CMS Region 7 Updates – 11/10/2017

Table of Contents

Weekly Enrollment Snapshot: Week One

Week 1, Nov 1-4, 2017

In week one of Open Enrollment for 2018, 601,462 people selected plans using the HealthCare.gov platform. As in past years, enrollment weeks are measured Sunday through Saturday. Consequently, week one was only four days long this year - from Wednesday to Saturday.

Every week during Open Enrollment, the Centers for Medicare and Medicaid Services (CMS) will release enrollment snapshots for the HealthCare.gov platform, which is used by the Federally-facilitated Exchanges, the State Partnership Exchanges, and some State-based Exchanges. These snapshots provide point-in-time estimates of weekly plan selections, call center activity, and visits to HealthCare.gov or CuidadoDeSalud.gov.

The final number of plan selections associated with enrollment activity during a reporting period may change due to plan modifications or cancellations. In addition, the weekly snapshot only reports new plan selections and active plan renewals and does not report the number of consumers who have paid premiums to effectuate their enrollment.

Definitions and details on the data are included in the glossary.

HealthCare.gov Platform Snapshot

HealthCare.gov Platform Snapshot	Week 1 Nov 1 – 4
Plan Selections	601,462
New Consumers	137,322
Consumers Renewing Coverage	464,140
Consumers on Applications Submitted	1,351,499
Call Center Volume	527,046
Calls with Spanish Speaking Representative	35,365
HealthCare.gov Users	2,571,931
CuidadoDeSalud.gov Users	65,538
Window Shopping HealthCare.gov Users	338,294
Window Shopping CuidadoDeSalud.gov Users	5,725

Glossary

Plan Selections: The cumulative metric represents the total number of people who have submitted an application and selected a plan, net of any cancellations from a consumer or cancellations from an insurer that have occurred to date. The weekly metric represents the net change in the number of non-cancelled plan sections over the period covered by the report.

Plan selections will not include those consumers who are automatically re-enrolled into a plan.

To have their coverage effectuated, consumers generally need to pay their first month's health plan premium. This release does not report the number of effectuated enrollments.

New Consumers: A consumer is considered to be a new consumer if they did not have 2017 Exchange coverage through December 31, 2017 and had a 2018 plan selection.

Renewing Consumers: A consumer is considered to be a renewing consumer if they have 2017 Exchange coverage through December 31, 2017 and either actively select the same plan or a new plan for 2018.

Exchange: Generally, references to the Federally-facilitated Exchange in this report refer to 39 states that use the HealthCare.gov platform. The states using the HealthCare.gov platform are Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

HealthCare.gov States: The 39 states that use the HealthCare.gov platform for the 2018 benefit year, including the Federally-facilitated Exchanges, State Partnership Exchanges, and some State-based Exchanges.

Consumers on Applications Submitted: This includes a consumer who is on a completed and submitted application to the Exchange using the HealthCare.gov platform. If determined eligible for Exchange coverage, a new consumer still needs to pick a health plan (i.e., plan selection) and pay their premium to get covered (i.e., effectuated enrollment). Because families can submit a single application, this figure tallies the total number of people on a submitted application (rather than the total number of submitted applications).

Call Center Volume: The total number of calls received by the call center for the 39 states that use the HealthCare.gov platform over the time period covered by the snapshot. Calls with Spanish speaking representatives are not included.

Calls with Spanish Speaking Representative: The total number of calls received by the call center for the 39 states that use the HealthCare.gov platform over the time period covered by the snapshot where consumers chose to speak with a Spanish-speaking representative. These calls are not included within the Call Center Volume metric.

HealthCare.gov Users or CuidadoDeSalud.gov Users: These user metrics total how many unique users viewed or interacted with HealthCare.gov or CuidadoDeSalud.gov, respectively, over the course of a specific date range. For cumulative totals, a separate report is run for the entire Open Enrollment period to minimize users being counted more than once during that longer range of time and to provide a more accurate estimate of unique users. Depending on an individual's browser settings and browsing habits, a visitor may be counted as a unique user more than once.

Window Shopping HealthCare.gov Users or CuidadoDeSalud.gov Users: These user metrics total how many unique users interacted with the window-shopping tool at HealthCare.gov or CuidadoDeSalud.gov, respectively, over the course of a specific date range. For cumulative totals, a separate report is run for the entire Open Enrollment period to minimize users being counted more than once during that longer range of time and to provide a more accurate estimate of unique users. Depending on an individual's browser settings and browsing habits, a visitor may be counted as a unique user more than once. Users who window-shopped are also included in the total HealthCare.gov or CuidadoDeSalud.gov user total.

###

Open Enrollment Social Media Tools

We are encouraging national faith-based organizations to share social media messages on Facebook and Twitter. As you may know, much health care information is being shared by social media. Please like and follow HealthCare.gov and Medicare.gov on Facebook and Twitter. Information is being posted on open enrollment. Here is a recent post from Medicare.gov that you may want to share: https://twitter.com/MedicareGov/status/923923496295653376.

Below is our updated Medicare social media toolkit. Please share these resources as appropriate.

Guide to sharable social media posts
Generic Open Enrollment images for Facebook
Generic Open Enrollment images for Twitter
Countdown Open Enrollment images for Facebook
Countdown Open Enrollment images for Twitter

###

What's New for SHOP in 2018

Considering enrolling in Small Business Health Options Program (SHOP) health and/or dental coverage for 2018? Here are a few things to know about signing up for a SHOP plan that **starts on or after January 1, 2018**:

- You will work with your insurance company or a SHOP-registered agent or broker to apply for and enroll in SHOP health and/or dental insurance.
- You will use HealthCare.gov to verify your eligibility to purchase SHOP insurance, but you won't need to create a HealthCare.gov account to enroll in health and/or dental coverage.
- You can find lots of helpful resources on HealthCare.gov and explore the SHOP plans available in your area.
- You will pay your premiums to your insurance company, not to SHOP or on HealthCare.gov.

If you are enrolling in SHOP insurance for the first time or have experienced a gap in SHOP insurance, you will still use HealthCare.gov to verify your eligibility to purchase SHOP insurance.

###

Enroll in SHOP While the Minimum Participation Rate Is Waived

Thinking about offering Small Business Health Options Program (SHOP) health and/or dental coverage to your employees but don't meet the minimum participation rate?

For one month each year, the SHOP minimum participation rate is waived. Take advantage of this opportunity between **November 15 and December 15** to enroll your small business in SHOP insurance and get the coverage that works for you and your employees.

SHOP-registered agents and brokers are ready to help you apply for and enroll in coverage – all at no cost to you. Work with your current SHOP-registered agent or broker, or find one near you today.

Get Started

The deadline to enroll in SHOP coverage that begins in December through HealthCare.gov is November 15. As a reminder, to enroll in SHOP insurance that begins on or after January 1, 2018, you should contact your agent, broker or insurance company.

Already enrolled in a SHOP plan? Learn how to renew or change your SHOP coverage so that you don't experience a gap in coverage.

Questions? Contact the SHOP Call Center at 1-800-706-7893 (TTY: 711) weekdays from 9 a.m. to 7 p.m. Eastern Time.

###

Marketplace Open Enrollment Resources for Faith and Community Organizations 2018 Coverage

Marketplace Open Enrollment Bulletin Insert and Community Announcement

Copy and paste the language and replace the **bold text** inside the **< >** symbols with information about specific activities.

Sample Announcement – ABOUT OPEN ENROLLMENT:

We are working with our community to make sure people know about an important opportunity to sign up for health insurance. Open Enrollment for 2018 coverage through HealthCare.gov starts on November 1, 2017 and runs through December 15, 2017.

If you, or someone you know, needs health insurance, it's time to visit HealthCare.gov to sign up for a 2018 health insurance plan. Plans offered at HealthCare.gov cover things like doctor visits, hospital stays, preventive care, and prescription drugs. Learn about options available in our community by visiting HealthCare.gov or call 1-800-318-2596.

Sample Announcement – PROMOTING AN ENROLLMENT EVENT:

We are working with our community to make sure people know about an important opportunity to sign up for health insurance. Open Enrollment for 2018 coverage through HealthCare.gov starts on November 1, 2017 and runs through December 15, 2017.

If you, or someone you know, needs health insurance, join us this **<Insert Friday/Saturday/Sunday>** for Open Enrollment Day at **<Name>**. At this event, trained enrollment specialists will provide free and confidential assistance. They'll talk you through your options and share other important advice, including financial help, how to start an application, or how to re-enroll if you currently have Marketplace coverage. Be sure to join us on **<Insert Friday/Saturday/Sunday> <Date>** at **<Time>.**

Four-Step Guide to Planning a Health Care Enrollment Event

Many faith-based and community organizations can host events to help individuals and families enroll in health insurance.

- **Open enrollment in the Health Insurance Marketplace starts November 1, 2017**
- **Open enrollment ends on December 15, 2017.**
- **Coverage begins on January 1, 2018.**

Here are some suggested steps to make your enrollment event a success:

1. Planning the event

- **Contact Navigators and Certified Application Counselors for help:** Connect with Navigators and Certified Application Counselors that work in your community by entering your zip code at localhelp.healthcare.gov.
- **Prepare the Setting**: After choosing a date, time, and location for the enrollment event. Identify a room that will allow for private conversations. Be sure to have tables, chairs and internet service.
- **Listen:** Consider starting a conversation in your community to better understand who may be uninsured as you plan outreach efforts.
- **Plan for Support:** Ask for volunteers from your organization to help with set-up, break-down, hospitality, and coordination of the enrollment event.

2. Advertising the event

- **Get the word out**: Advertise the enrollment event during your organization's announcement time, in a congregation or community bulletin, in your newsletter, on your website and/or through Facebook or Twitter.
- **What to say**: Include information about what people should bring to the enrollment event, such as W-2 forms for anyone in their tax household to verify income, social security numbers, and immigration cards (if appropriate). Check out the

full list of what to bring in the Marketplace Application Checklist. You may want to have people register for the enrollment event so that you can schedule the best number of Navigators and Assisters to meet the demand.

- **Engage Partners**: Identify other faith-based or community groups that might want to partner with you. Ask them to join your event and/or advertise it in their publications.

3. Conducting the event

- **Gather information**: Have a sign-in sheet and ask for contact information so that you can follow up when you host your next enrollment event.
- **Set up the space**: Make sure the enrollment room is set up with tables, chairs, and access to the internet. Arrange the space so that Navigators or Certified Application Counselors can have private conversations with people who are getting enrolled. Confirm that Navigators and Certified Application Counselors are bringing laptop computers to enroll people.
- **For a larger event**: If you expect a large turnout, have a room set up with computers, internet and volunteers to help people create an email account (if needed) and create their HealthCare.gov account.
- **Working while they wait**: Designate a waiting area where people can read about the Health Insurance Marketplace. Have translators (if needed) and volunteers available to answer questions about the enrollment process.

4. Following up on the Event

- **Show your appreciation**: Thank Navigators, Certification Application Counselors, and volunteers for their help with the event.
- **Follow-up**: For those who were unable to enroll at the event but still wish to do so, provide contact information for the Navigators or Certified Application Counselors who may be able to assist with individual enrollment. Remember that the deadline to enroll for 2018 coverage is December 15, 2017.

SAMPLE FLYER or BULLETIN NOTICE

Health Insurance Enrollment Fair – Sunday, December 3 from Noon to 3 pm
at the Welcome Center

Health insurance is now available during open enrollment, from November 1 to December 15, 2017. If you want to learn more about getting insurance, stay after the service on December 3 from noon to 3 pm to learn more and get enrolled. Navigators trained in helping people enroll in health insurance will be present.

If you want to enroll in health insurance, you must bring the following with you:

- Social Security Number (and immigration documents for legal immigrants)
- Employer and income information for every member of your household (for example, pay stubs or W2 forms – Wage and Tax Statements)
- Policy information on health insurance if you or someone in your household have it from a job or another source
- For a full list of what to bring, see this list: https://marketplace.cms.gov/outreach-and-education/marketplace-application-checklist.pdf.

If you have questions, email a member of our congregation, Mary Smith at Sampleemailaddress@Sample.org.

###

MACRA/Quality Payment Program (QPP) Updates

Eligible Hospitals and Critical Access Hospitals Attesting to CMS: Create Your Account in the QualityNet Secure Portal for Meaningful Use Attestations in 2018

Beginning January 2, 2018, eligible hospitals and critical access hospitals (CAHs) attesting to CMS will submit their 2017 meaningful use (MU) attestations through the QualityNet Secure Portal (QNet).

Eligible hospitals and CAHs attesting to CMS must have an active and updated QNet account before submitting MU attestations.

Enroll and Update Your QNet Account

Beginning in October:

- Eligible hospitals and CAHs attesting to CMS who are **new to the QNet system** need to enroll to create a QNet account and select the MU option.
- Eligible hospitals and CAHs attesting to CMS who are **existing QNet users** need to select the MU option in their QNet accounts.

For a step-by-step guide to enrolling in QNet and adding the MU option to your QNet account, review the QualityNet Secure Portal Enrollment and Login User Guide.

For More Information

- Visit the QNet webpage
- Visit the EHR Incentive Programs website
- Follow CMS on Twitter

Subscribe to the EHR Incentive Programs listserv

###

PAC QRP Quick Reference Guides Now Available

Quick Reference Guides for Home Health Quality Reporting Program (QRP), Hospice QRP, Inpatient Rehabilitation Facilities (IRF) QRP, and Long-Term Care Hospital (LTCH) QRP are now available. These guides include frequently asked questions, information on QRP help desks, and helpful links to additional resources for the QRPs. The guides are available in the downloads section of the following webpages:

- Home Health Quality Reporting Requirements
- HQRP Requirements and Best Practices
- IRF Quality Reporting Data Submission Deadlines
- LTCH Quality Reporting Data Submission Deadlines

###

Quality Payment Program Resources in New Location on CMS.gov

Visit CMS.gov to View New and Existing Quality Payment Program Resources

To make it easier for clinicians to search and find information on the Quality Payment Program, CMS has moved its library of Quality Payment Program resources to CMS.gov. Clinicians will be able to search the library for Quality Payment Program resources by title, topic, or year.

Resources include fact sheets, user guides, and other materials to help clinicians successfully participate in the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) in 2017.

New Resources

In addition to including all existing Quality Payment Program resources on CMS.gov, CMS has posted the following new materials:

- **Quality Payment Program final rule with comment and the interim final rule with comment**: Learn more using the Year 2 Overview fact sheet and the final rule executive summary.
- **2017 Medicare Shared Savings Program and MIPS Interactions:** Describes Track 1 Accountable Care Organization (ACO) status for the MIPS performance categories and the MIPS APM scoring standard.
- **Advancing Care Information – Information Blocking Fact Sheet**: Provides details on the process by which MIPS eligible clinicians must show that they have not knowingly and willfully limited or restricted the compatibility or interoperability of their certified electronic health record (EHR) technology.
- **CMS Web Interface Fact Sheet (updated):** Provides an overview of the CMS Web Interface, which is an internet-based MIPS data submission option for groups of 25 or more MIPS eligible clinicians.
- **CMS Web Interface & CAHPS for MIPS Survey Assignment Methodology:** Describes the process for assigning beneficiaries to a group participating in MIPS. Assigned beneficiaries are used in CMS Web Interface reporting, the CAHPS for MIPS survey, and in cost measure calculations.
- **CMS Web Interface Sampling Methodology:** Explains the sampling methodology for the 15 clinical quality measures reported via the CMS Web Interface. This guidance applies to all Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program and the Next Generation ACO Model, and all groups participating in the MIPS program who elected and registered to report as a group using the CMS Web Interface.
- **MIPS Data Validation Criteria**: Details the criteria CMS will use to audit and validate measures and activities for the 2017 transition year of MIPS for the Quality, Advancing Care Information, and Improvement Activities performance categories.
- **MIPS Scoring 101 Guide:** Offers a deep-dive into scoring for the MIPS performance categories, and how the final score affects payment adjustments.
- **MIPS Specialty Guides for Podiatrists and Radiologists**: Highlight non-exhaustive samples of measures and activities for the Quality, Improvement Activities, and Advancing Care Information performance categories that may apply to podiatry and radiology in 2017.

In case you missed it, CMS recently posted the **MIPS Claims Data Submission Fact Sheet** and **Eligible Measure Applicability Toolkit**.

For More Information

- Visit **qpp.cms.gov** to check your participation status, explore measures, and to review guidance on MIPS, APMs, what to report, and more.
- Go to the **QPP Resource Library on CMS.gov** to review new and existing Quality Payment Program resources.

Questions?

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

###

Now Available: Accredited Online Course – Quality Payment Program in 2017: Advanced Alternative Payment Models Web-Based Training (WBT) Course

A new, online and self-paced overview course on the Quality Payment Program is now available through the MLN Learning Management System. Participants will receive information on:

- Identifying Advanced Alternative Payment Models (APMs)
- CMS Advanced APMs
- How to participate in the Quality Payment Program via an Advanced APM

This course is the sixth course in an evolving curriculum on the Quality Payment Program, where participants will gain knowledge and insight on the program all while earning valuable continuing education credit. Keep checking back with us for updates on new courses. First time participants will need to register for the MLN Learning Management System. Once registered, you will be able to access additional courses without having to register. For information on how to login or find training, please visit our MLN Learning Management System FAQ sheet.

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

Accreditation Statements

Please click here for accreditation statements

###

Upcoming Webinars

Title: Quality Payment Program Year 2 Overview Webinar

Date: Tuesday, November 14

Time: 1:00 – 2:30 p.m. ET

Registration page: https://engage.vevent.com/rt/cms/index.jsp?seid=938

On Tuesday, November 14 at 1:00 p.m. ET, the Centers for Medicare & Medicaid Services (CMS) will host an overview webinar on the Quality Payment Program Year 2 final rule.

Join the webinar to hear CMS policy experts provide an overview of the final requirements for the second year of the Quality Payment Program.

###

Title: CMS Innovation Center Medicare Quality Payment Program Year 2 Final Rule – All-Payer Combination Option

Date: Thursday, November 16

Time: 1:00 – 2:30 p.m. ET

Registration page: https://engage.vevent.com/index.jsp?eid=5779&seid=703

On Thursday, November 16th at 1:00 p.m. ET, the CMS Innovation Center will host an overview webinar on the Medicare Quality Payment Program Year 2 final rule, with a focus on the participation of non-Medicare payers through the All-Payer Combination Option. Non-Medicare payers includes Medicaid, Medicare Health Plans, and payers participating in CMS Multi-Payer models. This event is for all CMMI model participants, their partnering providers and the general public. Join the webinar to hear CMS policy experts provide an overview of the All-Payer Combination Option requirements for the Quality Payment Program.

###

Title: Virtual Groups Train-the-Trainer

Date: Friday, November 17

Time: 2 – 3 p.m. ET

Registration page: https://engage.vevent.com/rt/cms/index.jsp?seid=942

The Centers for Medicare & Medicaid Services (CMS) is hosting a Train-the-Trainer session on **Friday, November 17** on the Virtual Groups provisions included in the Quality Payment Program Year 2 Final Rule. CMS will provide an overview of Virtual Groups and the election process, and address questions from participants.

###

Title: Quality Payment Program Year 2 Final Rule Call

Date: Thursday, November 30

Time: 1:30 – 3:00 p.m. ET

Registration page: https://blh.ier.intercall.com/

Target Audience: Medicare Part B Fee-For-Service clinicians, office managers and administrators; state and national associations that represent healthcare providers; and other stakeholders.

The Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways:

- The Merit-based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)

The Quality Payment Program allows clinicians to choose the best way to deliver quality care and participate based on their practice size, specialty, location, or patient population. During this call, learn about the Quality Payment Program Year 2 provisions in the final rule with comment and interim final rule with comment; participants should review the final rules prior to the call. A question and answer session follows the presentation.

###

Learn More About Forming a Virtual Group to Participate in MIPS in 2018

Apply Now Until December 31 to Form a Virtual Group for MIPS in 2018

Solo practitioners and groups can choose to participate in the Merit-based Incentive Payment System (MIPS) as a **virtual group** for the 2018 performance period. To form a virtual group for 2018, solo practitioners and groups must follow an election process, and submit their election to CMS by **December 31, 2017**.

What is a Virtual Group?

As outlined in the Quality Payment Year 2 Final Rule, a virtual group is a combination of two or more Taxpayer Identification Numbers (TINs) made up of one or more solo practitioners or one or more groups consisting of 10 or clinicians (including at least 1 MIPS eligible clinician), or both, that elect to form a virtual group for a performance period for a year.

To be eligible to join a virtual group, you must be a:

- **Solo practitioner** who exceeds the low-volume threshold; and who is not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
- **Group** that exceeds the low-volume threshold at the group level (i.e., the NPIs within the TIN collectively exceed the low-volume threshold) and has 10 or fewer clinicians (including at least 1 MIPS eligible clinician).

How Do I Form a Virtual Group?

To form a virtual group, there is a two-stage virtual group election process:

- **Stage 1 (optional):** If you're a solo practitioner or a group with 10 or fewer eligible clinicians, you can choose to contact your Quality Payment Program Technical Assistance representative. Your representative can help you figure out if you're eligible to join or form a virtual group before you:

1. Make any formal written agreements.

2. Send in your formal election registration.

3. Budget your resources for your virtual group.

For groups that don't participate in stage 1 of the election process and don't ask for an eligibility determination, CMS will see if they're eligible to be in a virtual group during stage 2 of the election process.

- **Stage 2 (required):** As part of the stage 2 election process, a virtual group must have a formal written agreement between each solo practitioner and group that composes the virtual group prior to submitting an election to CMS.

Each virtual group has to name an official representative who is responsible for submitting the virtual group's election via e-mail to MIPS_VirtualGroups@cms.hhs.gov by **December 31, 2017**.

If all the criteria for forming a virtual group are met, CMS will contact the virtual group's representative and provide the virtual group with **a performance identifier.**

Learn More about Virtual Groups

For more information about participating in MIPS as part of a virtual group, the election process, and formal agreements, please see the Virtual Groups Toolkit. The toolkit contains:

- Virtual Group Participation Overview Fact Sheet
- Virtual Groups Election Process Fact Sheet
- Virtual Groups Agreement Checklist
- Virtual Groups Sample Agreement Template

Need Help with the Election Process?

Contact the QPP Service Center at QPP@cms.hhs.gov or 1-866-288-8292 (TTY: 1-877-715-6222). Or, contact your

###

Draft 2018 CMS QRDA III Implementation Guide Now Available for Public Comment

Visit the JIRA Website to Submit Official Comments on Draft 2018 CMS QRDA III Implementation Guide by November 17, 2017

The Centers for Medicare & Medicaid Services (CMS) published the draft 2018 CMS Quality Reporting Document Architecture (QRDA) Category III Implementation Guide (IG) for Eligible Professionals (EPs) and Eligible Clinicians (referred to as the Draft 2018 CMS QRDA III IG). The IG is posted in JIRA, ticket number QRDA-605, for public comment. A JIRA account is required to comment. The public comment period begins **November 6, 2017** and ends **November 17, 2017**.

The Draft 2018 CMS QRDA III IG provides implementation guidance for the 2018 performance period for submitting QRDA Category III (QRDA-III) files for the following CMS Programs:

- Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
- Comprehensive Primary Care Plus (CPC+)
- Medicaid Electronic Health Record (EHR) Incentive Program for EPs; based on individual state submission acceptant requirements

The Draft 2018 CMS QRDA III IG:

- Is based on the Health Level Seven (HL7) QRDA Category III R1, Standard for Trial Use R2.1. There are no changes to the QRDA templates from the 2017 CMS QRDA III IG.
- Includes updated electronic clinical quality measure (eCQM) specifications for EPs and Eligible Clinicians universally unique identifier (UUID) list for the 2018 performance period.
- Includes updates to the advancing care information measures and improvement activities for the 2018 performance period.

For more detail regarding the changes from previous versions of the CMS QRDA III IG, visit the "Change Log" section of the document. We look forward to receiving your feedback.

Additional QRDA-Related Resources:

- You can find current and past CMS QRDA Implementation Guides, Schematrons, and Sample Files on the eCQI Resource Center.
- For questions related to the QRDA IGs or Schematrons, visit the ONC QRDA JIRA Issue Tracker.
- For questions related to the Quality Payment Program, visit the Quality Payment Program website or contact the Service Center by phone 1-866-288-8292 (TTY 1-877-715-6222) or email qpp@cms.hhs.gov.

###

CMS Launches Open Source Tool for QDRA III Conversion

QDRA III Converter First in Series of Open Source Offerings from the Quality Payment Program

The Centers for Medicare & Medicaid Services (CMS) has released an open source tool that validates and converts Quality Reporting Document Architecture Category (QRDA) III data files for 2017 Quality Payment Program (QPP) reporting.

Designed for IT developers and available in the CMS Github repository, the tool is for converting QRDA III files to QPP JSON format. The tool can also be used to test whether QRDA III files can be consumed by QPP.

The QDRA III tool is the first in a series of open source tools we're developing for QPP. Stay tuned for updates!

Details for IT Developers: Using the New QDRA III Tool

The tool:

- Converts QRDA III files to the QPP JSON (JavaScript Object Notation) format for QPP data submission.
- Allows you to test your QRDA III file to see if it:

1. Complies with 2017 CMS QRDA III Implementation Guide for Eligible Clinicians and Eligible Professionals Reporting v1.0
2. Can be successfully submitted to QPP

The open source package contains the same code that CMS will use to convert QRDA III files. If you can create a QRDA III file that can be converted using this tool, then you can create one that can be successfully submitted to QPP.

QRDA III Application Programming Interface (API) Submission

CMS will accept QRDA III files via the QPP submissions API as well as by manual file upload when submitting data for the 2017 performance period. The data submission period opens on January 2, 2018.

- **API Developer Preview participants** can test submitting QRDA III files via the API now by using the /converter endpoint at https://qpp.cms.gov/api/submissions/converter.

For More Information

Visit the Quality Payment Program website for more information and resources for developers.

###

CMS Announces Transition of Electronic Clinical Quality Measures to Clinical Quality Language for the CY2019 Reporting/Performance Periods

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that following more than one year of testing and input from the vendor and implementer communities, electronic clinical quality measures (eCQMs) in CMS quality programs will be transitioned to use the Clinical Quality Language (CQL) standard (CQL Release 1, Standard for Trial Use (STU) 2) for logic expression. CQL is a Health Level Seven International standard and aims to unify the expression of logic for eCQMs and Clinical Decision Support (CDS). CQL provides the ability to better express logic defining measure populations to improve the accuracy and clarity of eCQMs.

Measures expressed using CQL logic will continue to use the Quality Data Model (QDM) as the conceptual model to express clinical concepts contained within quality measures. Refer to the QDM v5.3 Annotated version and current version of the CQL standard to better understand how they work together to provide eCQMs that are human readable, yet structured for electronic processing.

The transition to reporting CQL-based measures will begin with the calendar year (CY) 2019 reporting period for Eligible Hospitals and Critical Access Hospitals (CAHs), and CY 2019 performance period for Eligible Professionals (EPs) and Eligible Clinicians. To support the transition, CMS will publish CQL-based eCQMs in Spring 2018 for potential inclusion in the following programs:

- Hospital Inpatient Quality Reporting Program
- Medicare Electronic Health Record Incentive Program for Eligible Hospitals and CAHs

- Medicaid EHR Incentive Program for EPs, Eligible Hospitals, and CAHs
- Quality Payment Program: The Merit-based Incentive Payment System (MIPS) and Alternative Payment Models

Draft eCQM specifications using CQL will be available through November 13, 2017 on the CQM Issue Tracker via the following tickets. Please note, that these draft specifications are for informational review only and are not intended for implementation and/or submission:

- Eligible hospital and critical access hospital measures (CQM-2858)
- Eligible professional and eligible clinician measures (CQM-2860)

Available Resources and Tools:

- CQL-based Health Quality Measure Format (HQMF) Implementation Guide Release 1, STU 2.1 - Defines the approach to using the CQL with the QDM and HQMF to define eCQMs. This STU 2.1 includes a Terminology section and vocabulary management guidance.
- CQL Formatting and Usage Wiki - A collaborative workspace for the development of CQL formatting conventions and usage patterns for the representation of logic within quality measures.
- CQL GitHub Tools Repository - Provides tooling in support of the standard, including the CQL-to-ELM translator, with a reference implementation for syntactic and semantic validation of CQL and example measures used by the translator.
- Measure Authoring Tool - A web-based tool that allows measure developers to author eCQMs using the QDM.
- Bonnie Testing Tool - A tool designed to support streamlined and efficient pre-testing of eCQMs.

CMS will be offering general and targeted educational sessions to share how CQL is used to support eCQMs beginning in November 2017. To learn more about CQL, please check the eCQI Resource Center Events page for information on upcoming webinars.

For More Information: You can find more CQL and QDM resources on the eCQI Resource Center. Please submit CQL related questions to the ONC CQL Issue Tracker

###

RF/LTCH/SNF QRP November 15 Submission Deadline Reminder

The submission deadline for the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) and Long-Term Care Hospital (LTCH) QRP is approaching. IRF-PAI and LTCH CARE Data Set assessment data and data submitted to CMS via the Center for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) for April-June (Q2) of calendar year (CY) 2017 are due with this submission deadline.

All data must be submitted no later than 11:59 p.m. Pacific Standard Time on November 15, 2017.

The Skilled Nursing Facility (SNF) QRP deadline has been extended to May 15, 2018 for CY 2017 data. However, SNFs are encouraged to review their data submission on at least a quarterly basis.

The list of measures required for this deadline can be found on the CMS QRP websites:

- IRF Quality Reporting Data Submission Deadlines
- LTCH Quality Reporting Data Submission Deadlines
- SNF Quality Reporting Program Data Submission Deadlines

As a reminder, it is recommended that providers run applicable validation/analysis reports prior to each quarterly reporting deadline, in order to ensure that all required data has been submitted.

*For providers affected by hurricanes Harvey, Irma, or Maria: CMS has issued reporting exceptions related to these events. Information on the exceptions can be found on the following webpages:

- IRF Quality Reporting Reconsideration and Exception & Extension

- LTCH Quality Reporting Reconsideration and Exception & Extension
- SNF Quality Reporting Reconsideration and Exception & Extension

###

CMS Finalizes Policies that Lower Out-of-Pocket Drug Costs and Increase Access to High-Quality Care

2018 Medicare Annual Payment Rules Finalized for Outpatient Hospital Departments, Ambulatory Surgical Centers, and Home Health settings

The Centers for Medicare & Medicaid Services (CMS) finalized two Medicare payment rules moving the agency in a new direction by putting patients first and ensuring that payments support access to high quality, affordable care. Among other things, the Hospital Outpatient payment rule will lower out-of-pocket drug costs for people with Medicare and empower patients with more choices. Both rules finalized today increase access to care. Importantly, the Hospital Outpatient rule takes steps to preserve access in rural communities.

"As part of the President's priority to lower the cost of prescription drugs, Medicare is taking steps to lower the costs Medicare patients pay for certain drugs in the hospital outpatient setting. Medicare beneficiaries would benefit from the discounts hospitals receive under the 340B Program by saving an estimated $320 million on copayments for these drugs in 2018 alone," said Seema Verma, Administrator of CMS.

Hospital Outpatient Prospective Payment System Rule published today, lowers out-of-pocket drug costs for Medicare benes:

In the Hospital Outpatient Prospective Payment System (OPPS) final rule, CMS is helping to lower the cost of prescription drugs for seniors and other Medicare beneficiaries by reducing the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B Program. The savings from this change will be reallocated equally to all hospitals paid under the OPPS. Children's hospitals, certain cancer hospitals, and rural sole community hospitals will be excepted from these drug payment reductions for 2018. CMS looks forward to working with Congress to provide HHS additional 340B programmatic flexibility, which could include tools to provide additional considerations for safety net hospitals. These hospitals play a critical role in serving our most vulnerable populations.

Additionally, the OPPS final rule provides relief to rural hospitals and rural clinicians. It includes a provision that would alleviate some of the burdens rural hospitals experience by placing a two-year moratorium on the direct physician supervision requirements for rural hospitals and critical access hospitals.

"CMS understands the importance of strengthening access to care, especially in rural areas," said Administrator Verma. "This policy helps to ensure access to outpatient therapeutic services for seniors living in rural communities and provides regulatory relief to America's rural hospitals."

The OPPS final rule also has policies that would make OPPS payment available when Medicare beneficiaries receive certain procedures in a lower cost setting of care – the outpatient department – where those procedures can be safely performed in that setting. The new availability of OPPS payment applies to six procedures, including a common and costly Medicare surgical procedure, total knee replacements. Starting January 2018, Medicare beneficiaries undergo any of these procedures can opt to have them performed in a lower cost setting of care where a clinician believes such a setting is appropriate.

In the Home Health Prospective Payment System final rule, CMS is not finalizing the Home Health Groupings Model and will take additional time to further engage with stakeholders to move towards a system that shifts the focus from volume of services to a more patient-centered model. CMS will take the comments submitted on the proposed rule into further consideration regarding patients' needs that strikes the right balance in putting patients first.

For a fact sheet on the OPPS final rule with comment period, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-01.html.

For a fact sheet on the Home Health final rule, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-01-2.html.

The OPPS final rule with comment period (CMS-1678-FC) can be downloaded from the *Federal Register* at: https://www.federalregister.gov/public-inspection.

The Home Health Prospective Payment System final rule (CMS-1672-F) can be downloaded from the *Federal Register* at: https://www.federalregister.gov/public-inspection.

###

Physician Fee Schedule Final Policy, Payment, and Quality Provisions for CY 2018

On November 2, CMS issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2018.

The overall update to payments under the PFS based on the finalized CY 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience Act of 2014. After applying these adjustments, and the budget neutrality adjustment to account for changes in Relative Value Units, all required by law, the final 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

The Final Rule Includes:

- Patients over Paperwork Initiative
- Changes in valuation for specific services
- Payment rates for nonexcepted off-campus provider-based hospital departments
- Medicare telehealth services
- Malpractice relative value units
- Care management services
- Improvement of payment rates for office-based behavioral health services
- Evaluation and management comment solicitation
- Emergency department visits comment solicitation
- Solicitation of public comments on initial data collection and reporting periods for Clinical Laboratory Fee Schedule
- Part B drugs: Payment for biosimilar biological products
- Part B drug payment: Infusion drugs furnished through an item of durable medical equipment
- New care coordination services and payment for rural health clinics and federally-qualified health centers
- Appropriate use criteria for advanced diagnostic imaging
- Medicare Diabetes Prevention Program expanded model
- Physician Quality Reporting System
- Patient relationship codes
- Medicare Shared Savings Program
- 2018 Value Modifier

For More Information:

- Final Rule
- Press Release: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices

See the full text of this excerpted CMS Fact Sheet (issued November 2).

###

Hospital OPPS and ASC Payment System and Quality Reporting Programs Changes for 2018

On November 1, CMS issued the CY 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period, which includes updates to the 2018 rates and quality provisions and other policy changes. CMS adopted a number of policies that will support care delivery; reduce burdens for

health care providers, especially in rural areas; lower beneficiary out of pocket drug costs for certain drugs; enhance the patient-doctor relationship; and promote flexibility in healthcare.

CMS is increasing the OPPS payment rates by 1.35 percent for 2018. The change is based on the hospital market basket increase of 2.7 percent minus both a 0.6 percentage point adjustment for multi-factor productivity and a 0.75 percentage point adjustment required by law. After considering all other policy changes under the final rule, including estimated spending for pass-through payments, CMS estimates an overall impact of 1.4 percent payment increase for providers paid under the OPPS in CY 2018.

CMS updates ASC payments annually by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). The Medicare statute specifies a Multi-Factor Productivity (MFP) adjustment to the ASC annual update. For CY 2018, the CPI-U update is 1.7 percent. The MFP adjustment is 0.5 percent, resulting in a CY 2018 MFP-adjusted CPI-U update factor of 1.2 percent. Including enrollment, case-mix, and utilization changes, total ASC payments are projected to increase approximately 3 percent in 2018.

The Final Rule Includes:

- Patients over Paperwork Initiative
- Payment for drugs and biologicals purchased through the 340B drug pricing program
- Supervision of hospital outpatient therapeutic services
- Packaging of low-cost drug administration services
- Inpatient only list
- High cost/low cost threshold for packaged skin substitutes
- Revisions to the laboratory date of service policy
- Partial Hospitalization Program rate setting
- Comment solicitation on ASC payment reform
- ASC covered procedures list
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program

For More Information:

- Final Rule
- Press Release: CMS Finalizes Policies that Lower Out-of-Pocket Drug Costs and Increase Access to High-Quality Care

See the full text of this excerpted CMS Fact Sheet (issued November 1).

###

HHAs: Payment Changes for 2018

On November 1, CMS issued a final rule that updates the CY 2018 Medicare payment rates and the wage index for Home Health Agencies (HHAs) serving Medicare beneficiaries. The rule also finalizes proposals for the Home Health Value-Based Purchasing Model and the Home Health Quality Reporting Program.

CMS projects that Medicare payments to HHAs in CY 2018 will be reduced by 0.4 percent, or $80 million, based on the finalized policies. This decrease reflects the effects of a one percent home health payment update percentage ($190 million increase); a -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9 percent ($170 million decrease); and the sunset of the rural add-on provision ($100 million decrease).

The Final Rule Includes:

- Patients over Paperwork Initiative
- Annual home health payment update percentage
- Adjustment to reflect nominal case-mix growth
- Sunset of the rural add-on provision

For More Information:

- Final Rule
- Press Release: CMS Finalizes Policies that Lower Out-of-Pocket Drug Costs and Increase Access to High-Quality Care

See the full text of this excerpted CMS Fact Sheet (issued November 1).

###

Quality Payment Program Rule for Year 2

On November 2, CMS issued the final rule with comment for the second year of the Quality Payment Program (CY 2018), as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), as well as an interim final rule with comment. We finalized policies for Year 2 of the Quality Payment Program to further reduce your burden and give you more ways to participate successfully. We are keeping many of our transition year policies and making some minor changes.

The Final Rule Includes:

- Weighting the Merit-based Incentive Payment System (MIPS) Cost performance category to 10% of your total MIPS final score, and the Quality performance category to 50%
- Raising the MIPS performance threshold to 15 points in Year 2
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2 for the Advancing Care Information performance category, and giving a bonus for using only 2015 CEHRT
- Awarding up to 5 bonus points on your MIPS final score for treatment of complex patients
- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the MIPS final score for clinicians impacted by Hurricanes Irma, Harvey and Maria and other natural disasters
- Adding 5 bonus points to the MIPS final scores of small practices
- Adding Virtual Groups as a participation option for MIPS
- Issuing an interim final rule with comment for extreme and uncontrollable circumstances where clinicians can be automatically exempt from these categories in the transition year without submitting a hardship exception application
- Decreasing the number of doctors and clinicians required to participate as a way to provide further flexibility by excluding individual MIPS eligible clinicians or groups with ≤$90,000 in Part B allowed charges or ≤200 Medicare Part B beneficiaries
- Providing more detail on how eligible clinicians participating in selected Advanced Alternative Payment Models (APMs) will be assessed under the APM scoring standard
- Creating additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option

For More Information:

- Final Rule
- Fact Sheet
- Executive Summary
- Press Release: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices
- Quality Payment Program website
- Register for a webinar on November 14

###

CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices

2018 Quality Payment Program and Physician Fee Schedule finalized

The Centers for Medicare & Medicaid Services (CMS) issued a final rule for the 2018 Physician Fee Schedule and final rule with comment period for the Quality Payment Program (QPP). While part of CMS's broader strategy to relieve regulatory burdens for providers, these rules also reflect the agency's efforts to promote innovation in healthcare delivery aimed at lowering prices, increasing competition and strengthening the relationship between patients and their doctors.

"During my visits with clinicians across the country, I've heard many concerns about the impact burdensome regulations have on their ability to care for patients," said Seema Verma, Administrator of CMS. "These rules move the agency in a new direction and begin to ease that burden by strengthening the patient-doctor relationship, empowering patients to realize the value of their care over volume of tests, and encouraging innovation and competition within the American healthcare system."

As part of the President's priority to reduce drug costs for Americans, CMS is taking an important step in the Physician Fee Schedule to modernize the Medicare payment system through innovation in the biopharmaceutical market. Beginning in 2018, CMS will update payment for biosimilars, which are lower-cost alternatives to certain types of drugs known as "biologicals." This change promotes competition to ensure millions of patients will have access to new lower cost therapies.

To strengthen access to care, especially for those living in rural areas, CMS is transforming access to Medicare telehealth services by paying for more services and making it easier for providers to bill for these services. Improving access to telehealth services reflects CMS's work to modernize Medicare payments to promote patient-centered innovations.

Additionally, this rule includes a number of policies designed to provide clinicians with a smoother transition to the Quality Payment Program (QPP). The QPP final rule includes policies that reduce burden and support clinicians in small and rural practices to successfully participate in this program. CMS is decreasing the number of clinicians required to participate.

To further ease clinician burden, CMS is adding an option to help clinicians and small, rural practices join together and share the responsibility of participating in value-based payments. CMS is also adding a new hardship exception to assist small practices and clinicians impacted by hurricanes Harvey, Irma, and Maria. This change mitigates the absence of Electronic Health Records as a result of the natural disasters.

The final rule provides additional detail on clinician participation in Advanced Alternative Payment Models (APMs). Clinicians can receive credit for payment bonuses through participation in these APMs. In keeping with its theme of innovation in healthcare delivery, CMS intends to develop a demonstration project testing the effects of counting as credit participation prior to 2019 and through 2024 in Medicare Advantage plans that meet certain criteria.

The Physician Fee Schedule final rule (CMS-1676-F) can be downloaded from the *Federal Register* at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-23953.pdf.

For a fact sheet on the Physician Fee Schedule final rule, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-02.html.

The Quality Payment Program final rule with comment period (CMS-5522-FC and CMS-5522-IFC) can be downloaded from the *Federal Register* at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-24067.pdf.

For a fact sheet on the Quality Payment Program final rule with comment period, please visit: https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf.

###

CMS Finalizes Quality Payment Program Rule for Year 2 to Increase Flexibility and Reduce Burdens

Quality Payment Program Year 2 Policies are Gradually Preparing Clinicians for Full Implementation

The Centers for Medicare & Medicaid Services (CMS) issued the final rule with comment for the second year of the Quality Payment Program (calendar year 2018), as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) as well as an interim final rule with comment.

CMS listened to feedback from the health care community and used it to inform policy making. As a result, the Year 2 final rule continues many of the flexibilities included in the transition year, while also preparing clinicians for a more robust program in Year 3. CMS wants to ensure that the program consists of meaningful measurement while minimizing burden, improving coordination of care, and supporting a pathway to participation in Advanced Alternative Payment Models (APMs).

Year 2 Final Rule Highlights

We've finalized policies for Year 2 of the Quality Payment Program to further reduce your burden and give you more ways to participate successfully. We are keeping many of our transition year policies and making some minor changes. Major highlights include:

- Weighting the MIPS Cost performance category to 10% of your total MIPS final score, and the Quality performance category to 50%.
- Raising the MIPS performance threshold to 15 points in Year 2 (from 3 points in the transition year).
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2 for the Advancing Care Information performance category, and giving a bonus for using only 2015 CEHRT.
- Awarding up to 5 bonus points on your MIPS final score for treatment of complex patients.
- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the MIPS final score for clinicians impacted by Hurricanes Irma, Harvey and Maria and other natural disasters.
- Adding 5 bonus points to the MIPS final scores of small practices.
- Adding Virtual Groups as a participation option for MIPS.
- Issuing an interim final rule with comment for extreme and uncontrollable circumstances where clinicians can be automatically exempt from these categories in the transition year without submitting a hardship exception application (note that Cost has a 0% weight in the transition year) if they were have been affected by Hurricanes Harvey, Irma, and Maria, which occurred during the 2017 MIPS performance period.
- Decreasing the number of doctors and clinicians required to participate as a way to provide further flexibility by excluding individual MIPS eligible clinicians or groups with ≤$90,000 in Part B allowed charges or ≤200 Medicare Part B beneficiaries.
- Providing more detail on how eligible clinicians participating in selected APMs (known as MIPS APMs) will be assessed under the APM scoring standard.
- Creating additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option. This option will be available beginning in performance year 2019.

The final rule with comment further advances the agency's goals of regulatory relief, program simplification, and state and local flexibility in the creation of innovative approaches to healthcare delivery.

Technical Support

CMS will continue to provide free hands-on support to help individual clinicians and groups participate in the Quality Payment Program.

For More Information

- The Quality Payment Program final rule with comments can be downloaded from the Federal Register at: https://www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-programs-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme.
- For an overview of the final rule with comment, please visit: https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf.
- For an executive summary of the rule, visit: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf.
- Register here to join CMS on November 14 for a public webinar on the Quality Payment Program Year 2 Final Rule with comment.

For more information about the Quality Payment Program, please visit: qpp.cms.gov

###

CMS Hospital Value-Based Purchasing Program Results for Fiscal Year 2018

Hospital Value-Based Purchasing Program Overview

The Hospital Value-Based Purchasing (VBP) Program adjusts what Medicare pays hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of inpatient care they provide to patients. For fiscal year (FY) 2018, the law requires that the applicable percent reduction, which is the portion of Medicare payments available to fund the program's value-based incentive payments, remain at 2 percent of the base operating Medicare Severity Diagnosis-Related Group

(MS-DRG) payment amounts for all participating hospitals. We estimate that the total amount available for value-based incentive payments for FY 2018 discharges will be approximately $1.9 billion.

The Hospital VBP Program is one of many quality programs Medicare has established to pay for the quality of care rather than the quantity of services provided to patients. The Hospital VBP Program is part of our long-standing effort to structure Medicare payments to improve care across the entire healthcare delivery system, including hospital inpatient care. In FY 2018, more hospitals will receive positive payment adjustments than will receive negative payment adjustments, indicating improved quality of care and the rewarding of better value, outcomes, and innovations.

Fiscal Year 2018 Hospital VBP Program Results

The measurement domains for the FY 2018 Hospital VBP Program and the weighting for these domains are:

- Clinical Care (25 percent)
- Safety (25 percent)
- Patient and Caregiver-Centered Experience of Care (25 percent)
- Efficiency and Cost Reduction (25 percent)

We have posted the Hospital VBP incentive payment adjustment factors for each participating hospital for FY 2018 in Table 16B, available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

This is the sixth year of the Hospital VBP Program, affecting payment for inpatient stays in approximately 3,000 hospitals across the country. Hospitals' payments will depend on:

- How well they performed – compared to their peers – on important healthcare quality and cost measures during a performance period.
- How much they have improved the quality of care provided to patients over time.

For FY 2018, more hospitals will have an increase in their base operating MS-DRG payments than will have a decrease. In total, close to 1,600 hospitals will have a positive payment adjustment.

For FY 2018, about half of hospitals will see a small change in their base operating MS-DRG payments (between -0.5 and 0.5 percent). After taking into account the 2 percent withhold as required by law, the highest performing hospital in FY 2018 will receive a net increase in payments of slightly more than 3 percent, and the lowest performing hospital will incur a net reduction in payments of 1.65 percent.

Computing the VBP Score

The Hospital VBP Program is a budget-neutral program funded each year through a reduction of participating hospitals' base operating MS-DRG payments for the applicable fiscal year. These payment reductions are redistributed to hospitals as incentive payments based on their Total Performance Score. The actual amount earned back by participating hospitals will depend on:

- Each hospital's Total Performance Score;
- Each hospital's value-based incentive payment percentage; and
- The total amount available under the program for value-based incentive payments.

Hospitals may earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable percent by which their payments were reduced for that program year. This means hospitals could see an increase, a decrease, or no change to their Medicare IPPS payments for the applicable fiscal year. The total estimated amount available for value-based incentive payments for FY 2018 discharges is approximately $1.9 billion.

The calculation of hospital Total Performance Scores were subject to minimum case size and measure requirements. Also, hospitals must have a domain score for at least three of the four measurement domains in order to have a Total Performance Score calculated. Hospitals that do not meet the minimum domain requirements do not have their payments adjusted in the corresponding fiscal year. For every measure, each participating hospital receives an achievement score

(based on how well they performed compared to other hospitals) and an improvement score (based on how much they improved over time); the higher of the two scores is awarded as the measure score.

New Program Requirements for FY 2019

The measure set for the FY 2019 program year will include a few changes:

- We are removing the Patient Safety for Selected Indicators Composite (PSI 90) from the Safety domain.
- We are adding a risk-standardized elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA) complications measure to the Clinical Care domain.

The measurement domains and domain weighting for the FY 2019 Hospital VBP Program will remain unchanged.

Moving Forward

As we more closely link patient outcomes and treatment costs to value-based hospital payment, the Hospital VBP Program not only aims for quality gains on paper, it also aims to promote a culture that prioritizes quality and value of care and better empowers patients and their healthcare providers through the public display of program results. Value-based purchasing is an important step to revamping how care and services are paid for, moving increasingly toward rewarding better value, outcomes, and innovations.

Additional Information

For more information on the Hospital VBP Program, please visit the CMS website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html and the QualityNet website at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937 .

###

Eligible Hospitals and CAHs: How to View Your Meaningful Use Data

The Centers for Medicare & Medicaid Services (CMS) is streamlining the Medicare attestation process by migrating the meaningful use attestation system from the Medicare & Medicaid EHR Incentive Program Registration and Attestation System to the QualityNet Secure Portal (QNet).

As part of this transition, **meaningful use data is now in view-only mode on the EHR Incentive Program Registration and Attestation System**. Starting January 2, 2018, eligible hospitals and CAHS will be able to access this meaningful use data on QNet.

Attesting in 2018

Don't forget that starting in January, Medicare eligible hospitals and CAHs must attest to CMS for meaningful use through QNet. The change applies to 2017 meaningful use data, as well as future reporting periods. QNet is the same system Medicare eligible hospitals and CAHs currently use for CQM reporting.

- **Medicaid eligible hospitals** should contact their state Medicaid agencies for specific information on how to attest. The Registration and Attestation System will still be available to these hospitals.
- **Dually eligible hospitals and CAHs** will register and attest for Medicare on the QNet portal and update and submit registration information in the Registration and Attestation System.

Create or Update Your QNet Account

QNet enrollment is now open, and you can take one of two actions:

- **If you don't have an account on QNet** already from previous CQM submissions, you'll need to create a new one before you attest.

- **If you—or the person/department at your hospital who usually submits meaningful use data—already has an account**, you'll need to update that existing account by adding the "meaningful use" role before attestation. If your organization's account has several users associated with the account, you may not have permission to make the change. The account's designated Security Administrators can make the meaningful use role update.

Step-by-step instructions for updating your account and enrolling on QNet are available in the QNet User Guide.

Get More Info

Visit the CMS EHR Incentive Programs website and follow us on Twitter for up-to-date information on the transition.

You can also submit questions to the EHR Information Center, available at 1-888-734-6433 (press option 1) from 9:00 a.m. to 5:00 p.m. CT Monday through Friday, except federal holidays.

Don't forget to review the 2017 Modified Stage 2 and Stage 3 EHR Incentive Program requirements to ensure you are ready to attest in 2018.

###

Medicare and Medicaid Updates

New Medicare Card: Provider Ombudsman Announced

The Provider Ombudsman for the New Medicare Card serves as a CMS resource for the provider community. The Ombudsman will ensure that CMS hears and understands any implementation problems experienced by clinicians, hospitals, suppliers, and other providers. Dr. Eugene Freund will be serving in this position. He will also communicate about the New Medicare Card to providers and collaborate with CMS components to develop solutions to any implementation problems that arise. To reach the Ombudsman, contact: NMCProviderQuestions@cms.hhs.gov.

The Medicare Beneficiary Ombudsman and CMS staff will address inquiries from Medicare beneficiaries and their representatives through existing inquiry processes. Visit Medicare.gov for information on how the Medicare Beneficiary Ombudsman can help you.

###

CMS Offers Medicare Enrollment Relief for Americans Affected by Recent Disasters

Agency provides help to people who missed first enrollment options in Medicare Parts A and B

The Centers for Medicare & Medicaid Services (CMS) is providing immediate relief to people who want to make a Medicare Part A or Part B enrollment request, but may have been impeded by the recent hurricanes and the wildfires in California.

This important relief gives certain individuals who have been affected by these events additional time to enroll in Part B and premium-Part A if they were unable to make a request during their initial enrollment period or special enrollment period.

"CMS will ensure access to healthcare coverage for many individuals whose lives have been affected by the recent hurricanes and wildfires," said Administrator Verma. "Through this relief, individuals who missed these important times for Medicare enrollment will still get the Medicare coverage they would otherwise have, if not for the impacts of these devastating events."

CMS established this relief due to major devastation caused by the storms, which disrupted mail delivery, power and other enrollment operations resources necessary to deliver critical enrollment information to eligible enrollees and their ability to make a timely enrollment request. Under this relief, certain individuals impacted by these disasters can enroll in Part B and premium-Part A. In addition, individuals who were automatically enrolled in Part B may request to cancel the automatic Part B coverage.

This opportunity will apply to individuals who, at the start of the disaster, were in their initial enrollment period or a special enrollment period, and resided in an area for which the Federal Emergency Management Agency has declared a weather-related emergency or major disaster. The changes to Medicare coverage will be in effect as though the individual made their request during the required enrollment period.

Individuals who believe they are eligible for this relief should contact Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) or visit their local Social Security office to make their enrollment request and mention the weather-related event.

For more information on Medicare enrollment periods:

General guidance: https://www.medicare.gov/sign-up-change-plans/get-parts-a-and-b/when-sign-up-parts-a-and-b/when-sign-up-parts-a-and-b.html, and https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Disaster-Memo-Medicare-SEP.pdf

Social Security Administration guidance: https://secure.ssa.gov/apps10/reference.nsf/links/10252017125325PM

CMS continues to update its emergency page (www.cms.gov/emergency) with important information on its efforts to support disaster response and recovery efforts.

For information regarding HHS disaster response activities, please visit https://www.hhs.gov/about/news.

###

CMS Waives Provider Enrollment and Screening Requirements in California during Wildfire Recovery Efforts

The Centers for Medicare & Medicaid Services (CMS) is suspending certain Medicare enrollment screening requirements for certain healthcare providers and suppliers that are assisting with the wildfire recovery efforts in areas impacted in California.

CMS Administrator Seema Verma announced that the Agency has established a hotline for certain healthcare providers and suppliers in the impacted areas in California to call in order to enroll in Medicare and receive temporary billing privileges.

"This is an unprecedented opportunity to work with healthcare providers to put our patients and people with Medicare first," said Administrator Verma. "While we have heard from providers and suppliers that are willing and able to help, we know that by temporarily relaxing certain Medicare provider and supplier enrollment requirements, we can make the services of skilled professionals more readily available to those in need. We are working to ensure that doctors, facilities, suppliers, and their teams are in place to help those impacted by damage from the California wildfires."

The new toll free Hotline Telephone Number: 1-855-259-2396
Hours of Operation: 8:00 AM – 6:00 PM PDT

CMS established a toll-free hotline servicing Medicare's Part B providers and suppliers in California. The hotline is intended for non-certified Part B suppliers, physicians and non-physician practitioners to receive temporary Medicare billing privileges under its waiver authority. Noridian Healthcare Solutions LLC, the Medicare Administrative Contractor (MAC) responsible for enrolling most Medicare Fee-For-Service providers and suppliers in California, will work to assist providers and suppliers in the state to temporarily enroll in Medicare. As part of this effort, CMS is waiving the following Medicare enrollment requirements for non-certified Part B suppliers, physicians and non-physician practitioners in the state of California:

1. Application fee (42 CFR § 424.514)
2. Fingerprint-based criminal background checks (42 CFR § 424.518(c)(2)(ii) and (d))
3. Site visits – (42 CFR § 424.510(d)(8) and §424.517)
4. In-state licensure requirements (42 CFR § 424.510(d)(2)(iii)(A) and 424.516(a)(2))

Beginning Monday, October 30, 2017, certain providers and suppliers will be able to request temporary Medicare billing privileges over-the-phone and receive privileges the same day. In addition, CMS is:

- Exercising waiver authority to allow providers who are not currently enrolled to receive temporary Medicare billing privileges by providing limited information, including, but not limited to, National Provider Identifier (NPI), Social Security Number (SSN) or a business Employer Identification Number or Taxpayer Identification Number (SSN/EIN/TIN), and valid in-state or out-of-state licensure.
- Temporarily ceasing revalidation efforts for Medicare providers and suppliers located in California areas otherwise directly impacted by the wildfires so providers and suppliers who would otherwise be required to revalidate their enrollment can focus on their patients.
- Waiving the practice location reporting requirements and not taking administrative actions with respect to providers or suppliers who fail to notify CMS of their temporary practice location via the CMS-855 enrollment application. This temporary process will remain in effect from the declared disaster effective dates (October 8, 2017) until the disaster designation is lifted, after which time the provider shall resume all reporting requirements. If the temporary location is still being utilized until the previous location is re-established, it must be reported to the appropriate MAC through the appropriate CMS-855 enrollment application.

CMS will continue to work with California in their recovery. The Agency continues to update its emergency page (www.cms.gov/emergency) with important information for state and local officials, providers, healthcare facilities, and the public.

To read previous updates regarding HHS activities related to the California wildfires, please visit https://www.hhs.gov/about/news.

###

Northern California Wildfires - Disaster Exceptions/Exemptions for Medicare Certified Providers

The Centers for Medicare & Medicaid Services (CMS) is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to acute care hospitals, inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, long-term care hospitals, renal dialysis facilities, and ambulatory surgical centers located in areas affected by the devastating impacts of the Northern California wildfires since October 8, 2017, in and around counties in Northern California. These providers will be granted exceptions without having to submit an extraordinary circumstances exception request if they are located in one of the California counties which has been designated by the Federal Emergency Management Agency (FEMA) as a major disaster county.

The scope and duration of the exception under each Medicare quality reporting program is described in the memo posted on 10-30-17, however, all of the exceptions are being granted to assist these providers while they direct their resources toward caring for their patients and repairing structural damages to facilities.

In addition, CMS will continue to monitor the situation and adjust exempted reporting periods and submission deadlines accordingly.

Further details and materials are available on the CMS 2017 California Wildfires webpage. Please check back frequently for updates.

###

Medicare's Income-Related Premiums: A Data Note

As a result of recent legislation, Medicare Part B (medical coverage) and Part D (prescription drug coverage) enrollees may now pay more for their health care coverage. If you earned more than $133,500 according to your 2016 individual federal tax return, you could be affected. Similarly, if you are married and earned more than $267,000 according to your 2016 federal tax return, you could be affected. The additional costs, known as the Income Related Monthly Adjustment Amount (IRMAA), are in addition to your Medicare Part B and Part D premium, and are detailed in the table below:

2016 Federal Income	IRMAA in 2017	IRMAA in 2018
$133,501 - $160,000 (single)	50%	65%
$160,001 - $214,000 (single)	65%	80%
$267,001 - $320,000 (married, joint return)	50%	65%
$320,001 - $428,000 (married, joint return)	65%	80%

If your income status has changed or you disagree with the IRMAA amounts you owe, you may contact the Social Security Administration to request a reconsideration at https://www.ssa.gov/forms/ or call toll free 1-800-772-1213. TTY users should call 1-800-325-0778.

As some of you may know, the income "bands" that are used to determine IRMAA (both for Part B and Part D) will be changing in 2018 as a result of MACRA. This article from Kaiser does a good job of explaining the change, with Figure 3 providing an excellent illustration.

###

CMS announces new Medicaid policy to combat the opioid crisis by increasing access to treatment options

Approves demonstrations in both New Jersey and Utah

The Centers for Medicare & Medicaid Services (CMS) announced a new policy to allow states to design demonstration projects that increase access to treatment for opioid use disorder (OUD) and other substance use disorders (SUD). CMS's new demonstration policy responds to the President's directive and provides states with greater flexibility to design programs that improve access to high quality, clinically appropriate treatment. In addition, CMS is announcing the immediate approval of both New Jersey and Utah's demonstration waivers under the new policy.

Through this updated policy, states will be able to pay for a fuller continuum of care to treat SUD, including critical treatment in residential treatment facilities that Medicaid is unable to pay for without a waiver.

"This new demonstration policy comes as a direct result of the President's commitment to address the opioid crisis and ensure states have immediate relief and flexibility," said CMS Administrator Seema Verma. "Previous policies ignored the growing urgency of the national opioid epidemic and instead put onerous requirements on states that ultimately prevented individuals from accessing these needed services. The Trump Administration's approach reflects the pressing nature of the issues states are facing on the ground."

Previously, states had been required to build out their entire delivery system for SUD treatment while also meeting rigid CMS standards before Medicaid demonstration approvals could be granted. The new policy will allow states to provide greater treatment options while improving their continuum of care over time.

Under the new CMS demonstration policy, New Jersey will provide a comprehensive and coordinated SUD benefit to adults and children while also allowing for the continuum of SUD services provided to Medicaid beneficiaries who reside in residential treatment facilities. The services covered as part of the SUD benefit will include residential treatment, withdrawal management, medication-assisted treatment, peer supports and targeted case management.

"CMS' approval of New Jersey's Medicaid Demonstration will remove a decades-old federal barrier so that thousands more New Jerseyans with the disease of addiction will have access to treatment and recovery," said New Jersey Gov. Chris Christie. "President Trump acknowledged the need for this policy change when he addressed the nation last week and declared a national public health emergency. This is a tremendous step forward in our efforts to aggressively combat the opioid epidemic and save lives."

Utah's program is part of a broader delivery system reform effort to address the needs of individuals with SUD, individuals who are chronically homeless, and individuals within the justice system. The demonstration will also expand access to SUD treatment to a more complete continuum of services, including previously excluded residential treatment sites.

"I've always maintained the role of the federal government should be to provide states with the flexibility to be innovative in how they operate their Medicaid programs. Nobody knows how to address the unique challenges we face as a state better than we do," said Utah Gov. Gary R. Herbert. "Today's announcement from the Centers for Medicare and Medicaid Services will allow us to address a specific challenge - extending health care coverage, including substance abuse and mental health services, to the homeless population. I applaud CMS for approving our waiver request, and look forward to getting to work on providing these critical services."

The new policy also dramatically enhances the ability for CMS to evaluate how effectively the demonstration programs are working through the collection of information and data that can be used to inform CMS on best practices and methods to specifically combat the opioid epidemic, increasing the agency's capacity to learn what treatment delivery methods are the most effective in addressing our nation's public health emergency.

Today's announcement further builds on a commitment from CMS to partner with states in improving the Medicaid program and the lives of those it serves. A March 14, 2017 letter from the Administration to governors expressed this commitment to "ensuring that states have the tools they need to combat the growing opioid epidemic that is devastating families and communities" and in developing "a more streamlined approach for substance abuse treatment."

To view a copy of the SMD # 17-003 letter to state Medicaid directors, https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

###

Verma Outlines Vision for Medicaid, Announces Historic Steps Taken to Improve the Program

New Policies Help Ensure States Can Focus More Resources, Time Achieving Positive Health Outcomes for Beneficiaries

The Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma discussed her vision for the future of Medicaid and unveiled new CMS policies that encourage states to propose innovative Medicaid reforms, reduce federal regulatory burdens, increase efficiency, and promote transparency and accountability during a plenary session at the National Association of Medicaid Directors (NAMD) Fall Conference in Arlington, Virginia.

During her first major speech on the subject, Verma noted that when the federal government established Medicaid, it was intended to be a partnership with state governments to care for society's most vulnerable citizens. With the growth of the

program over the last several years came increased federal and state spending, which naturally meant increased federal oversight and regulation, said Verma.

"Our vision for the future of Medicaid is to reset the federal-state relationship and restore the partnership, while at the same time modernizing the program to deliver better outcomes for the people we serve," said Administrator Verma. "We need to ensure that we are building a Medicaid program that is sound and solvent to help all beneficiaries reach their highest potential."

Verma emphasized her commitment to "turn the page in the Medicaid program" by giving states more freedom to design innovative programs that achieve positive results for the people they serve and pledged to remove impediments that get in the way of states achieving this goal. She announced several new policies and initiatives that break down the barriers that prevent state innovation and improvement of Medicaid beneficiary health outcomes:

Web Site Content on Section 1115 Demonstrations: CMS updated Medicaid.gov to give states a clearer indication of how their reform strategies might align with a core objective of the Medicaid program: serving the health and wellness needs of the nation's vulnerable and low-income individuals and families. The revised web site content signals a new, broader view of Section 1115 demonstrations, in which states can focus on evidence-based interventions that drive better health outcomes and quality of life improvements. The update signals CMS's willingness to work with state officials requesting flexibility to continue to provide high quality services to their Medicaid beneficiaries, support upward mobility and independence, and advance innovative delivery system and payment models.

In a significant shift from prior policies, in speaking about the new approach to Section 1115 demonstrations, Verma emphasized the agency's commitment to considering proposals that would give states more flexibility to engage with their working-age, able-bodied citizens on Medicaid through demonstrations that will help them rise out of poverty. As Medicaid has expanded to able-bodied individuals, the needs of this population are even more imperative, she said. During her remarks, the Administrator made it clear that CMS will openly consider proposals that promote community engagement and work activities.

"Every American deserves the dignity and respect of high expectations and as public officials we should deliver programs that instill hope and say to each beneficiary that we believe in their potential," said Administrator Verma. "CMS believes that meaningful work is essential to beneficiaries' economic self-sufficiency, self-esteem, well-being, and health of Americans."

Streamline and Improve 1115 Demonstration, State Plan Amendments, and 1915 Waiver Processes: CMS released several new policies that improve federal and state program management, specifically through improvements in the review, approval process, and monitoring of 1115 Demonstrations and Medicaid and Children's Health Insurance Program (CHIP) state plan amendments (SPA) and 1915 waivers. Taken together, these policies include provisions that will allow states to:

- Request approval for certain 1115 demonstrations for up to 10 years;
- More easily pursue "fast track" federal review, which makes it easier for states to continue their successful demonstration programs;
- Spend time administering innovative demonstrations by reducing certain 1115 reporting requirements;
- Expedite SPA and 1915 waiver efforts through a streamlined process and by participating in a new "within 15-day" initial review call with CMS officials.

In addition, the policies will improve how waivers and demonstration projects are monitored and evaluated. Waivers and demonstration projects that are less complex and have been running smoothly will require much less reporting, and waivers and demonstration projects that have a good track record of producing positive results will find an easier path to renewal. In her remarks, the Administrator underscored that these new policies were intended to relieve the regulatory burden on states, avoid increasing administrative costs for taxpayers, and refocus time and resources on improving the health outcomes of Medicaid beneficiaries.

Creation of First-Ever Medicaid and CHIP Scorecards: CMS is in the early stages of developing Scorecards that will provide greater transparency and accountability of the Medicaid program by tracking and publishing state and federal Medicaid outcomes. In her remarks, Verma said that the Scorecards were a "historic opportunity" to demonstrate to taxpayers that their hard-earned tax dollars were being spent appropriately. In addition, the reporting will provide validation to Medicaid beneficiaries that the $558 billion spent on Medicaid is producing positive results and improved health outcomes.

To close her remarks, Administrator Verma noted that federal and state officials have a higher purpose than "just handing out Medicaid cards and being a financier of healthcare." She stressed that the Administration's new vision for Medicaid, and the new policy changes outlined today represented the results of a promise to Medicaid beneficiaries and to the American people that fund the program.

"We will not just accept the hollow victory of numbers covered [in the program], but will dig deeper and demand more of ourselves and of you," said Verma. "For those unable to care for themselves, we will create sustainable programs that will always be there to provide the care you need, to provide choices and allow you to live as independently as possible. For those that just need a hand up, we will provide you the opportunity to take charge of your health care and assist and empower you to rise out of poverty and government dependence to create a better life for yourselves and your family."

To visit the new updated Medicaid 1115 Demonstration Project page click here.

To view the Section 1115 Demonstration Process Improvements Informational Bulletin, click here.

To view the State Plan Amendment and 1915 Waiver Informational Bulletin, click here.

Information on the new CMS Medicaid Scorecards will be publicly released when more information becomes available.

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August 2017 Medicaid and Children's Health Insurance (CHIP) Enrollment Data Available

The Centers for Medicare & Medicaid Services today posted the August 2017 monthly enrollment report detailing state Medicaid and Children's Health Insurance Program (CHIP) data. The report represents state Medicaid and CHIP agencies' eligibility activity for the calendar month of August 2017. The report can be found on the Medicaid website alongside reports for each month of 2017 and going back through 2013.

WHAT: States announce August 2017 enrollment data for Medicaid and CHIP programs.
WHEN: Tuesday, October 31st at 1:30PM
WHO: Centers for Medicaid and CHIP Services

###

Programmatic and Financial Information Regarding CHIP in a Federal Funding Shortfall Informational Bulletin

CMS has released an Informational Bulletin (CIB) that provides programmatic and financial information for states regarding operating their Children's Health Insurance Programs (CHIP) in a title XXI/CHIP federal funding shortfall. The CIB describes state options for transitioning children from a separate CHIP to other sources of coverage, actions for states to consider as they effectuate these changes, key federal requirements for submitting State Plan Amendments (SPA), and operational information regarding how states can access the remaining funds available in FY 2018. The bulletin can be found here: https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html

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Administrator's National Association of Medicaid Directors NAMD Speech

It's truly a pleasure for me to join you today and it's great to see so many familiar faces. I, and everyone at the Centers for Medicare and Medicaid Services, truly understand the importance of the Medicaid program. It makes an incredible difference to millions of Americans. But behind every statistic is a life, a face.

Individuals like Richard, a gentleman I met in Indiana. He's paraplegic. Yet, when we were passing the Healthy Indiana Plan he showed up with his caretaker, to hearings and other meetings, in a bed that carried all of the equipment necessary to keep him alive. It wasn't easy for him to come, but he felt strongly about making sure that the Medicaid program was providing high quality healthcare, and speaking on behalf of beneficiaries was something that was so important to him.

I also have a colleague whose sister Kristy has both autism and epilepsy. The severity of her condition requires her to receive 24- hour care, and a Medicaid waiver makes it possible for her to receive that care in her home.

For people like Richard and Kristy, Medicaid is more than a safety net, it's a lifeline, one that needs to be preserved and protected for those who truly need it. This is not only about caring for our less fortunate citizens, but doing what is possible to help ensure that none of them are left out, left behind, or left on the sidelines of the American dream.

For all of Medicaid's recipients, we work to provide for the best quality of life possible that works best for them. Whether it be seniors living in the community through the support of personal care services, or the respite care that allows a parent to keep their child with a disability living at home. We have a higher purpose than just handing out Medicaid cards. The Medicaid program is a promise to help individuals live up to their highest potential, leading healthier, more fulfilling, and more independent lives.

Medicaid is central to our promise to the American people. It's a promise that we at CMS, and President Trump, care deeply about, and it's a promise that must be refitted and renewed for each generation. We fail to live up to that promise when Medicaid merely provides a card without care. That's why we're ushering in a new day for Medicaid at CMS, not closing the book, but turning the page and starting a new chapter.

For those of you who don't know me, I have worked in the trenches of Medicaid for many years, working side by side with states to help them reform and strengthen their programs. I've shared the hopes, fears, and trust of countless Medicaid recipients, as well as their families and caregivers. I've seen the difference it has made in the lives of people like Richard and Kristy, and I am deeply committed to this program.

However, I have also seen that our safety net should be stronger to ensure that no deserving Americans fall through the cracks. We must and we can serve them better. The challenges are great and so must be our solutions.

When the federal government established the Medicaid program, it was intended to be a partnership between the federal and state governments to care for society's most vulnerable citizens, with both jointly contributing towards the costs. The relationship has changed over the years, and I would not describe our current status as a partnership. With Medicaid being an open-ended entitlement, the program has grown and grown and states have spent more and more. In 1985, Medicaid spending consumed less than 10% of state budgets and totaled just over $33 billion dollars[1]. In 2016 that number had grown to consume 29% of total state spending at a total cost of $558 billion dollars [2]diverting state resources from other areas such as education and economic development. And with increased state spending came increased federal spending, which naturally meant increased federal oversight and regulation……and regulation…… and more regulation. Today the federal government reviews and scrutinizes every single decision… dictating how the program is run in many aspects. As an example, the state of Nebraska recently reviewed its original Medicaid State Plan, and it was only 17 pages long. Today, that agreement is thousands of pages long.

However, despite our growth in spending, and in regulations, more than 1/3 of doctors won't even see Medicaid patients[3]. And as the rolls have greatly expanded, it has led to longer delays…longer travel times…longer waits for care for those who rely on the program. Not only is this unacceptable, it puts increasing burdens on some of our most vulnerable populations, people like Richard and Kristy.

To paraphrase Hubert Humphrey, the moral tests of any government is how it treats those in the dawn, the twilight, and the shadows of life.

Our vision for the future of Medicaid is to reset the federal-state relationship, and restore the partnership, while at the same time modernizing the program to deliver better outcomes for the people we serve. It's what I believe we all want. We have an obligation to help those who need it most, and we need to ensure that we are building a Medicaid program that is sound and solvent and helps all beneficiaries reach their highest potential.

In order to accomplish this, we are focused on three areas: Flexibility, Accountability, and Integrity.

First let me discuss flexibility. We are a diverse country, and that diversity gives us strength, but New York doesn't have the same challenges as Mississippi, or even Alaska – a frontier state that has to fly patients to receive even routine

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[1] https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/ER_1987.PDF

[2] https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/State%20Expenditure%20Report%20(Fiscal%202014-2016)%20-%20S.pdf

[3] https://khn.org/news/third-of-medicaid-doctors-say-no-new-patients/

care. No two states are alike, the delivery systems and needs are different. When I was working on behalf of states, I never designed the exact same program twice, because every state had different ideas, different needs, and different challenges.

That's why Washington shouldn't design a cookie cutter Medicaid program. Instead, we need to respond to this diversity by empowering states to work with their communities, their providers, and citizens to design a program that meets their diverse needs. As we turn the page in the Medicaid program, CMS wants to support states in their efforts, we want you to create innovative programs for the people you serve, because we believe you know what is best.

Past administrations haven't always respected this diversity, and instead imposed a "Washington knows best" one-size-fits all Medicaid policy. Maybe that is why Medicaid has faced problems for decades. Problems with access, problems with quality, and problems with program integrity, and rather than fixing these problems, the Affordable Care Act just put more people in the program, further exacerbating the issues and jeopardizing care to our most vulnerable citizens, the population that the program was originally designed for.

The ACA moved millions of working-age, non-disabled adults into a program that was created to care for seniors in need, pregnant mothers, children and people with disabilities, stretching the safety net for some of our most fragile populations, many of whom are still on waiting lists for critical home-care services while states enroll millions of newly-eligible able-bodied adults. The ACA also gave states a higher federal reimbursement than they do for our most vulnerable citizens. If the match rate is a reflection of the value we place on caring for our neediest citizens, this is backwards.

While many responded to this expansion with celebration, we shouldn't just celebrate an increase in the rolls, or more Medicaid cards handed out. For this population, for able bodied adults, we should celebrate helping people move up, move on, and move out. We have a moral responsibility to do more than just give them a card, we have a responsibility to give them care.

The thought that a program designed for our most vulnerable citizens should be used as a vehicle to serve working age, able-bodied adults does not make sense, but the prior administration fought state led reforms that would've allowed the Medicaid program to evolve to meet the needs of these new individuals, and they did this, even when increased coverage was at stake.

Before becoming Administrator, I experienced this first-hand when I worked with states to adapt to the ACA. When designing waivers, I found that many states wouldn't even put their own ideas forward because they assumed they would be rejected by Washington. Those days are over. We are resetting the partnership between the states and the federal government and that work has already begun.

I am pleased to announce several initiatives today that demonstrate our commitment to supporting states and innovation. But, before I do that, I want to take some time to thank my Deputy Administrator Brian Neale and the entire team at the Center for Medicaid and CHIP Services for the amazing accomplishments and progress they've made in such a short amount of time. They are truly dedicated public servants and care deeply about the Medicaid program. Thank you for your service.

Today, the CMS website contains new information for states about our expanded vision of what types of projects can achieve Medicaid's objectives. As you know, demonstration projects offer an avenue for states to pioneer innovative approaches that deliver local solutions to local problems. In support of this, we want to make sure that the lens through which we view proposals is clear, and responsive, to the requests we have received from states.

One of the things that states have told us time and time again is that they want more flexibility to engage their working-age, able bodied citizens on Medicaid. They want to develop programs that will help them break the chains of poverty and live up to their fullest potential. We support this.

As Medicaid has expanded to able-bodied individuals, the needs of this population are even more imperative. These are individuals who are physically capable of being actively engaged in their communities, whether it be through working, volunteering, going to school or obtaining job training. Let me be clear to everyone in this room, we will approve proposals that promote community engagement activities.

Every American deserves the dignity and respect of high expectations and as public officials we should deliver programs that instill hope and say to each beneficiary that we believe in your potential.

For the future of our country, we need all Americans to be active participants in their communities. Currently, the labor-force participation rate for men 25 to 54 is lower than it was during the Great Depression[4]. To maintain the continued strength of the American economy, this must change. But this isn't just about the strength of our economy, it is also vital for the quality of life of our beneficiaries. For people living with disabilities, CMS has long believed that meaningful work is essential to their economic self-sufficiency, self-esteem, wellbeing and improving their health. Why would we not believe that the same is true for working age, able-bodied Medicaid enrollees?

Believing that community engagement requirements do not support or promote the objectives of Medicaid is a tragic example of the soft bigotry of low expectations consistently espoused by the prior administration. Those days are over.

[4] http://www.aei.org/publication/where-did-all-the-men-go/

We owe our fellow citizens more than just giving them a Medicaid card, we owe a card with care, and more importantly a card with hope. Hope that they can achieve a better future for themselves and their families. Hope that they can one day break the chains of generational poverty and no longer need public assistance, and the hope that every American, no matter their race, creed, or origin, can reach their highest potential. We will approve proposals that accomplish this goal.

Ultimately, Medicaid laws needs to change, so that states don't need permission from CMS to develop unique and innovative solutions. Initiatives that restructure Medicaid away from an open-ended entitlement to a more fiscally-secure program will allow all of us to move away from the back-and-forth negotiations between states and CMS over waivers, plan changes, and expenses, to a collective focus on improving health outcomes for the people we serve. Preserving the program for future generations.

But until the law changes, I am proud to announce we are taking action through a number of changes that make it easier than ever before for states to design innovative approaches to improving quality, lowering costs, and delivering value to our beneficiaries. We will begin the review of every proposal by clearly defining timelines so that we can hold each other accountable and we can both plan effectively. We will move to fast-track approvals for certain routine or prior approved proposals, and for the first time in CMS history, we will approve some waivers for a period of up to ten years if they are shown to be successful. This will relieve the burden of states having to come back to CMS time and time again, increasing administrative costs for taxpayers, and detracting our focus from improving the health outcomes of our beneficiaries. We are also minimizing the administrative burden on states by reducing the onerous amount of waiver reporting that has been required in the past. We need data but we will only ask states for what is essential.

We are making innovation easier. If we approve an idea in one state, and another state wants to do the same thing, we will expedite those approvals. However, we won't approve every idea, the law will be our guideposts, and we will also ensure that proposals will not result in additional costs for taxpayers.

CMS is also going to rollback burdensome regulations that the federal government has imposed on states. We will focus on modifying regulations that dictate processes but don't meaningfully contribute to improving outcomes for beneficiaries, and we will start this effort beginning with both the managed care and access rules.

Medicaid must also be flexible enough to allow states to respond quickly to emerging health threats. Today, drug overdose is the leading cause of death among people under 50. This is a national tragedy. Many of us, including myself had friends and neighbors fall victim to this crisis. In response to this, President Trump has asked HHS to declare a national public health emergency and has directed all federal agencies to take swift action to respond to this crisis. In response, CMS released new guidance to increase access to treatment for Medicaid beneficiaries. We are expediting states' ability to respond to this epidemic by allowing them to unlock critical residential services for Americans with substance use disorder. We are waiving the 1970s era law that prevented Medicaid beneficiaries from receiving treatment for substance use in certain settings. Currently, many individuals are desperately waiting for treatment and we can now give states immediate freedom and resources to unlock new treatment options and ultimately save lives. The previous administration allowed this pathway, but created onerous upfront requirements that ultimately were a barrier to states trying to respond to the growing epidemic. Only four states gained approval during the prior administration, in contrast, we have already approved waivers in New Jersey and Utah, and many more approvals are coming in following weeks.

Another area greatly needing improvement is the process for reviewing and approving state plan amendments, which are routine changes a state wants to make to their programs.

When I came to CMS, I inherited over 300 state requests, some of them as old as eight years. This is unacceptable and we are taking swift action to correct this. Our improvements will result in faster processing, and a strategy to reduce the current backlog of unresolved state requests.

So now it is up to you, the states, to put your innovative ideas into practice. We very much look forward to your proposals and helping you implement successful initiatives that improve the health and lives of the diverse set of beneficiaries you serve.

On to our second area: accountability. With this new era of flexibility, however, must also come a new era of accountability. For all those depending on Medicaid, CMS must be a good steward for the program. Otherwise we won't be able to help our neediest citizens, either now or in the future. While we will support you with increased flexibility and reduced regulations, we will also hold you accountable for achieving positive outcomes. Waivers will require strong evaluation components, so we can understand the impact on recipients, duplicate best practices, and identify areas needing improvement.

As long as I am CMS Administrator you will hear that we have a higher purpose than just funding healthcare. We owe it to our beneficiaries to make sure that our spending produces tangible results. Medicaid serves nearly 75 million Americans at a cost of over $558 billion per year to taxpayers, and despite that spending, we have wide disparity between states when it comes to healthcare spending, some appropriate, and some not.

We need to ask serious questions about a system that, according to a Kaiser Family Foundation report earlier this year, allows one state to spend nearly $45 thousand per person to care for the same category of enrollee that it costs

another state less than $9 thousand[5]. We need greater accountability and transparency to find out why this disparity exists, if we are all going to work together to make Medicaid a more sustainable program.

Medicaid also covers approximately half of the babies born in this country. With such a large impact on the next generation of Americans, it is vital that we track birth outcomes. We should be able to assess our impact, how many Medicaid babies are thriving due to the early interventions you have designed, but also how many children are born with an addiction or other health challenge so that we can find ways to help mothers deliver healthy babies and give the next generation the start in life they deserve.

We not only owe it to the beneficiaries we serve both young and old, but to the taxpayers funding them to make sure that our investments are actually producing positive health outcomes and helping our recipients lead better, more independent lives.

To this end, I am proud to announce, that we are creating the first ever state by state Medicaid and CHIP Scorecard. This is a historic opportunity to transition from merely following federal rules and processes to focusing on achieving positive health outcomes – tangible results that will improve the lives of our beneficiaries. The Scorecard will allow us to demonstrate your progress to the nation and allow others the opportunity to learn from your successes. This Scorecard isn't just for States, but for CMS as well, because good partners hold each other accountable.

The public deserves transparency from us. They deserve to know if we are spending their hard-earned tax dollars appropriately and our beneficiaries deserve to know if the $558 billion spent on Medicaid is producing positive results. But for this to be possible, it is critical that we have timely, accurate and complete data that allows us to tell the whole story – your story. You are doing amazing work that should be talked about, debated, and replicated. We now have 48 states that are live and reporting a more complete dataset to CMS. We will work with you in the coming months to onboard the remaining states and ensure that this data is accurate and of high quality. I ask that you commit yourselves and your resources to join us in this effort, as meaningful data collection is an important priority for CMS and this administration. I truly believe that the data we collect and report through our Scorecard will lead to a stronger, more sustainable and accountable Medicaid program.

And now to our third area, program integrity. Medicaid is a vital part of our social safety net, and we must ensure the sustainability of Medicaid by stopping waste, fraud and abuse. Many of you in this room have been leading the charge on this at the state level, and we are committed to providing more resources to help in this effort.

The examples are endless. One is a medical supply store that was fraudulently billing Medicaid for equipment that never made it to patients. In January, a physician in New York was convicted for helping to fuel the opioid epidemic by selling prescriptions for pain medications, authorizing his staff to issue prescriptions for controlled substances, and falsifying medical records.

We will partner with you to stop waste, fraud, and abuse. We will work with you to ensure that all of our expenditures are appropriate and our eligibility determinations are accurate and consistent with federal policies. We will work to refine budget neutrality calculations and the use of designated state health programs.

As I said earlier, and will continually say, Medicaid is too vital a program to let fraud and inappropriate spending threaten it. We have a responsibility to those who depend on us, to make sure that the Medicaid program will be around for them and for those who might need it in the future.

We have a higher purpose than just handing out Medicaid cards and being a financier of healthcare. Medicaid is a promise, both to our beneficiaries and to the American people that fund our programs. Our promise to beneficiaries is that we will ensure that our programs address your specific needs and give you access to high quality healthcare. We will not just accept the hollow victory of numbers covered, but will dig deeper and demand more of ourselves and of you. For those unable to care for themselves, we will create sustainable programs that will always be there to provide the care you need, to provide choices, and allow you to live as independently as possible. For those that just need a hand up, we will provide you the opportunity to take charge of your healthcare and assist and empower you to rise out of poverty and government dependence to create a better life for yourselves and your family. In 1964, while members of Congress from both parties were debating the creation of Medicaid, President Johnson said: "Our aim is not only to relieve the symptoms of poverty, but to cure it and, above all, to prevent it." If we are going to live up to the promise of Medicaid, we need to do more than simply pay for healthcare services…it's why we believe community engagement requirements are actually in the spirit of Johnson's idea. What I ask for from those of you in this room today and those that are working in Medicaid programs all across the country… Join with us in creating a Medicaid system that reaches its full potential to be a force for good in American life.

Local communities are the cradles of innovation and we need your ideas. Help us create a better, stronger Medicaid program. Help us create the accountability and transparency that the American people deserve to make sure that we are all doing our jobs.

I would like to invite everybody here today who have fought the political healthcare battles over the last decade to take a deep breath, exhale, and agree to reset as a group. We are all here for the exact same reason. We care about

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[5] https://www.kff.org/medicaid/fact-sheet/data-note-variation-in-per-enrollee-medicaid-spending/

the most vulnerable Americans. And while we may debate about how Medicaid should be structured and how to apply resources, the simple fact remains that we are on the same team. We are Americans working together to help Americans in need. It's not simply about providing people with a card—but with care, and with hope.

If we are going to be successful in confronting our present challenges, and prepare for the challenges of the future, it's going to take all of us – the entire healthcare community, to come together to find creative solutions. I invite you to join us in this dialogue and I am honored to have had the opportunity to speak with you today.

Thank you.

###

Upcoming Webinars and Events and Other Updates

Quality Payment Program Year 2 Overview Webinar

Date: Tuesday, November 14 **Time:** 1:00 – 2:30 p.m. ET

Registration page: https://engage.vevent.com/rt/cms/index.jsp?seid=938

On Tuesday, November 14 at 1:00 p.m. ET, the Centers for Medicare & Medicaid Services (CMS) will host an overview webinar on the Quality Payment Program Year 2 final rule.

Join the webinar to hear CMS policy experts provide an overview of the final requirements for the second year of the Quality Payment Program.

###

CMS Innovation Center Medicare Quality Payment Program Year 2 Final Rule – All-Payer Combination Option

Date: Thursday, November 16 **Time:** 1:00 – 2:30 p.m. ET

Registration page: https://engage.vevent.com/index.jsp?eid=5779&seid=703

On Thursday, November 16th at 1:00 p.m. ET, the CMS Innovation Center will host an overview webinar on the Medicare Quality Payment Program Year 2 final rule, with a focus on the participation of non-Medicare payers through the All-Payer Combination Option. Non-Medicare payers includes Medicaid, Medicare Health Plans, and payers participating in CMS Multi-Payer models. This event is for all CMMI model participants, their partnering providers and the general public. Join the webinar to hear CMS policy experts provide an overview of the All-Payer Combination Option requirements for the Quality Payment Program.

###

Virtual Groups Train-the-Trainer

Date: Friday, November 17 **Time:** 2 – 3 p.m. ET

Registration page: https://engage.vevent.com/rt/cms/index.jsp?seid=942

The Centers for Medicare & Medicaid Services (CMS) is hosting a Train-the-Trainer session on **Friday, November 17** on the Virtual Groups provisions included in the Quality Payment Program Year 2 Final Rule. CMS will provide an overview of Virtual Groups and the election process, and address questions from participants.

###

Quality Payment Program Year 2 Final Rule Call

Date: Thursday, November 30 **Time:** 1:30 – 3:00 p.m. ET

Registration page: https://blh.ier.intercall.com/

Target Audience: Medicare Part B Fee-For-Service clinicians, office managers and administrators; state and national associations that represent healthcare providers; and other stakeholders.

The Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways:

- The Merit-based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)

The Quality Payment Program allows clinicians to choose the best way to deliver quality care and participate based on their practice size, specialty, location, or patient population. During this call, learn about the Quality Payment Program Year 2 provisions in the final rule with comment and interim final rule with comment; participants should review the final rules prior to the call. A question and answer session follows the presentation.

###

HHS Opioid Symposium and Code-a-Thon

On December 6 and 7 the U.S. Department of Health and Human Services (HHS), Office of the Chief Technology Officer (CTO) will host an Opioid Symposium & Code-a-Thon to promote innovative ways that technology and data can be used to address the nationwide opioid epidemic. Acting Secretary Eric D. Hargan will deliver opening remarks followed by TED Talk style presentations from leaders on the front lines of the opioid epidemic that showcase promising practices that have improved outcomes in communities across the country. The Symposium will be immediately followed by a Code-a-Thon, where coders will have access to federal, state, and local (city, county) datasets to create innovative data-driven solutions to the opioid epidemic. Learn more about the event and how you can get involved.

POC: Elizabeth Squire, Elizabeth.Squire@hhs.gov

- Calling all data enthusiasts! HHS is inviting coders to Washington, DC for an opioid Code-a-Thon: http://bit.ly/2gthGXh #DataforOpioids
- Interested in learning how technology & data can address the opioid epidemic? Attend the Opioid Symposium on Dec 6: http://bit.ly/2gthGXh
- Join HHS in Washington, DC to explore how data and technology can be used to address the opioid epidemic: https://www.hhs.gov/challenges

You can join the HHS Opioid Symposium via livestream on Dec 6. **Register for the livestream here**: **http://bit.ly/2gthGXh** #DataforOpioids

###

MLN Connects

News & Announcements

- New Medicare Card: Help Notify Your Patients
- Medicare Diabetes Prevention Program Expanded Model Implementation
- Hospital Value-Based Purchasing Program Results for FY 2018
- Low Volume Appeals Settlements
- Hospice Item Set Data Freeze: November 15
- Draft 2018 CMS QRDA III Implementation Guide: Submit Comments by November 17
- CMS Innovation Center New Direction RFI: Submit Comments by November 20
- Therapeutic Shoe Inserts: Comment on DMEPOS Quality Standards through December 11
- Quality Payment Program Resources in New Location
- Post-Acute Care: Quality Reporting Program Quick Reference Guides Available
- Provider and Pharmacy Access during Public Health Emergencies
- Raising Awareness of Diabetes in November

Provider Compliance

- Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims

Upcoming Events

- Quality Payment Program Year 2 Overview Webinar — November 14
- SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16
- Quality Payment Program Virtual Groups Train-the-Trainer Webinar — November 17
- Quality Payment Program Year 2 Final Rule Call — November 30
- Medicare Diabetes Prevention Program Model Expansion Call — December 5

- LTCH Quality Reporting Program In-Person Training — December 6 and 7

Medicare Learning Network Publications & Multimedia

- Quality Payment Program in 2017: Advanced Alternative Payment Models Web-Based Training Course — New
- Medicare FFS Response to the 2017 California Wildfires MLN Matters Article — Updated
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article— Revised
- Transition to New Medicare Numbers and Cards Fact Sheet — Revised
- Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Revised
- Remittance Advice Information: An Overview Booklet — Reminder

###

New / Updated CMS Publications

- You're getting a new Medicare card!
- Things to Think About When Choosing a Plan for Your Business
- How Retiree Coverage Works with Medicare Prescription Drug Coverage
- Get Your Medicare Questions Answered
- Medicare & Your Mental Health Benefits
- What is Medicare? What is Medicaid?
- Questions to Ask about Medicare Preventive Services
- Staying Healthy: Medicare's Preventive Services
- Medicare: Getting Started
- My Tax Checklist
- Apply for Medicaid & CHIP through the Health Insurance Marketplace
- Report Life Changes to the Marketplace After You Enroll in Coverage
- SHOP Employer Billing & Premium Payment Process
- About the SHOP Marketplace
- The Small Business Health Care Tax Credit & Premium Assistance Programs
- SHOP Employee Minimum Participation Rate
- Helping People Understand Their Explanation of Benefits
- New Medicare Card Enlarged Training Sample
- New Medicare Card-Conference Card - Spanish

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Newly Posted Training Materials

Revised Medicare Learning Activities

- Medicare Alphabet Soup 2017
- Medicare Board Game
- Medicare Puzzles

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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.