ever wish someone would explain and walk you through applying for NIH grants step by step? If so, the new page from NIH Office of Extramural Research may be just for you.
Linked from the How to Apply page, you will find four new interactive tutorials on the basics of preparing, writing, and submitting your application. Tutorials take between 4 to 11 minutes each to listen through, and you can easily jump ahead to chapters of interest, or navigate back to review something you've missed. These tutorials link to additional resources and transcripts.

###

Rural Health Opioid Program - Grant Opportunity from HHS Health Resources and Services Administration (HRSA)

This announcement solicits applications for the Rural Health Opioid Program (RHOP). The purpose of RHOP is to promote rural health care services outreach by expanding the delivery of opioid related health care services to rural communities. The program will reduce the morbidity and mortality related to opioid overdoses in rural communities through the development of broad community consortiums to prepare individuals with opioid-use disorder (OUD) to start treatment, implement care coordination practices to organize patient care activities, The program supports three (3) years of funding. This program incorporates a range of objectives to respond comprehensively to the opioid crisis within rural communities. For more information visit the Rural Health Opioid Program Grant Opportunity.

###

National Medicare Education Program (NMEP) Meeting Save the Date- September 27, 2017

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