CMS Region 7 Updates – 11/24/2017

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Weekly Enrollment Snapshot: Week Two

Week 2, Nov 5-11, 2017

In week two of Open Enrollment for 2018, 876,788 people selected plans using the HealthCare.gov platform. As in past years, enrollment weeks are measured Sunday through Saturday.

Every week during Open Enrollment, the Centers for Medicare & 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 2 Nov 5 – 11	Cumulative Nov 1-11
Plan Selections	876,788	1,478,250
New Consumers	208,397	345,719
Consumers Renewing Coverage	668,391	1,132,531
Consumers on Applications Submitted	1,569,712	2,921,211
Call Center Volume	757,217	1,284,263
Calls with Spanish Speaking Representative	56,174	91,539
HealthCare.gov Users	3,677,831	5,788,238
CuidadoDeSalud.gov Users	112,600	164,957
Window Shopping HealthCare.gov Users	355,164	648,219
Window Shopping CuidadoDeSalud.gov Users	7,499	11,545

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, this report refers to 39 Exchanges that use the HealthCare.gov platform. The states using the HealthCare.gov platform for the individual market Exchanges 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 Exchanges 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 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 Exchanges 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 Exchanges 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.

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Weekly Enrollment Snapshot: Week Three

Week 3, Nov 12-18, 2017

In week three of Open Enrollment for 2018, 798,829 people selected plans using the HealthCare.gov platform. As in past years, enrollment weeks are measured Sunday through Saturday.

Every week during Open Enrollment, the Centers for Medicare & 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 3 Nov 12 – 18	Cumulative Nov 1-18
Plan Selections	798,829	2,277,079
New Consumers	220,323	566,042
Consumers Renewing Coverage	578,506	1,711,037
Consumers on Applications Submitted	1,233,938	4,155,149
Call Center Volume	774,511	2,058,774
Calls with Spanish Speaking Representative	55,847	147,386
HealthCare.gov Users	2,993,178	8,111,328
CuidadoDeSalud.gov Users	101,477	246,556
Window Shopping HealthCare.gov Users	276,197	873,098
Window Shopping CuidadoDeSalud.gov Users	6,620	16,339

HealthCare.gov State-by-State Snapshot

The Snapshot provides cumulative individual plan selections for the 39 states using the HealthCare.gov platform. Individual plan selections for the states using the HealthCare.gov platform include:

State	Cumulative Plan Selections Nov 1 – 18
Alaska	5,667
Alabama	50,348
Arkansas	15,136
Arizona	43,499
Delaware	5,717
Florida	498,168
Georgia	119,968
Hawaii	5,391
Iowa	14,284
Illinois	77,960
Indiana	35,183
Kansas	25,848
Kentucky	23,494
Louisiana	25,502
Maine	19,880
Michigan	70,891

Missouri	64,281
Mississippi	22,889
Montana	11,365
North Carolina	138,932
North Dakota	5,672
Nebraska	27,093
New Hampshire	12,210
New Jersey	64,369
New Mexico	12,652
Nevada	22,517
Ohio	48,916
Oklahoma	36,198
Oregon	42,834
Pennsylvania	101,286
South Carolina	54,506
South Dakota	8,123
Tennessee	62,235
Texas	271,737
Utah	52,054
Virginia	100,350
Wisconsin	64,974
West Virginia	6,602
Wyoming	8,348

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Navigator Grant Recipients and Enrollment Goal

The Centers for Medicare & Medicaid Services (CMS) posted the final list of Navigator grant recipients in states with a Federally-facilitated Exchange (FFE) or State Partnership Exchange for the 2017-2018 budget period. It can be found here:

In addition, CMS posted the annual enrollment goal set by each Navigator for the 2017 plan year, compared to the enrollment numbers as recorded by the MIDAS system, November 1, 2016 – August 1, 2017, available here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html

Navigator Award Summaries (PDF) – or click here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Navigator-Grant-Recipients.pdf

Navigator Qualified Health Plan (QHP) Goals vs Enrollments (PDF) or click here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Navigator-QHP-Goals-Enrollments.pdf

###

PY2018 Open Enrollment Reminders: System Maintenance / Waiting Rooms / Window Shopping

CMS has released a fact sheet that discusses key updates to the Federal Health Insurance Exchange 2018 Open Enrollment Period. To read it, click here

HealthCare.gov Maintenance

Every major website needs routine maintenance and updates to keep things running smoothly and efficiently. This year, CMS is keeping the potential hours for planned website and partner maintenance similar to previous years, and limiting potential system downtime to the lowest-traffic time periods on HealthCare.gov. CMS also made sure to share those

potential plans in advance of Open Enrollment with Navigators and certified application counselors, in response to your requests, to help you plan your interactions with consumers.

HealthCare.gov Waiting Rooms

Similar to previous years, CMS may deploy a "waiting room" when website traffic is high for some consumers logging in or creating an account on HealthCare.gov. The waiting room is one tool we utilize to optimize a consumers' experience because it allows us to control the volume of users resulting in better performance of the website. Consumers see a message asking them to stay on the page. The waiting room will refresh when a consumer can continue to apply and enroll with a smooth experience.

Window Shopping

On October 25, 2017, CMS launched updates to window shopping ("See plans & prices") which allow consumers to preview 2018 plans and prices before Open Enrollment begins. As in previous years, window shopping lets consumers browse plans without logging in, creating an account, or filling out the official application. Starting November 1, consumers can log in to HealthCare.gov and CuidadodeSalud.gov or call 1-800-318-2596 to fill out an application and enroll in a 2018 Exchange health plan.

See this fact sheet released on October 25th for more open enrollment updates including important information about re-reenrollment.

Marketplace Assister Call Lines

Similar to the previous open enrollments, there will once again be a designated call center line for Assisters. This year the line features several enhancements designed to help better streamline the call process. Utilizing the Assister line will only allow Assisters to bypass the regular call center line if they need help with password resets or accessing certain call center-initiated SEPs. This enhancement is designed to help minimize the time they have to spend on the phone trying to resolve certain consumer issues. For all other issues, the wait time will be the same as the regular call center line.

The Call Center will be tracking the topics assisters request assistance with through the designated assister lines. We encourage assisters to use the assister line when working with consumers not only to receive enhanced service, but also in order to enable the Call Center to better monitor and meet assisters' needs. Please note there are two different Assister lines, one for Navigators and one for CACs:

Assister Line for Navigators: **1-855-868-4678**

Assister Line for CACs: 1-**855-879-2683**

If Assisters are having difficulty accessing the Assister line, please reach out to your project officer if a Navigator, or email the CACInbox@cms.hhs.gov if you are a CAC. CCIIO will verify that the code you are utilizing matches our records.

###

Failure to Reconcile (FTR) Updates

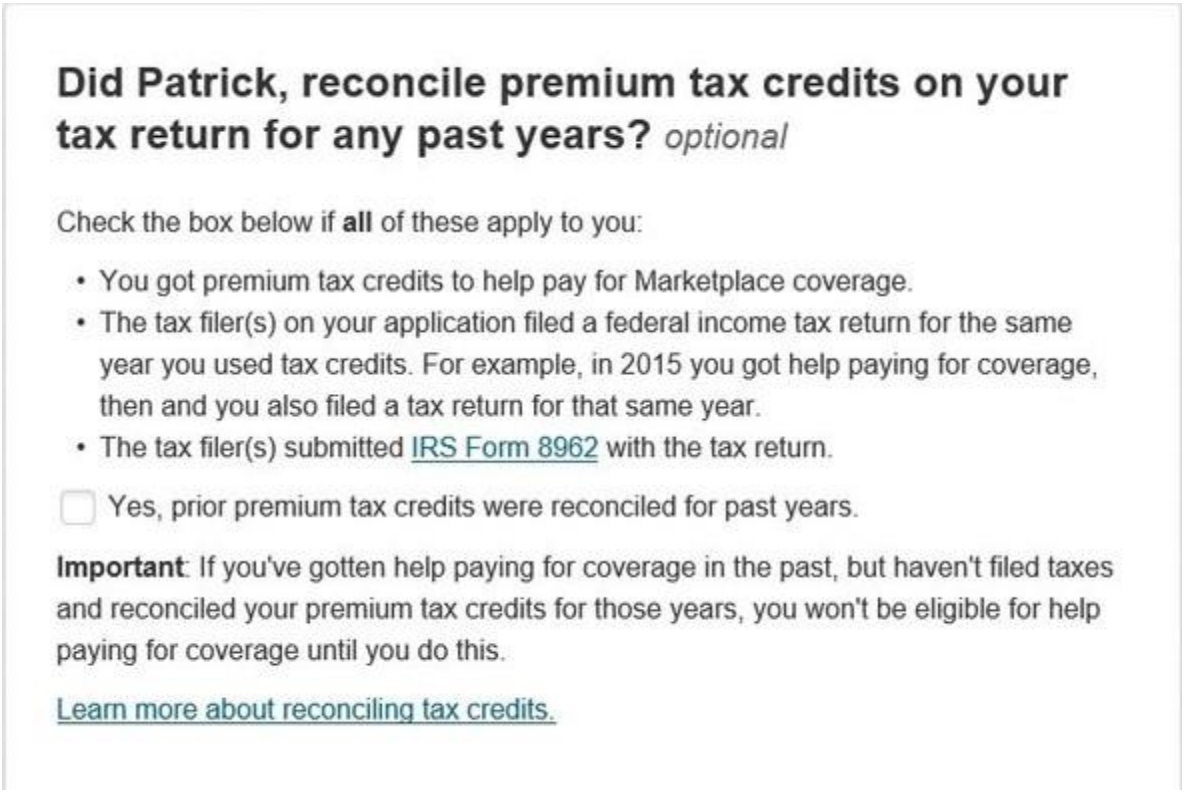
Summary: A consumer may not be determined eligible for advance payments of premium tax credit (APTC) if the tax filer for the household did not comply with the requirement to file an income tax return for a year in which APTC was paid on his/her behalf and reconcile the associated APTC for that year. This situation is called "failure to file and reconcile" or "FTR."

Policy

Starting January 1, 2016, a consumer was determined ineligible for APTC if APTC was paid on his or her behalf in a prior year, but the tax filer for the household did not file a tax return for that year. In 2018, if a consumer's tax filer filed a tax return but did not reconcile the associated APTC using IRS Form 8962 (known as a "non-reconciler"), the Marketplace will determine him or her ineligible for APTC, in addition to the non-filers.

Tax filers use IRS Form 8962 to reconcile the APTC paid on their behalf (based on projected household income) with the final premium tax credit the enrollee is eligible for (based on actual household income for the year during which APTC was paid on his or her behalf.

Generally, it takes IRS 3 to 10 weeks to process a tax return, depending on how it is filed (electronic vs. paper) and IRS updates the Marketplace on tax filing and reconciliation status for enrollees on a weekly basis. To account for these delays in IRS data available to the Marketplace, a question displays on the application to allow consumers to attest, under penalty of perjury, that their tax filer did file a tax return and reconcile all past APTC. This attestation allows the consumer to obtain or maintain eligibility for APTC (if otherwise eligible) even if IRS' data has not yet been updated.



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Avoid Losing APTC in 2018

Enrollees can avoid losing APTC in 2018 by filing their 2016 tax returns and reconciling their 2016 APTC IMMEDIATELY. For more information on how to file and reconcile visit: https://www.irs.gov/affordable-care-act/individuals-and-families/premium-tax-credit-claiming-the-credit-and-reconciling-advance-credit-payments.

- After, filing/reconciling for 2016, enrollees should return to the Marketplace, create a 2018 application and attest on the application that their tax filer has filed a tax return and reconciled all past APTC.
- In mid-December 2017, the Marketplace will do a final check of IRS data for FTR enrollees who did not return to the Marketplace, in order to retain APTC for those who filed and reconciled since the original IRS data check in September 2017.

Enrollees whose APTC is discontinued beginning January 1, 2018, due to failure to file and reconcile can still take additional steps to restore their APTC. As long as the enrollee remains enrolled in their Marketplace plan, he or she may return to the Marketplace application, report a life change, attest to filing and reconciling, receive a new eligibility determination, select a plan, and receive APTC prospectively, following the 15th of the month coverage effective date rules.

What Assisters Can Do

- Encourage enrollees who haven't yet filed their 2016 federal income taxes and who had APTC paid on their behalf in 2016 to file and reconcile **as soon as possible**.

https://www.irs.gov/affordable-care-act/individuals-and-families/premium-tax-credit-claiming-the-credit-and-reconciling-advance-credit-payments.

- Remind enrollees that even if they usually don't have to file an income tax return based on their income, if APTC was paid on their behalf, they must file a return for that year.
- Help enrollees who haven't yet filed their taxes understand what steps to take, including helping them access their Forms 1095-A

For more information, including how you as an assister can help consumers, check out the slides from the Wednesday, November 8 Assister Webinar here (insert hyperlink to the deck).

###

Extension of Equitable Relief for Beneficiaries Dually Enrolled in Medicare and Marketplace

CMS is extending the deadline through Sept 30, 2018, for equitable relief assistance to Medicare beneficiaries currently enrolled in Medicare Part A and the Marketplace. This assistance provides eligible individuals with an opportunity to enroll in Medicare Part B without penalty. Further, CMS is offering assistance to eligible individuals who were dually enrolled in Medicare Part A and the Marketplace and subsequently enrolled in Medicare Part B with a penalty. This assistance provides these individuals an opportunity to request a reduction in their Medicare Part B late enrollment penalty.

The limited equitable relief fact sheet can found here.

###

Marketplace Application Refreshers: Identity Proofing / Family & Household / APTCs & CSRs / Plan Compare

Identity Proofing

Identity proofing is an essential part of completing a Marketplace application. If this step is not completed, the consumer cannot move forward with creating an application. This step is used to verify a consumers identity by asking questions based on the consumers personal and financial history. This process helps prevent an unauthorized person from going to the Marketplace to create an application in a consumer's name, without their knowledge.

If a consumer's identity cannot be verified they will be referred to the Experian helpdesk for assistance. If the Experian helpdesk is unable to verify, the consumer will need to upload or mail in documents to verify his or her identity. If the consumer uploads documents for verification, processing time will be sooner than if they have to mail them. If mailed, it typically takes 7-10 business days to process. After identity is verified, a written notice will be sent letting the consumer know whether his or her identity has been verified or if he or she needs to submit more information to verify.

Some helpful tips/reminders:

- Prepare consumers to complete ID proofing. They might need to answer questions on topics such as: addresses of current and past places they have lived; names of current and past employers; and information about mortgages, credit cards, and/or loans they may have.
- Tell consumers the Center for Medicare and Medicaid Services (CMS) uses credit reporting agencies like Experian and Equifax to verify their identity and application information, so they may see an inquiry from CMS when checking their credit reports. This CMS inquiry does not affect consumers' credit scores.
- Tell consumers whose identities couldn't be verified through HealthCare.gov to resolve their ID proofing issues:

- Call the Experian Help Desk at 1-866-587-5409 and provide the reference code as shown on the Marketplace application screen.
- If the Experian Help Desk cannot verify a consumer's identity, the consumer can upload documents showing his/her identity to his/her Marketplace account on HealthCare.gov or mail documents to the Marketplaces.

If consumers are still having trouble with ID proofing, consumers should contact the Marketplace Call Center and complete the online application with a Marketplace Call Center representative.

- For more information on identity proofing visit marketplace.cms.gov, identity proofing and information inconsistencies, including why it is important and what to do if consumers have issues (also available in Spanish).
- Consumers who want to learn more about why they need to submit personally identifiable information (PII) and how the Marketplaces use this information should review should visit HealthCare.gov: How We Use Your Data (also available in Spanish) and the Privacy Act Statement (also available in Spanish) on HealthCare.gov.

###

The Family & Household Section of the Marketplace Application

Consumers who apply for health coverage through the Marketplace must fill out the Family & Household section of the Marketplace application to help determine their eligibility for coverage.

It is important to remember that eligibility for the Advance Payments of the Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSR's) are calculated based on a family's size and their total household income. This is why the Marketplace asks questions about the applicant's family members, even those who are not applying for coverage for themselves.

Assisters should remind consumers that a tax household includes the tax filer, his or her spouse, if applicable, and anyone they claim as a dependent, even if they aren't applying for coverage for themselves and file their own taxes. Only members of the same tax household can enroll in a Marketplace plan together if they apply for financial assistance to purchase coverage. Family members in a different tax household must apply for coverage separately. Other members of the household who are part of a separate tax household should still be listed on the application as non-applicants, so they are counted in the applicant' family size and their income can be included in household income. Married couples are required to file a joint return to be eligible for APTC.

Assisters should also advise consumers to enter the Social Security Numbers (SSN's) for everyone in the household who has one. Including a SSN helps confirm an individual's income and will aid in speeding up the application process.

For more on the Family & Household section of the Marketplace application, assisters can review the following resources:

- Who To Include In Your Household: https://www.healthcare.gov/income-and-household-information/household-size/
- Health Coverage for Immigrants: https://www.healthcare.gov/immigrants/
- Webinar with more information about how to help applicants denied Medicaid and CHIP eligibility because of their immigration status can be found here: (https://marketplace.cms.gov/technical-assistance-resources/immigrants-with-income-under-100-percent-fpl.pdf).

###

APTC/CSR's

Consumers applying for coverage through the Marketplaces may be eligible for financial assistance in the form of APTC to help save on their monthly premiums and CSRs to help save on their out-of-pocket health care costs. Eligibility for these savings depends on a consumer's household income, family size, and whether they already have access to or are enrolled in certain other forms of minimum essential coverage. Some consumers seeking financial assistance may also be assessed or determined to be presumptively eligible for Medicaid or the Children's Health Insurance Program (CHIP) by the Marketplaces.

Assisters should explain to consumers who receive APTC through the Marketplaces that they must file a federal income tax return, even if their income level would not otherwise require them to do so. As outlined in the above FTR article, assisters should advise consumers if they don't file a tax return to reconcile the APTC they received, their financial assistance may be discontinued in future years. For consumers who receive APTC, the Marketplaces will send consumers a Form 1095-A with information that they will need. Once consumers receive their 1095-A, they are required to complete Form 8962, to reconcile the APTC they received with their actual income for the year.

Consumers who make between 100% and 400% of the Federal Poverty level (FPL) may be eligible to receive APTC. In many cases, consumers who make 250% or below of the FPL may be eligible for CRSs to help reduce their out-of-pocket costs. Assisters should remind consumers that to benefit from CSRs, consumers must select a silver plan.

- Check out this list of IRS Premium Tax Credit resources for more information or visit the IRS page on premium tax credits:https://marketplace.cms.gov/technical-assistance-resources/income-resource-chart.pdf
- Find information that you can share with consumers about how they may be able to save on monthly premiums by receiving APTC (also available in Spanish**).** At this link, you will find a tool that you can share with consumers that can help them determine if they may qualify for APTC based on their household size and the state in which they live.
- Find information you can share with consumers about how they may be able to save on out-of-pocket costs through CSR's (also available in Spanish).

###

Plan Comparison and Selection

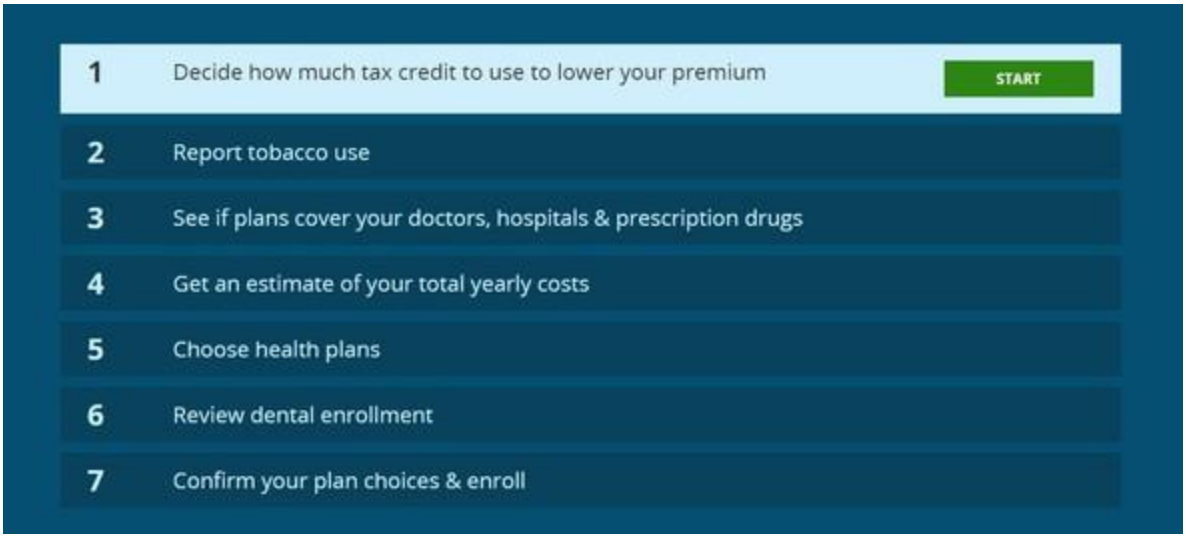
The plan comparison and selection process is a very important step in determining the coverage consumers will have for an entire year. Once the open enrollment period is over, they cannot change their plan until the next open enrollment period, unless they qualify for a special enrollment period. It is vital that consumers complete the application "To-Do-List" appropriately, in order to view the plans that are available to them and their families.

After receiving eligibility results, the application will take the applicant to the "Enroll to-do list" which helps the applicant navigate through the plan comparison process. The "Enroll to-do-list" will take the applicant through seven steps, if they are eligible for Advance Premium Tax Credits (APTCs), and six steps if they are not eligible for APTCs. Below you will see an example of the "Enroll to-do-list when a member has APTCs available.

Detailed information on the To-Do-List can be found here: Plan Compare Job Aid.

Helpful Information:

- Consumers have the option to browse plans before walking through the entire application by visiting HealthCare.gov. To browse plan options click here: See Plans.
- Find information about how to choose Marketplace coverage for consumers (also available in Spanish).
- Find information about using Marketplace coverage for consumers (also available in Spanish).
- Here are 5 questions consumers should ask when choosing a plan.



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COBRA Coverage Overview

COBRA allows temporary continuation of group health coverage that otherwise might be terminated to eligible covered employees, their spouses, their former spouses, and their dependent children.

COBRA is only available when coverage is lost due to certain specific qualifying events:

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
- Reduction in the hours worked by the covered employee;
- Divorce or legal separation of the covered employee;
- Death of the covered employee; or,
- A dependent child reaching the age at which he or she is no longer eligible for active coverage under the group plan (usually age 26).

When one of the above qualifying event occurs, consumers have 60 days to decide whether to enroll in COBRA coverage. Once they choose COBRA coverage, they have 45 days after making the election to pay the first month's premium. Consumers may also elect to have their COBRA coverage start retroactively to the date the job-based insurance ended, as long as the election is made within the 60 day eligibility period.

In most cases COBRA coverage lasts for 18 months. However, if a COBRA participant is determined to be disabled by the Social Security Administration, then coverage may continue for up to an additional 11 months; for a total maximum period of 29 months. Additionally, COBRA participants who experience a divorce or death qualifying event are eligible for an 18-month extension; giving a total maximum period of 36 months of continuation coverage.

If consumers decide not to elect COBRA coverage, they may enroll in a Marketplace plan instead within 60 days if they qualify for a Special Enrollment Period (SEP). Consumers may also be eligible for advance premium tax credits (APTC) or cost-sharing reductions (CSRs) through the Marketplace. Consumers should carefully consider things such as total cost, access to care, and whether or not they may keep their current providers before making a decision. If they decide to terminate their COBRA coverage early, they may have to wait until the next Open Enrollment Period to enroll in a Marketplace plan.

###

Frequently Asked Questions Received During the September 22, 2017 Webinar:

Q1. Are organizations with fewer than 20 employees allowed to participate in COBRA coverage?

A1. The law generally applies to all group health plans maintained by private-sector employers with 20 or more employees, or by state or local governments. The law does not apply to plans sponsored by the Federal Government or by churches and certain church-related organizations. In addition, many states have laws similar to COBRA, including those that apply to health insurers of employers with less than 20 employees (sometimes called mini-COBRA). Consumers should check with their state insurance commissioner's office to see if such coverage is available.

Q2. If the consumer has already paid toward their deductible before choosing COBRA, does the deductible start all over again with a COBRA plan or will the deductible rollover into the COBRA plan?

A2. Since COBRA is a continuation of the same health plan previously held through an employer, if the deductible has already been met, it does not start again with COBRA. Any payment towards the deductible with the employed based plan would be applied towards the COBRA plan. Consumers are subject to the same rules and limits that would apply to a similarly situated participant or beneficiary, such as co-payment requirements, deductibles, and coverage limits. The plan's rules for filing benefit claims and appealing any claims denials also apply.

Q3. If a consumer has been on COBRA for a few months with no employer subsidy and then decides to cancel COBRA, is he or she eligible for a SEP?

A3. No, consumers do not qualify for a Special Enrollment Period if:

- They decide to end COBRA early (and are paying the full cost)
- They lose COBRA coverage because they didn't pay the premiums

Note: Consumers don't need a Special Enrollment Period if they voluntarily end COBRA early during a Marketplace Open Enrollment Period. Consumers can drop their COBRA plan and enroll in a Marketplace plan at that time.

Q4. If a consumer first elects to apply for COBRA at the end of the 60 day time frame, is there an option for the consumer to make to make their coverage effective for the current or next month or is backdating the only possibility?

A4. The election period is measured from the date of the qualifying event or the date the COBRA election notice is provided. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary.

Q5. Will the consumer receive documentation of the COBRA coverage and notification of any premium changes?

A5. Yes. Group health plans must give each employee and each spouse who becomes covered under the plan a general notice describing COBRA rights. This Notice of COBRA Rights must be provided within the first 90 days of coverage. The COBRA rights provided under the plan must be described in the plan's Summary Plan Description (SPD). The SPD is a written document that gives important information about the plan, including what benefits are available under the plan, the rights of participants and beneficiaries under the plan, and how the plan works.

A notice of COBRA rights generally includes the following information:

- A written explanation of the procedures for electing COBRA,
- The date by which the election must be made,
- How to notify the plan administrator of the election,
- The date COBRA coverage will begin,
- The maximum period of continuation coverage,
- The monthly premium amount,
- The due date for the monthly payments,
- Any applicable premium amount due for a retroactive period of coverage,
- The address to which to send premium payments,
- A qualified beneficiary's rights and obligations with respect to extensions of COBRA coverage, and
- The bases for early termination of the period of COBRA coverage.

Resources

- EMPLOYEE'S GUIDE TO HEALTH BENEFITS UNDER COBRA
- https://www.healthcare.gov/unemployed/cobra-coverage/
- https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html
- https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-consumer.pdf

###

Standing Assister Resources: Helpful Links / Call Center Hours / Contact Us

Links to Helpful Resources

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

Marketplace Call Center and Shop Center Hours

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

Navigator Marketplace Call Center line: 1-855-868-4678
CAC Marketplace Call Center line: 1-855-879-2683
General consumer Call Center line: 1-800-318-2596 (TTY: 1-855-889-4325)

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

Stay in Touch

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

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

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

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

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

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

###

MACRA/Quality Payment Program (QPP) Updates

New Deadline: Participate in Field Testing of Episode-Based Cost Measures by November 20

The Centers for Medicare & Medicaid Services (CMS) has extended the deadline for feedback on its cost measures field test to **November 20, 2017**.

As a reminder, CMS is conducting a field test for eight episode-based cost measures before consideration of their potential use in the cost performance category of the Merit-based Incentive Payment System (MIPS) of the Quality Payment Program. During the field test, clinicians may access confidential feedback reports with information about their performance on these new measures. **All stakeholders are also invited to comment on the measures and supplemental documents.**

The eight episode-based cost measures are:

1. Elective Outpatient Percutaneous Coronary Intervention (PCI)
2. Knee Arthroplasty
3. Revascularization for Lower Extremity Chronic Critical Limb Ischemia
4. Routine Cataract Removal with Intraocular Lens (IOL) Implantation
5. Screening/Surveillance Colonoscopy
6. Intracranial Hemorrhage or Cerebral Infarction
7. Simple Pneumonia with Hospitalization
8. ST-Elevation Myocardial Infarction (STEMI) with (PCI)

Participate in Field Testing through November 20, 2017

The field test is a voluntary opportunity for stakeholders to comment on the measure specifications and the report template for the eight measures in their current stage of development. This feedback will be considered in refining the measures and for future measure development activities.

If you or your clinician group perform(s) or manage(s) the care for one or more of the procedures or medical conditions represented in the measures above, you might have a confidential Field Test Report on the CMS Enterprise Portal. For group practices, reports are available for the TIN of the group practice. Please refer to the "2017-10-cost-measure-field-test-access-guide.pdf" in the zip file linked below for instructions on setting up or activating your EIDM account. The supplemental documentation listed below is included in a zip file on the MACRA page under the "What's new" section and "Episode-based cost measures" subsection. To download the zip file directly, please click here.

- Field Test Mock Report
- Draft Cost Measure Methodology
- Draft Measure Codes List

Please provide comments through this online survey **by 11:59 PM ET on November 20, 2017**.

For More Information

You may refer to the fact sheet or FAQs document for additional information. If you have any questions, please contact QPPCostMeasureTesting@ketchum.com.

###

2017 Quality Payment Program Frequently Asked Questions

The 2017 Quality Payment Program Frequently Asked Questions document was developed to serve as a quick reference for the Quality Payment Program. The document is only applicable for 2017 transition year and aims to address the top questions received though outreach and the service center.

Frequently Asked Questions Document (PDF) also found here: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2017-Quality-Payment-Program-Frequently-Asked-Questions.pdf

###

CMS announces a new user-centered resource to help improve alignment: the CMS Measures Inventory Tool (CMIT)

CMS is actively working to move the needle on improving quality in healthcare without additional burden to those providers on the frontlines. CMS recently launched a new initiative, 'Meaningful Measures,' which will streamline current measure sets – so providers can focus on the measures that are most impactful – and will move from process measures to outcome measures where possible. A great deal of attention has also been focused on alignment of quality measures within CMS and with commercial payers, and we are committed to working towards alignment of these measures to ensure delivery of high quality care to all Americans while minimizing burden on providers.

I am pleased to announce that CMS is deploying an innovative tool that provides all stakeholders improved visibility into the portfolio of CMS measures. The CMS Measures Inventory Tool (CMIT), an interactive web-based application that contains the same information that is currently included on the Excel spreadsheet, provides a comprehensive list of measures that are currently under development, implemented for use, and have been removed from a CMS quality program or initiative. The intuitive and user-friendly functions allow you to find measures quickly and to compile and refine sets of related measures. The tool increases transparency and can be used to identify measures across the continuum of care and will help coordinate measurement efforts across all conditions, settings, and populations. We have expanded the information contained in the inventory to better answer questions we have heard from the public; the CMIT lists each measure by program, dates of measure consideration and implementation, and measure specifications including, but not limited to, numerator, denominator, exclusion criteria, measure type, and National Quality Forum (NQF) endorsement status.

CMIT is an innovative approach that will help to promote the goal of increased alignment across programs and with other payers. We believe it is an easy to use valuable resource to various stakeholders, including commercial payers, clinicians, patients and measure developers.
For more information about CMIT and to access the tool, please visit the CMS.gov website.

###

Medicare and Medicaid Updates

CMS Faith and Community Partnerships Update

Note to Readers: All of the information below is cleared content from the Centers for Medicare and Medicaid Services (CMS) or other federal government agencies. Please feel free to cut and paste the information below and use in your communication tools (newsletters, websites) without attribution.

Faith-based Resources for National Diabetes Month

November is National Diabetes Month! Older adults are disproportionately affected by diabetes, with 25.2% of Americans age 65+ experiencing the disease, compared to 9.4% of the general population. The CDC National Diabetes Education Program has created a Faith Leaders Toolkit with resources to help faith and other community-based leaders share information on Type 2 Diabetes prevention and management. The toolkit also provides tips on organizing activities in the community and creating an environment that supports healthy choices. The toolkit is in English and Spanish. More information can be found on the CDC National Diabetes Education Program website.

Request for Information from the HHS Partnership Center

Religious and faith-based organizations are essential partners with unique expertise that is crucial to advancing the mission of the Department of Health and Human Services (HHS) to enhance and protect the health and well-being of the American people.

HHS is seeking input in identifying barriers that religious and faith-based organizations face as they seek to participate in HHS programs and support the HHS mission. We seek comment from faith-based organizations and other interested parties to inform us on how we may best identify and remove regulatory or other barriers in order for these organizations to participate in HHS programs, strengthen partnerships with them to improve service delivery to the American people, and ensure they are affirmatively accommodated and not excluded from programs or activities.

We also seek input on whether faith-based organizations could face potential obstacles to participation in state or locally funded programs, or restrictions on their privately funded activities, because of requirements imposed on state and local governments as a condition of receiving HHS funding.

Finally, we seek input on what policies, procedures, and assessment tools HHS should develop to affirmatively further the accommodation, equal treatment, and respect for the religious exercise of faith-based organizations.

The Federal Register citation is here. There is a 30 day period for comments, which may be submitted electronically, by email, regular mail, or express mail. The deadline is approaching soon! Thank you for your engagement with us in this important effort.

Applications Being Accepted for 2018 Capacity Building Opportunity: Intensive Technical Assistance

Applications are due by Monday, November 27 2017, at 8 p.m. Eastern Time for the SAMHSA Bringing Recovery Supports to Scale Technical Assistance Center 2018 Capacity Building Opportunity. This is an intensive technical assistance opportunity for peer-run organizations, recovery community organizations, family-run organizations, and youth- and young adult-run organizations. Up to 25 organizations will be selected to receive individualized consultation, training, and peer-to-peer support over the course of a 6-month period in one of five areas. For more information, visit the SAMHSA Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS)

Update from the CMS Office of Minority Health

The Roadmap to Behavioral Health is a companion guide to the C2C Roadmap to Better Care and a Healthier You. Developed in partnership with Substance Abuse and Mental Health Services Administration (SAMHSA), this consumer-facing resource offers important information to help them understand and connect to mental health and substance use disorder services. The Roadmap to Behavioral Health walks through 8 Steps to offer information specific to topics like finding a behavioral health provider, defining behavioral health terms, receiving services, and following up on care. It also links to other HHS resources.

Click here to download a copy today! (https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Coverage-to-Care-Behavioral-Roadmap.pdf)

Order copies of the Roadmap to Behavioral Health at no cost to your organization! Visit the CMS Product Ordering Website at https://productordering.cms.hhs.gov/ to request the latest resource by CMS' From Coverage to Care (C2C). C2C resources can be ordered and shipped directly to you at no cost to your organization. To place an order from the CMS Product Ordering Website, you must have a free account. Click here for instructions and help on how to create an account. Want to learn more or download C2C resources? Visit go.cms.gov/c2c or email CoverageToCare@cms.hhs.gov.

Health and Wellness Webinars

Working Together to Build a Network Webinar – November 29 at 1 pm ET
In Arizona, an innovative collaboration between Mercy Care, an Aetna-administered nonprofit health plan, and the Area Agency on Aging (AAA), Region One, is making major inroads toward the goals of improving health outcomes while lowering costs, delivering on the promise of integrated, person-centered care for vulnerable populations. By working together to identify and implement AAA services that support Mercy Care's members, the partnership benefits both organizations, deepening a relationship that increases community trust, bolsters organizational capacity and makes a real and positive difference in the lives of older adults and individuals with disabilities.

The webinar will cover how these forward-thinking partners built and maintain their strong connection across the care delivery spectrum; and pick up tips and advice on how you can help your organization plan for, support, and grow relationships with healthcare payers.

Please join the Aging and Disability Business Institute on **November 29 at 1:00 PM Eastern** for a one hour webinar. Barbara Hill, nurse supervisor for Mercy Care Plan; Chad Corbett, vice president of Long Term Care for Mercy Care Plan; and Melissa Elliott, social worker and vice president of programs and services for AAA Region One will present.

Learning objectives:

- Understand what Managed Care Organizations (MCO) offer and how we can enhance our services with AAAs and CBOs;
- Understand why AAAs are a viable community-based partner to support Managed Care Organizations; and,
- Describe the broad scope of services provided by the AAA Region One in Phoenix, AZ, that complement the services provided through MCOs to improve patient outcomes.

Register for the webinar.

Learn more about ACL's Business Acumen Initiative to help states and community-based organizations build networks and respond to delivery system changes, including technical assistance, building business capacity for successful contracting with integrated care entities, and developing pathways to sustainability.

"Do I Need this Pill? Understanding Pain and Prescription Drugs"
Webinar--Thurs., Dec. 7, Noon to 1:00 p.m. EST

Whether acute or chronic, poor pain treatment is a contributing factor to today's opioid crisis. Please join the HHS Partnership Center and the National Institute on Drug Abuse (NIDA) for this timely webinar, designed especially for faith-based and community leaders, as we explore the nature of pain and healthy strategies for pain management. Register here.

Interdisciplinary Care Teams for Older Adults Webinar – December 7 at Noon ET

The CMS Medicare-Medicaid Coordination Office (MMCO), in collaboration with the Lewin Group and the American Geriatrics Society, will hold a webinar Thursday, December 7th on Interdisciplinary Care Teams for Older Adults.

This webinar will identify common challenges and best practices for Interdisciplinary Care Teams (ICT) working with older adults. Presenters will also address the importance of clinical, psychosocial, long-term care, behavioral, and community-based support for older adults, particularly Medicare/Medicaid beneficiaries.

Participants will learn how to:

- Identify different members of the ICT and how the team's approach to care may change over time based on the social and health needs of the older adult.
- Describe effective approaches to create high performing teams including clarifying roles of team members and establishing methods of communication and information sharing with the individual, their family, and core team members.
- Demonstrate basic knowledge of strategies to integrate long-term services and supports into care planning and overall team coordination.
- Demonstrate an understanding of how the ICT interacts with the consumer, and if appropriate, their caregiver.

This webinar takes place Thursday, December 7 from 12:00 p.m. ET to 1:30 p.m. ET. Click here to register. Continuing Medical Education (CME) and Continuing Education (CE) credit is available for this webinar.

Presenters:

- Gwendolyn Graddy-Dansby, M.D., F.A.C.P., Medical Director, PACE Southeast Michigan
- Sandra White, LMSW, ACSW, PACE Southeast Michigan
- Ellen LaSalvia, MSW, LSW, Buckeye Health Plan

Learn more about MMCO.

To be added to the CMS Faith and Community Partnerships Update, please email Lisa Carr at Lisa.Carr@cms.hhs.gov.

###

2018 Medicare Parts A & B Premiums and Deductibles Announced

The Centers for Medicare & Medicaid Services (CMS) announced the 2018 premiums, deductibles, and coinsurance amounts for the Medicare Part A and Part B programs.

Medicare Part B Premiums/Deductibles

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and other items.

The standard monthly premium for Medicare Part B enrollees will be $134 for 2018, the same amount as in 2017. Some beneficiaries who were held harmless against Part B premium increases in prior years will have a Part B premium increase in 2018, but the premium increase will be offset by the increase in their Social Security benefits next year.

"Medicare's top priority is to ensure that beneficiaries have choices for affordable, high-quality care that fit their needs," said CMS Administrator Seema Verma. "Next year, no beneficiary protected by the hold-harmless provision will see a Part B premium increase that is greater than the increase in their Social Security benefits. We encourage Medicare beneficiaries to explore their options to make an informed choice between Original Medicare and Medicare Advantage before Open Enrollment ends on December 7."

CMS recently released the benefit, premium, and Star Ratings information for Medicare health and drug plans which shows that there will be more health coverage choices, improved access to high-quality health choices, and decreased premiums in 2018. CMS estimates that the Medicare Advantage average monthly premium will decrease by $1.91 (about 6 percent) in 2018, from an average of $31.91 in 2017 to $30. More than three-fourths (77 percent) of Medicare Advantage enrollees remaining in their current plan will have the same or lower premium for 2018. The average basic premium for a Medicare prescription drug plan in 2018 is projected to decline to an estimated $33.50 per month. This represents a decrease of approximately $1.20 below the average basic premium of $34.70 in 2017. The Medicare prescription drug plan average basic premium is projected to decline for the first time since 2012.

CMS also announced that the annual deductible for all Medicare Part B beneficiaries will be $183 in 2018, the same annual deductible in 2017. Premiums and deductibles for Medicare Advantage and Medicare Prescription Drug plans are already finalized and are unaffected by this announcement.

Medicare Part A Premiums/Deductibles

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. About 99 percent of Medicare beneficiaries do not have a Part A premium since they have at least 40 quarters of Medicare-covered employment.

The Medicare Part A annual inpatient hospital deductible that beneficiaries pay when admitted to the hospital will be $1,340 per benefit period in 2018, an increase of $24 from $1,316 in 2017.

For a fact sheet on the 2018 Medicare Parts A & B premiums and deductibles, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-17.html.

###

CMS updates Medicare Advantage Value-Based Insurance Design (VBID) Model for 2019

Expansion of model to 25 total states to provide Medicare beneficiaries with more choices and lower costs

The Centers for Medicare & Medicaid Services (CMS) announced several updates to the Medicare Advantage Value-Based Insurance Design (VBID) Model for 2019 that encourages customized benefit designs and flexibilities that meet the health needs of beneficiaries in a total of 25 states.

"This Administration is committed to making sure that our seniors have more choices and lower premiums in their Medicare Advantage plans," said CMS Administrator Seema Verma. "CMS expects that this demonstration will provide insights into future innovations for the Medicare Advantage program."

CMS recently announced in the Medicare Advantage and Part D proposed rule that it is providing new flexibility for customized benefit designs that address the specific health needs of certain beneficiaries under Medicare Advantage. This allows additional plan variety and options, reduced cost sharing for customized benefits and different cost-sharing for beneficiaries that meet specific medical criteria.

Medicare Advantage provides Medicare beneficiaries with choices and options that meet their unique health and financial needs. It remains a popular choice among beneficiaries and has high beneficiary satisfaction. Enrollment in Medicare Advantage is at an all-time high as approximately one-third of Medicare beneficiaries are in a Medicare Advantage plan. The number of Medicare Advantage plans available for individuals to choose from across the country is increasing from about 2,700 in 2017 to more than 3,100 in 2018 – and more than 85 percent of Medicare beneficiaries will have access to 10 or more Medicare Advantage plan choices in 2018.

Beginning in 2019, the VBID model will expand to an additional fifteen new states for a total of 25 states, allow Chronic Condition Special Needs Plans to participate, and allow participants to propose their own systems or methods for identifying eligible enrollees. This change will afford participants with the opportunity to include Medicare beneficiaries with different chronic conditions than those previously established by CMS -- such as lower back pain, chronic kidney disease, obesity/pre-diabetes, asthma, and tobacco use. This will provide beneficiaries across 25 states with new choices and access to customized care.

For 2018, CMS allowed Medicare Advantage plans in the following ten states to apply to the model: Alabama, Arizona, Indiana, Iowa, Massachusetts, Michigan, Oregon, Pennsylvania, Tennessee, and Texas. For 2019, CMS will include fifteen more states in the model: California, Colorado, Florida, Georgia, Hawaii, Maine, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia, and West Virginia.

Medicare Advantage Organizations that wish to participate in 2019 can access the Request for Applications now and applications will be due on January 26, 2018 at 5pm EST. Newly interested organizations may apply and existing participants must reapply for participation in 2019.

For more information on VBID Model and the CY 2019 Request for Applications, please visit: https://innovation.cms.gov/initiatives/VBID/

###

Medicaid Access to Care SMDL

The Centers for Medicare & Medicaid Services (CMS) is releasing a State Medicaid Director Letter (SMDL) to provide guidance and clarification to states on implementing the Medicaid access to care regulations issued November 2015. States have requested clarification regarding the circumstances in which provider payment reductions would likely not result in diminished access to care, including: states that pay at or above the Medicare rate under fee-for-service, are proposing relatively minor reductions to provider payment rates, or have high managed care penetration rates.

To read the full letter, click here: https://www.medicaid.gov/federal-policy-guidance/downloads/smd17004.pdf

###

CMS Releases Proposed Rule to Increase Choices and Lower Premiums for Medicare Advantage Enrollees

Medicare beneficiaries will see more choices and greater affordability as a result of increased flexibilities

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that will result in lower premiums and increased plan choices for Medicare beneficiaries. During this year's Medicare Advantage Open Enrollment, which started October 15th and runs until December 7th, seniors enrolling in Medicare Advantage have seen average monthly premiums drop by 6%, and CMS is proposing changes to continue to drive affordable options for Medicare beneficiaries that meet their unique health needs.

Medicare Advantage remains a popular choice among beneficiaries and has high beneficiary satisfaction. Enrollment in Medicare Advantage is at an all-time high as approximately one-third of Medicare beneficiaries are in a Medicare Advantage plan. The number of Medicare Advantage plans available to individuals to choose from across the country is increasing from about 2,700 to more than 3,100 – and more than 85 percent of Medicare beneficiaries will have access to 10 or more Medicare Advantage plan choices.

CMS is providing new flexibility for customized benefit designs that address the specific health needs of certain beneficiaries. This new flexibility will allow additional plan variety and options, reduced cost sharing for customized benefits and different cost-sharing for beneficiaries that meet specific medical criteria. CMS is also proposing to provide greater flexibility to encourage lower maximum out of pocket levels of beneficiary cost sharing.

This year, CMS received numerous ideas on how to improve Medicare Advantage from beneficiaries, Medicare Advantage plans, advocacy groups, and other stakeholders. The policies in the proposed rule are responsive to this feedback.

"This administration has been committed, from the beginning, to making sure that our seniors have more choices and lower premiums in their Medicare Advantage plans. To that end, we are adding new flexibilities that will allow seniors to choose plans that are tailor-made to their unique needs, with lower out of pocket costs," said CMS Administrator Seema Verma. "We have also been committed to reducing unnecessary regulations that have driven up the cost of healthcare without improving care, so we are eliminating burdensome regulations on plans and providers that have stood in the way of providing quality patient care."

The proposed rule also furthers CMS' Patients Over Paperwork initiative, which is an effort that aims to remove regulatory obstacles in order to empower patients and providers to make healthcare decisions; to develop innovative approaches to improving quality, accessibility, and affordability; and to improve Medicare beneficiaries' customer experience. Specifically, the proposed rule would reduce regulatory burdens by:

- Allowing CMS to permit electronic delivery of more materials to beneficiaries;

- Improving transparency of the Medicare Advantage Star Ratings to that give patients information about each plan's quality rating.
- Streamlining government review and approval of materials that Medicare Advantage plans use to communicate with beneficiaries; and
- Eliminating burdensome enrollment requirements for providers that bring value to Medicare Advantage beneficiaries.

For a fact sheet on the proposed rule, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-16.html.

The proposed rule (CMS-4182-P) can be downloaded from the *Federal Register* at: https://www.federalregister.gov/public-inspection.

###

CMS Proposes Policies to Lower the Cost of Prescription Drugs and Combat the Opioid Crisis

The proposed rule eliminates administrative hurdles to providing more affordable prescription drugs and will allow Medicare to combat opioid overprescribing and abuse.

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that includes a number of changes that, if finalized, will ensure that Part D Medicare enrollees have access to more affordable prescription drugs and more robust prescription drug coverage at the pharmacy they prefer. The rule also gives health plans a new tool to combat the opioid crisis.

The President has been committed to lowering drug prices for seniors and fighting the opioid epidemic. In response, CMS is working to lower drug prices by removing administrative hurdles to offer lower cost options to seniors on Medicare, as well as supporting private sector partners by providing them a much needed tool in the fight to end the opioid epidemic.

CMS is proposing to lower drug costs by providing flexibility for certain mid-year changes to prescription drug formularies when a new generic drug becomes available and is clinically appropriate, while protecting beneficiaries who require the brand name drug. This change will provide flexibility to switch to lower cost prescription drugs and pass those savings on to Medicare beneficiaries.

CMS is also proposing to lower drug costs by treating lower-cost "biosimilar" versions of biologic products like other generic drugs when determining how much certain beneficiaries pay for drugs out of pocket under Medicare Part D. This change will encourage the availability of lower-cost alternatives for Medicare beneficiaries.

The proposed rule also includes a Request for Information on applying discounts drug companies provide to health plans to the price beneficiaries pay at the pharmacy counter. CMS is requesting input on whether this idea would maximize cost-sharing savings for beneficiaries, how they might best be implemented and what the implications would be for various stakeholders and taxpayers.

CMS is also empowering beneficiaries to access their prescription drugs at the pharmacy they prefer. CMS is proposing to revise the pharmacy participation rules in Part D which will promote greater participation of local pharmacies in Part D and preserve beneficiary access to all types of pharmacy delivery services, including mail-order.

To help address the national health crisis created by opioid abuse, CMS is proposing to implement new authority that allows Part D plans to require certain beneficiaries to obtain their prescriptions for opioids from selected prescribers or pharmacies. The proposal would provide an important new tool to combat the growing opioid epidemic that is devastating families and communities across the nation.

For a fact sheet on the proposed rule, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-16.html.

The proposed rule (CMS-4182-P) can be downloaded from the *Federal Register* at: https://www.federalregister.gov/public-inspection.

###

Shared Decision Making (SDM) Model Request for Cancellation of Model

Centers for Medicare & Medicaid Services (CMS) has announced its decision to not implement the Shared Decision Making (SDM) Model. CMS is not implementing the SDM Model because it did not receive sufficient ACO interest to provide an adequate test of the Model. CMS will be terminating its participation agreements with ACOs as a result of the decision to not implement the SDM Model. Further details will be provided directly to ACOs impacted by this decision.

###

CAHs: The Deadline to Apply for a Hardship Exception to Avoid the 2016 Payment Adjustment is November 30th

The deadline for Critical Access Hospitals (CAHs) to submit a hardship exception application to avoid the 2016 payment adjustment based on the 2016 reporting year is **Thursday, November 30th**. The application must be submitted electronically or postmarked by the November 30th deadline.

Submit a Hardship Exception Application by Thursday, November 30th

CAHs can submit hardship exception applications in two ways:

- **Electronic submission**: Sent to ehrhardship@provider-resources.com.
- **Paper submission**: Submitted via fax to 814-456-7132.

All hardship exception determinations will be returned via email from ehrhardship@provider-resources.com to the email address provided on the application.

If approved, the hardship exception is valid for the 2016 payment year only. If the CAH claims a hardship exception for a following payment year, the CAH must submit a new application.

For More Information

Review the Critical Access Hospital Payment Adjustment and Hardship Exception Tipsheet and visit the Payment Adjustments and Hardship Information webpage on the EHR Incentive Programs website.

###

Rural Community Hospital Demonstration

Updated November 2017

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

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

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

CMS issued a solicitation for additional hospitals on April 17, 2017. Applications were due on May 17, 2017. CMS reviewed and evaluated these applications, and in Fall 2017 announced the hospitals selected for participation in the demonstration program, including previously participating and newly selected hospitals. (See *Selected Hospitals* section below.)

Background

Section 410A(a)(1) of the MMA requires this demonstration to test the feasibility and advisability of establishing rural community hospitals to furnish covered inpatient hospital services to Medicare beneficiaries. The demonstration tests payment under a reasonable cost-based methodology for Medicare inpatient hospital services furnished by rural hospitals with fewer than 51 acute care inpatient beds, that make available 24-hour emergency care services, and that are not eligible to be, or have not been designated as, Critical Access Hospitals (CAH).

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

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

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

Provisions of the 21 Century Cures Act

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

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

Payment Methodology

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

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

Extension Period Under the Cures Act

Implementation
CMS has developed a participation agreement specifying payment principles, as well as administrative, auditing, and reporting requirements. This participation agreement will apply to each hospital participating in the second extension period.

Extension Period for Previously Participating Hospitals
In the Fiscal Year 2018 Inpatient Prospective Payment System Final Rule (82 FR 37990, August 14, 2017), CMS finalized the terms of continuation for the previously participating hospitals. For each hospital choosing to continue participation, the demonstration cost-based payment methodology will be effective to the conclusion of the hospital's period of participation under the Affordable Care Act.

Eligibility Requirements
As stipulated in section 410A of the Medicare Prescription Drug Improvement and Modernization Act of 2003, a hospital must:

- be located in a rural area;
- have fewer than 51 acute care beds (not including beds in a psychiatric or rehabilitation unit that is a distinct part of the hospital), as reported on its most recent cost report;
- make available 24-hour emergency services; and
- not be eligible for designation or be designated as a Critical Access Hospital.

The authorizing statute in the 21st Century Cures Act states that additional hospitals selected for the demonstration under this solicitation may be located in any State. The authorizing statute adds that in determining which hospitals to select for participation in the demonstration, priority should be given to hospitals among the 20 States with the lowest population density according to the *2015 Statistical Abstract of the United States.*

The solicitation for additional participants for the RCH Demonstration, issued on April 17, 2017, identified the 20 States with lowest population density according to population estimates from the Census Bureau for 2013, from the *ProQuest Statistical Abstract of the United States, 2015*. These 20 States are: Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont, and Wyoming.

Selected Hospitals

The authorizing statute in the Affordable Care Act stipulates a maximum of 30 hospitals to participate in the demonstration. Section 15003 of the Cures Act, which authorizes the current extension period, states that hospitals that participated in the demonstration through the end of the first extension period, authorized by the Affordable Care Act, or participating effective December 30, 2014, are allowed to continue participation for the current extension period.

CMS confirmed that 17 of the previously participating hospitals will continue participation in the demonstration. So as to allow for the maximum of 30 hospitals to participate in the current extension period, CMS selected 13 additional hospitals. These 13 hospitals will begin their period of participation effective the start of the first cost reporting period on or after October 1, 2017.

The following are the 13 new selected hospitals:

Montrose Memorial Hospital; Montrose, CO
Trinity Regional Medical Center; Fort Dodge, IA
St. John's Medical Center; Jackson, WY
Valley View Hospital; Glenwood Springs, CO
Great Plains Regional Medical Center; Elk City, OK
The Aroostook Medical Center; Presque Isle, ME
Anderson Regional Medical Center - South; Meridian, MS
McPherson Hospital; McPherson, KS
Avera St. Luke's Hospital; Aberdeen, SD
Highland Community Hospital; Picayune, MS
Morton County Health System; Elkhart, KS
St. Anthony Summit Medical Center; Frisco, CO
Avera Queen of Peace Hospital; Mitchell, SD

The following are the 17 hospitals that participated previously and are continuing participation:

Central Peninsula Hospital; Soldotna, AK
Bartlett Regional Hospital; Juneau, AK
Brookings Health System; Brookings, SD
Columbus Community Hospital; Columbus, NE
Delta County Memorial Hospital; Delta, CO
Yampa Valley Medical Center; Steamboat Springs, CO
St. Anthony Regional Hospital and Nursing Home; Carroll, IA
Grinnell Regional Medical Center; Grinnell, IA
Skiff Medical Center; Newton, IA
Lakes Regional Healthcare; Spirit Lake, IA
Mercy Hospital Fort Scott; Fort Scott, KS
Geary Community Hospital; Junction City, KS
Bob Wilson Memorial Grant County Hospital; Ulysses, KS
Inland Hospital; Waterville, ME
Maine Coast Memorial Hospital; Ellsworth, ME
Marion General Hospital; Columbia, MS
Alta Vista Regional Hospital; Las Vegas, NM

For more information, please visit: https://innovation.cms.gov/initiatives/Rural-Community-Hospital/.

###

Community-Based Care Transitions Program (CCTP) Final Evaluation Report

The Centers for Medicare & Medicaid Services (CMS) issued on its website the final evaluation report of the Community-Based Care Transitions Program (CCTP). The CCTP, created by Section 3026 of the Affordable Care Act, was authorized to operate for five years to test models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. It ended in January 2017.

The final evaluation report found that the CCTP did not have hospital-wide impacts on readmissions or expenditures for all FFS beneficiaries at partner hospitals, and that receiving CCTP services was associated with lower readmissions and expenditures for participants directly served by the program.

For more information on the Final Evaluation Report click here: https://downloads.cms.gov/files/cmmi/cctp-final-eval-rpt.pdf or here CMMI data and reports webpage

###

Upcoming Webinars and Events and Other Updates

Learn More about Meaningful Measures Initiative on 11/28 Webinar

Register for CMS Webinar on November 28 to Find Out More about the New Meaningful Measures Initiative

Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma recently announced a new approach to quality measurement, called "Meaningful Measures." The Meaningful Measures Initiative will involve identifying the highest priorities to improve patient care through quality measurement and quality improvement efforts.

On November 28, Dr. Pierre Yong, Director of the Quality Measurement and Value-Based Incentives Group (QMVIG) in the Center for Clinical Standards and Quality at CMS, and Dr. Theodore Long, Acting Senior Medical Officer of QMVIG, will explain the new initiative.

Webinar Details

- **Title:** CMS Meaningful Measures Initiative
- **Date:** Tuesday, November 28
- **Time:** 1:00 – 2:00 p.m. ET
- **To register:** https://engage.vevent.com/index.jsp?eid=3523&seid=113

Please note: Space for this webinar is limited. Register now to secure your spot.

For More Information

To learn more about the Meaningful Measures Initiative, please visit the CMS website.

###

Upcoming Webinar: CAPG Educational Series 2017, How to Control Costs for the MIPS Resource Use Component

CAPG is pleased to present a new complimentary webinar series for physicians and physician groups participating in the Quality Payment Program, part of the Medicare Access and CHIP Reauthorization Act (MACRA). Through a co-branding agreement with the Centers for Medicare & Medicaid Services (CMS), the sessions combine CMS expertise on the regulation content with CAPG members' knowledge of how clinicians are responding on the ground to the important changes it brings.

Each session will include Q&A time with the presenters. We believe the webinars will be a valuable resource to help you successfully participate in MACRA in 2017 and beyond. The next session in the series will focus on:

Title: How to Control Costs for the MIPS Resource Use Component
Date: December 1, 2017
Time: 8am - 9:30am PT / 11am - 12:30pm ET

Register: http://eventcenter.commpartners.com/se/Rd/Rg.aspx?367504

Subject matter experts from CMS will review the MACRA policies for the MIPS cost category and clarify the final rule statements.

CAPG members will share best practices and lessons learned, what has worked well and where are the opportunities? Additionally, CAPG members will share with the audience about the rationale behind their strategies and any implications for their organizations.

Speakers:

CMS:

- Theodore G Long, MD, MHS, Acting Senior Medical Officer, Quality Measurement and Value-Based Incentives Group

CAPG:

- Meena Bansal, MD, Deputy Chief Medical Officer, Mount Sinai Health Partners and Chief Medical Officer, Mount Sinai Care, LLC
- Samuel Bauzon, MD, MMM, CPE, Senior Medical Director of Clinical Documentation and Quality Initiatives, Southwest Medical Associates

For more information, please contact Dr. Amy Nguyen, anguyen@capg.org or 213.239.5051.

###

LTCH QRP In-Person Provider Training

The Centers for Medicare & Medicaid Services (CMS) will be hosting a 2-day Long Term Care Hospital (LTCH) Quality Reporting Program (QRP) 'Train the Trainer' in-person provider training event on December 6 and 7, 2017, in Dallas, TX. **The training will cover changes to the LTCH CARE Data Set v4.00, including data collection for the new Drug Regimen Review and Ventilator Liberation quality measures that go into effect on July 1, 2018.** See the LTCH Quality Reporting Training webpage for details.

###

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.

###

SNF QRP: Assessment-Based Measures Confidential Feedback Report Webinar

Wednesday, December 6, 2017 2-3 pm EST

Click here to register

CMS experts provide information on the Confidential Feedback Reports for the assessment-based measures adopted for the Skilled Nursing Facility Quality Reporting Program (SNF QRP). These reports will be made available to SNFs via providers' Certification and Survey Provider Enhanced Reporting (CASPER) folders in late November of this year. CMS will present information on the assessment-based IMPACT Act measures included in the reports and direct participants to measure specifications.

CMS discusses the following items during this webinar:

- Assessment-based IMPACT Act measures
- Confidential feedback reports
- Additional resources

- Next steps
- Questions & Answers

An audio recording and transcript is available from the September 28, 2017 call during which CMS covered the Claims-Based Measures Confidential Feedback Report.

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

###

CMS National Training Program Learning Series Webinar

December 14, 2017 1:00 – 2:30 pm ET

This webinar will provide an overview of **Medicare and the Health Insurance Marketplace** including:

- Medicare Eligibility and Enrollment
- Enrollment Decisions
- Medicare and Marketplace Considerations
- Medicare and Eligibility for Advanced Premium Tax Credits (APTC)
- Medicare Periodic Data Matching (PDM)
- Helpful Resources

To register for the webinar, visit

goto.webcasts.com/starthere.jsp?ei=1130000&tp_key=823a90f990

###

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

###

Special Open Door Forum: Revisions to DMEPOS Quality Standards for Therapeutic Shoe Inserts

Tuesday, November 28, 2017 2:00-3:00 pm Eastern Time Conference Call Only

The Center for Program Integrity (CPI) will host a Special Open Door Forum (ODF) to allow suppliers and other interested parties to ask questions on the proposed revisions to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards released in DRAFT form on November 2, 2017.

The purpose of the proposed revisions to the DMEPOS Quality Standards is to make sure the Quality Standards account for recent technological changes in the creation of therapeutic shoe inserts for individuals with diabetes. Historically, the typical method to achieve a "molded to patient model" fit for a therapeutic shoe insert was to create a physical model of the patient's foot through the use of a negative impression. Computer-aided design/computer-aided manufacturing (CAD/CAM) software now allows direct milling of a therapeutic shoe insert without molding it to the patient's foot or negative impression of the patient's foot, CMS proposes revisions to the definitions of Custom Fabricated and Therapeutic Inserts located in Appendix C to account for this technological change. The proposed revisions will allow Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) to account for the use of this technology in the creation process when processing claims; however, prior to implementation §1834(a)(20)(E) of the Social Security Act requires CMS to consult with relevant stakeholders. The Special ODF will be used to consult with stakeholders who may also submit comments to CMS at ReducingProviderBurden@cms.hhs.gov. For information about the proposed changes to the definitions contained in the Quality Standards, please refer to:

- Special Open Door Forum Presentation
- Full Revised DMEPOS Quality Standards
- Revised Definitions Only
- Frequently Asked Questions

You can find the revised Quality Standards by going to CMS' Reducing Provider Burden webpage.

Feedback and questions on the revisions to the DMEPOS Quality Standards can be sent to: ReducingProviderBurden@cms.hhs.gov

We look forward to your participation.

Special Open Door Participation Instructions:

Participant Dial-In Number: 1-800-837-1935

Conference ID #: 6573429

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website at https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at http://www.cms.gov/OpenDoorForums/.

###

Medicare Learning Network

News & Announcements

- New Medicare Card: New Webpage Information
- CAHs: Deadline to Apply for a Hardship Exception is November 30
- Virtual Group for MIPS in 2018: Apply by December 31
- QMB Remittance Advice Issue
- IRF/LTCH Quality Measure Reports: Measures Added
- Hospice Quality Reporting Program: Quarterly Update
- Physician Compare: How to Update Your Listing
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout
- Medicare Clinical Laboratory Fee Schedule: Final CY 2018 Payment Rates

- National Rural Health Day
- 2017 Medicare FFS Improper Payment Rate Below 10 Percent for First Time Since 2013
- CMS Measures Inventory Tool
- 2016 PQRS Feedback Reports and Annual QRURs: Informal Review Period Ends December 1
- Hospice Compare: Guidance on Updating Demographic Data
- Hospice Compare Refresh Delayed
- Submit Suggestions for Precedential Medicare Appeals Council Decisions
- IPPS Hospitals: Review FY 2014 and FY 2015 Worksheet S-10 Cost Report Data
- Recommend Influenza Vaccination: Each Office Visit is an Opportunity

Provider Compliance

- Evaluation and Management: Correct Coding — Reminder
- OIG Video: Reporting Fraud to the Office of the Inspector General — Reminder

Upcoming Events

- Quality Payment Program Year 2 Final Rule Call — November 30
- Revisions to DMEPOS Quality Standards for Therapeutic Shoe Inserts Special Open Door Forum — November 28
- Quality Payment Program Year 2 Final Rule Call — November 30
- Medicare Diabetes Prevention Program Model Expansion Call — December 5
- SNF QRP: Assessment-Based Measures Confidential Feedback Report Webinar — December 6
- LTCH Quality Reporting Program In-Person Training — December 6 and 7
- IMPACT Act Special Open Door Forum — December 12
- National Partnership to Improve Dementia Care and QAPI Call — December 14
-

Medicare Learning Network Publications & Multimedia

- Hospital Call: Audio Recording and Transcript — New
- Medicare and Medicaid Basics Booklet — Revised
- Looking for Educational Materials?
- Medicare Fraud & Abuse Poster — New
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet — Revised
- Medicare Disproportionate Share Hospital Fact Sheet — Revised
- ABCs of the Initial Preventive Physical Examination Educational Tool — Reminder

###

New / Updated CMS Publications

- How Employers Enroll in SHOP Insurance
- Medicare and Home Health Care – Spanish
- What is Medicare? What is Medicaid? – Spanish
- Understanding Your Medicare Advantage Network Plan – Spanish
- You're Getting a New Medicare Card – Spanish

###

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.