CMS Region 7 Updates – 12/08/2017

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ACA/Marketplace Updates

Weekly Enrollment Snapshot: Week Three: 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.

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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Weekly Enrollment Snapshot: Week Four: Nov 19-25, 2017

In week four of Open Enrollment for 2018, 504,181 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.

HealthCare.gov Platform Snapshot

HealthCare.gov Platform Snapshot	**Week 4 Nov 19 – 25**	**Cumulative Nov 1-25**
Plan Selections	504,181	2,781,260
New Consumers	152,243	718,285
Consumers Renewing Coverage	351,938	2,062,975
Consumers on Applications Submitted	708,335	4,863,484
Call Center Volume	485,977	2,544,751
Calls with Spanish Speaking Representative	36,595	183,981
HealthCare.gov Users	1,962,730	9,450,075
CuidadoDeSalud.gov Users	66,599	298,978
Window Shopping HealthCare.gov Users	164,934	989,052
Window Shopping CuidadoDeSalud.gov Users	4,583	19,163

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 – 25
Alaska	6,718
Alabama	58,173
Arkansas	18,058
Arizona	51,615
Delaware	6,852
Florida	626,144
Georgia	146,899
Hawaii	6,490
Iowa	17,525
Illinois	95,434
Indiana	43,364
Kansas	31,088
Kentucky	27,979
Louisiana	30,354
Maine	23,996
Michigan	87,717
Missouri	78,676
Mississippi	27,772
Montana	13,926
North Carolina	164,436
North Dakota	6,669
Nebraska	32,759
New Hampshire	14,895
New Jersey	79,212
New Mexico	15,440
Nevada	27,159
Ohio	60,278
Oklahoma	43,253
Oregon	51,882
Pennsylvania	124,081
South Carolina	65,266
South Dakota	9,883
Tennessee	72,903
Texas	334,328
Utah	62,844
Virginia	121,325
Wisconsin	78,269
West Virginia	7,828
Wyoming	9,770

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Weekly Enrollment Snapshot: Week Five: Nov 26- Dec 2, 2017

In week five of Open Enrollment for 2018, 823,180 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.

HealthCare.gov Platform Snapshot

HealthCare.gov Platform Snapshot	Week 5 Nov 26 – Dec 2	Cumulative Nov 1- Dec 2
Plan Selections	823,180	3,604,440
New Consumers	271,207	989,492
Consumers Renewing Coverage	551,973	2,614,948
Consumers on Applications Submitted	1,104,604	5,968,088
Call Center Volume	816,856	3,361,607
Calls with Spanish Speaking Representative	60,929	244,910
HealthCare.gov Users	2,760,668	11,423,182
CuidadoDeSalud.gov Users	92,589	371,733

Window Shopping HealthCare.gov Users	248,804	1,179,066
Window Shopping CuidadoDeSalud.gov Users	6,596	23,710

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 – Dec 2
Alaska	8,349
Alabama	73,294
Arkansas	24,044
Arizona	67,266
Delaware	8,846
Florida	802,711
Georgia	190,523
Hawaii	8,155
Iowa	22,218
Illinois	126,720
Indiana	58,255
Kansas	41,009
Kentucky	36,314
Louisiana	39,238
Maine	30,954
Michigan	115,595
Missouri	103,198
Mississippi	36,224
Montana	18,428
North Carolina	209,050
North Dakota	8,773
Nebraska	42,470
New Hampshire	19,486
New Jersey	104,142
New Mexico	20,191
Nevada	35,448
Ohio	80,498
Oklahoma	56,839
Oregon	66,792
Pennsylvania	161,388
South Carolina	84,868
South Dakota	13,113
Tennessee	92,341
Texas	437,919
Utah	81,117
Virginia	156,195
Wisconsin	100,228
West Virginia	10,070
Wyoming	12,171

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How Assisters Can Help Consumers Apply for Coverage through the Marketplace Call Center

The November 8, 2017 assister webinar included a presentation called "How Assisters Can Help Consumers Apply for Coverage through the Marketplace Call Center." We know that many assisters help consumers enroll through the call center, as well as through the online application. This presentation provided an overview on working with the Marketplace Call Center, including information about what issues the Call Center can help resolve, and tips for assisters to help consumers apply for and enroll in coverage through the Call Center.

Call Center Representatives can help consumers reset their passwords, walk them through how to select plans, access translation services, report changes, and find out how to cancel a Marketplace plan.

- Marketplace **Call Center** (contact information in **Spanish**)
- Phone number and hours1-800-318- 2596 (TTY: 1- 855-889-4325)
- Open 24 hours a day, 7 days a week
- Closed on Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day

Assisters should use the **assister line** when working with consumers for faster service and so that the Call Center can better monitor and meet assisters' needs. Using the assister line will only allow assisters to bypass the regular Call Center line if they need to help consumers with password resets or accessing certain Special Enrollment Periods (SEPs) that aren't granted through the application. For all other issues, the wait time will be the same as the regular Call Center line.

Note there are two different assister lines— one for Navigators and one for certified application counselors (CACs).

- Assister line for Navigators: 1-855-868-4678
- Assister line for CACs: 1-855-879-2683

Here are some key tips to help assisters work with consumers and the Marketplace Call Center:

- Before helping consumers apply online or with the Marketplace Call Center, help consumers gather everything they need to apply using this **checklist.**
- If you are helping a consumer enroll in Marketplace coverage and are planning to use the Marketplace Call Center, you can use "**See Plans and Prices**," and enter the consumer's zip code to compare plan options before the consumer calls the Marketplace Call Center. Although this information may be slightly different than the options that appear after completing the application, this tool can be used to compare different plans available to the consumer while reviewing with the Call Center representative.
- Remember consumers can report changes to the Marketplace online or through the Marketplace Call Center, and are encouraged to report changes to the Marketplace. We encourage consumers to apply and report changes online if they have a Marketplace Account.
- Consumers who experience certain changes in their circumstances or other qualifying life events may qualify for an SEP. While many qualifying life events can be reported either online at HealthCare.gov or by calling the Marketplace Call Center, some events can only be reported to the Marketplace Call Center and may need to be handled by a Marketplace Caseworker.
- Remember, consumers should contact their insurance company about post-enrollment issues (e.g. when premium payments are due and how to pay premiums, issues with claims or coverage, finding network providers or drug formularies).

Summary: Consumers who enroll in a qualified health plan (QHP), through the Federally-facilitated Exchanges, must pay their first monthly premium (or "binder payment") in order to effectuate their coverage. Consumers must pay their binder payment to complete the enrollment process and to begin their coverage on the effective date. However, in accordance with the Market Stabilization Rule, under certain circumstances QHP issuers can require satisfaction of delinquent payments before issuing or renewing coverage for the 2017-2018 Open Enrollment Period. Thus, if a consumer owes any past due premium amount, the QHP issuer may attribute the money paid to effectuate coverage to that past due premium amount for coverage that begins on January 1, 2018.

How to Assist Consumers with their First Premium Payment

After a consumer has selected a QHP, the Marketplace may redirect the consumer to the issuer's website—when applicable—or will instruct the consumer to contact the health insurance company directly, to make premium payments. Consumers should contact their health insurance company with any specific questions about acceptable methods or deadlines for premium payment. Please ensure that consumers understand that the individual Marketplace does not accept payments on behalf of insurance companies.

Before assisting consumers with making a payment, it's important to understand that consumers' financial payment information (e.g., bank account, debit cards, credit cards) must be kept private and secure, just like all consumer personally identifiable information (PII) that you may encounter while helping a consumer.

What happens if a consumer misses a payment?

The Marketplace may give consumers who have paid their binder payment, and have outstanding premium payments, an additional period to pay before the insurance company can terminate their coverage. This short period of time is called a "grace period" and it varies depending on whether a consumer is receiving advanced premium tax credits (APTCs) or not.

Under current rules, marketplace plan issuers must:

- Allow consumers who receive APTCs a three-month grace period, if they have paid at least one full month's premium, during the benefit year (See 45 CFR 156.270(d)).
- Grant consumers who do not receive APTCs a grace period in accordance with state rules (See 45 CFR 155.430(d)(5)). Assisters may want to contact their state department of insurance (DOI) for more information on grace periods based on state rules.

How are medical claims managed when a consumer misses a payment?

If the consumer is receiving APTCs, the issuer must pay all appropriate claims for services rendered to the consumer during the first month of the three-month grace period. For a consumer receiving APTCs, the issuer may pend claims for services rendered during the second and third months of the grace period.

If a consumer fails to pay all outstanding premium, or an amount that satisfies any applicable premium threshold, before the end of the grace period:

- The consumer's coverage will be terminated for non-payment of their premium.
- The issuer will deny any claims that were pended during the second and third months of the three-month grace period.

Exception: For claims of consumers with a delinquent outstanding premium due to a 2017 Hurricane Disaster, the issuers must:

- Provide consumers with adequate notice that the consumers' coverage will not be terminated. QHP issuers may implement these grace period extensions from the date one week before the start of an incident period designated by FEMA through the end of such incident period.
- Provide consumers with adequate notice, on how grace period extensions might affect guaranteed availability, for consumers during the 2018 Open Enrollment.

- Pay all appropriate claims for services rendered to the consumer during the first month of the grace period and may pend claims for services rendered to the consumer in subsequent months of the grace period.
- Notify the U.S. Department of Health and Human Services of such non-payment of premiums.
- Notify providers, of the possibility for denied claims, when an enrollee is beyond the first month of the grace period.

Frequently Asked Questions (FAQ) by Assisters:

Q1: Are there any other requirements, besides receiving APTCs, that consumers must meet in order to receive a grace period if they fail to pay the full monthly premium payment for their health coverage?

A1: Yes. In addition to receiving APTCs, consumers must have previously paid at least one full month's premium, during the benefit year, in order to qualify for a three month grace period.

Q2: If a consumer reaches the end of his or her grace period and has not paid all outstanding premium payments in full, when does coverage terminate?

A2: In this situation, a consumer's coverage would terminate retroactive to the last day of the first month of the grace period. For example, if a consumer misses a premium payment in May, the grace period that went into effect would expire July 31 and the consumer could lose coverage retroactive to the last day of May.

Q3: Does a consumer need to pay all outstanding premiums during a grace period in order to avoid termination of coverage?

A3: Yes. It is very important to keep in mind that the start date for a three consecutive month APTC -related grace period does not "re-set" if a consumer does not pay in full all outstanding premiums owed within three months. For example: If a consumer misses a premium payment in May and then submits payments appropriately in June and July, but remains delinquent for May, the grace period will expire July 31 and the consumer could lose coverage retroactive to the last day of May, which is three months since the initial premium lapse, due to the still-outstanding May payment.

Q4: If a consumer believes that he or she has been wrongly terminated from coverage, is there a way that he or she can appeal the decision?

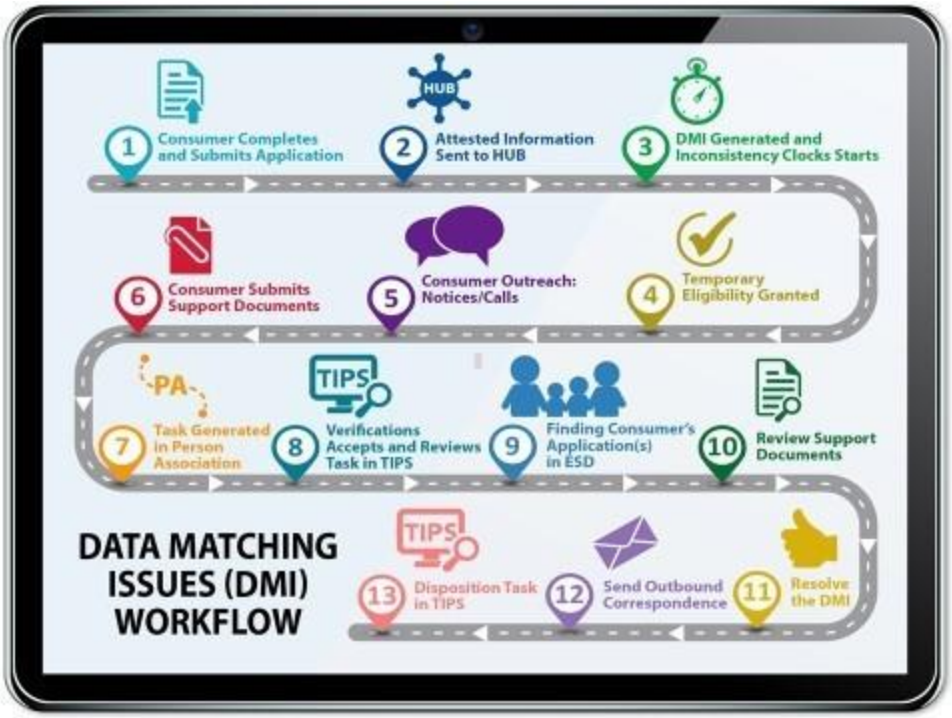
A4: Yes. If a consumer's health insurer refuses to pay a claim or ends his or her coverage, he or she has the right to appeal the decision and may have the ability to have the decision reviewed by a third party. See **this page on HealthCare.gov** for more information. It is important to be aware of the protections a grace period and the appeals process can offer, but we also encourage assisters to remind consumers that making the effort to pay premiums regularly, and on time, is the best way to avoid the challenges and confusion of lapses in coverage.

TIP: We also encourage assisters to see **this Tip Sheet on Helping Consumers Affected by Grace Periods Related to Non-Payment of Premiums**, and SOP-9 of the **Standard Operating Procedures Manual for Assisters in the Individual Federally-facilitated Marketplaces**.

Resolving DMIs and Tips for Preventing Them

A) Resolving Data Matching Issues (DMIs)

As open enrollment approaches, it's important for assister to understand how to reduce potential data matching issues (DMIs). Similarly, it's crucial for consumers to know how and when to submit requested information and the timeline to do so in order to resolve the DMI and avoid having their coverage terminated.

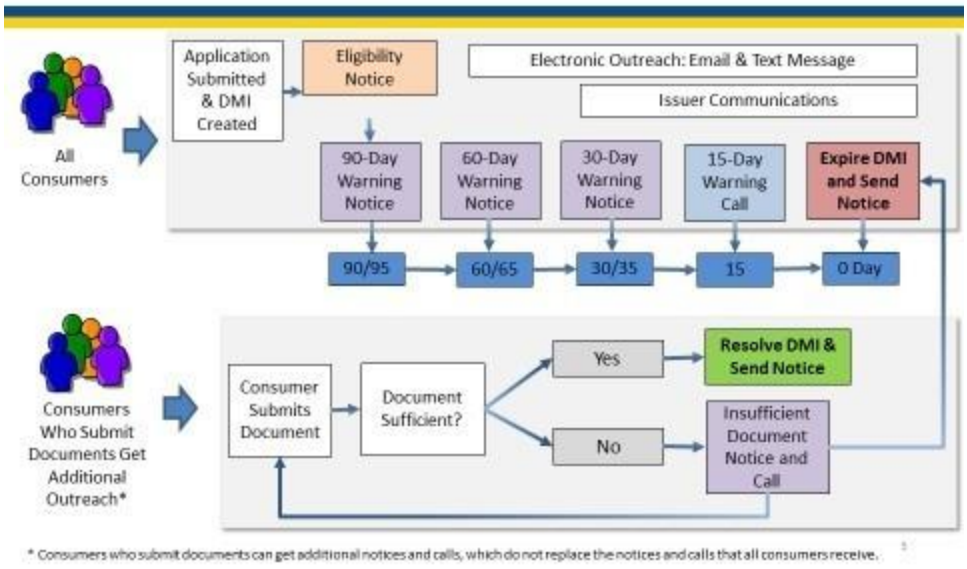


After submitting a Marketplace application, the system verifies the consumer's information to determine eligibility. But in some cases, the information the applicant provides does not match existing records from trusted data sources (TDSs) such as IRS, SSA, DHS, etc. or the applicant does not provide enough information to match existing records from TDSs. Under those circumstances, the application generates a DMI, and consumers are given 90/95 days to submit documentation to verify their application information.

Generally, the Marketplace grants temporary eligibility for coverage and financial assistance during the 90/95 days inconsistency period, however, consumers need to submit supporting documentation to resolve a DMI. If consumers fail to submit information within the 90/95-day window, they risk losing their Marketplace health care coverage and/or having their financial assistance adjusted, in some cases to $0.

For example, consumers with citizenship/immigration DMIs will be terminated from coverage if they do not submit the requested information, and consumers with annual income DMIs will have their advanced premium tax credits (APTCs) and/or cost sharing reductions (CSRs) re-determined based on available tax data. When Marketplace coverage is terminated as a result of an unresolved DMI, consumers may be liable for APTCs and/or CSRs they received during the 90/95-day period.

Consumer Outreach



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

Impact of DMI Expiration

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

B) Steps to Help Resolve DMIs

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

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

We strongly recommend that assisters work with consumers to clarify and simplify the DMI process, reduce confusion, improve document collection and submission, and negate the potential for disruptions in coverage. In cases that do require follow-up, assisters should follow these steps to help consumers resolve DMIs:

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

C) Preventing DMIs

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

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

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

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

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

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

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

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

A3: a) For Annual Income DMIs

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

b) For Minimal Essential Coverage DMIs

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

c) American Indian/Alaska Native DMI

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

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

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

###

Refresher: Marketplace Appeals

Consumers who have applied for coverage through a Marketplace will receive an eligibility notice explaining what coverage they qualify for. For example, the notice may say they are not eligible to enroll in Marketplace coverage, or they do not qualify for coverage through Medicaid or the Children's Health Insurance Program (CHIP). If a consumer disagrees with the determination in the notice, you should let them know they may be able to appeal that determination. Consumers have 90 days from the date they receive their eligibility notice to start an appeal. As an assister, you can help them understand this process.

- Consumers can submit an appeal request by mailing an appeal request form, mailing an appeal request letter, or faxing the form or letter. See the different ways consumers can **request an appeal** (also available in **Spanish**).
- Different states have different appeals request forms. Find **Appeal Request Forms** that apply for the consumer's state (also available in **Spanish**).
- Help consumers learn how to request an **expedited appeal** (also available in **Spanish**) if the time needed for the standard appeal process would jeopardize the consumer's life, health, or ability to attain, maintain, or regain maximum function.
- Some consumers will file certain appeals through the Marketplace or through their State Medicaid or CHIP agency; depending on their state and eligibility result. Make sure to review consumers' eligibility notices for directions. Find out what **eligibility notices** look like.
- Encourage consumers to include a copy of their eligibility notice when they file an appeal. Find **information** on what to do if a consumers submits and appeal request and the Marketplace Appeals Center tells them their appeal is "invalid." They might need to take certain actions to get their request considered.
- Check out this presentation to learn about the **Marketplace eligibility appeals process**.

- There is a different process for requesting an appeal of a decision a consumer's health insurance plan made not to cover a certain service or item. Check out this **resource** to understand key differences between appealing Marketplace decisions versus plan coverage decisions.

###

NEW: Information added to HealthCare.gov to help consumers account for a QSEHRA.

Starting in 2017, small employers that choose not to offer their employees health coverage can instead choose to reimburse a portion of their employees' medical care costs through what is called a Qualified Small Employer Health Reimbursement Arrangement, or QSEHRA. A QSEHRA is not employer-sponsored coverage but employees can use this money to help pay the cost of their medical expenses, like premiums, deductibles, and co-payments.

If an employer offers money to an employee through a QSEHRA, the employee's eligibility for a premium tax credit (PTC) will be impacted. The employee could be eligible for less or no PTC through the Marketplace, depending on the amount of money the employer offers the employee. The Federally Facilitated Marketplace (FFM) application cannot currently adjust the amounts of PTC consumers are determined eligible for based on a QSHERA. Therefore, the Marketplace recommends that consumers with QSEHRA offers adjust the amount of PTC they use. If consumers have a QSEHRA, direct them to the link below to learn how to adjust the PTC they use to lower the chance they'll have to pay back some or all of their PTC when they file their taxes. This link appears in the Plan Compare section of HealthCare.gov.

- Information on how consumers should adjust the amount of APTC they use when they get a QSEHRA from their employer can be found at: **https://www.healthcare.gov/help/qsehra/**

Please note that since QSEHRAs are not considered employer-sponsored coverage, consumers should answer "No" to the question on the FFM application that asks: Is [Applicant] currently eligible for health coverage through a job (even if it's through COBRA or from another person's job, like a spouse)? This will ensure these consumers can still qualify for APTC, if otherwise eligible.

###

NEW Assister Resources

- **Understanding the Guidance on 2017 Hurricane Disasters**
- **Application Spotlight on the Family and Household Section**
- **Application Walkthrough on Creating a Marketplace Account and Identity (ID) Proofing**
- **Create a Marketplace Account – October 13, 2017 (slides)**
- **Summary of Benefits and Coverage (SBC) Overview**
- **Batch Auto Re-enrollment (BAR) Updates for Open Enrollment 2018**
- 2018 Assister Certification Training Troubleshooting (**slides** , **video and audio slideshow presentation** , and **written transcript**)
- **Assister Dos and Don'ts for Open Enrollment Period 5 and Beyond**
- **Formulario Modelo de Autorización para Navegadores en el Mercado de Seguros Médicos Facilitado por el Gobierno Federal – posted November 3, 2017**
- **Formulario Modelo de Autorización para los Consejeros Certificados para Solicitudes (CAC) en el Mercado de Seguros Médicos Facilitado por el Gobierno Federal – posted November 3, 2017**

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.

###

Enroll in SHOP Insurance for 2018

The New Year is coming, and January 1 is an important date for many small businesses and non-profit organizations looking for Small Business Health Options Program (SHOP) coverage.

If you are looking to start your coverage on January 1, 2018, there are some **important changes for SHOP insurance plans** that you should be aware of**:**

- Instead of using HealthCare.gov to enroll in SHOP coverage, you will enroll by working with a SHOP-registered agent or broker or an insurance company. The enrollment process may vary by insurance company, so contact your agent, broker, or insurance company if you have questions.

- If you're enrolling your small business in SHOP insurance for the first time or your have experienced a gap in SHOP coverage, you'll use the SHOP Eligibility Determination Form to verify your eligibility.

You'll also work with your agent, broker, or insurance company to pay your premiums and manage coverage — you won't make payments through HealthCare.gov.

IMPORTANT: If you sign up **by December 15**, you will not have to meet a minimum participation rate requirement to enroll and your coverage will start on January 1.

###

MACRA/Quality Payment Program (QPP) Updates

Now Available - QRDA III Implementation Guide for the Calendar Year 2018 Performance Period

The Centers for Medicare & Medicaid Services (CMS) published the 2018 CMS Quality Reporting Document Architecture (QRDA) Category III Implementation Guide (IG) for Eligible Professionals (EPs) and Eligible Clinicians (referred to as the 2018 CMS QRDA III IG) with Schematrons and Sample Files.

The 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

About the 2018 CMS QRDA III IG:

- The 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 eCQM specifications for EPs and Eligible Clinicians universally unique identifier (UUID) list for the 2018 performance period.
- Includes updates to the MIPS 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.

Additional QRDA-Related Resources:

- You can find current and past CMS QRDA IGs, 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.

###

HHS Optimization Project Pilot

Providers and health plans use a variety of different formats for conducting electronic transactions. HIPAA Administrative Simplification transaction standards work towards reducing the variable formats, making it easier for data to be shared and transferred.

The 2016 CAQH Index estimates that industry-wide **compliance with the adopted standards could save providers nearly $8 billion annually, with overall savings to the industry projected at more than $9 billion**. The report analyzed the financial impact for the following transactions:

- Claim submission/receipt
- Eligibility and benefits verification
- Prior authorization
- Claim status inquiry
- Claim payment (electronic funds transfer)
- Claim remittance advice
- Claim attachments (standards not yet adopted)

Achieving the full benefits of Administrative Simplification requires industry-wide compliance. To that end, **HHS will pursue proactive compliance reviews of health plans and clearinghouses for compliance** with Administrative Simplification transaction standards. We intend that our compliance reviews for use of the HIPAA Administrative Simplification transaction standards will result in an environment that requires minimal government intervention because entities are conducting electronic transactions in adopted standard formats.

Why Compliance Reviews?

Health care providers, health plans, and clearinghouses have encouraged HHS to take proactive steps, including reviews, to ensure compliance with Administrative Simplification transaction standards, which will:

- Reduce the burden on compliant entities of needing to exchange health care information with trading partners that are not compliant with the adopted standards
- Improve efficiency across the health care system by streamlining communications about billing and insurance related matters, which allows providers and health plans to spend less time on these tasks

Our proactive approach implements a progressive penalty process with the goal of remediation, not punishment. Enforcement actions such as corrective action plans (CAPs) and HHS technical assistance are possible and may be included.

Health Plans and Clearinghouses: Volunteer for the HHS Optimization Project Pilot

Health plans and clearinghouses can verify compliance by volunteering for the HHS HIPAA Administrative Simplification Optimization Project pilot.

HHS is seeking a total of 6 volunteers—3 health plans and 3 clearinghouses. Volunteers will undergo reviews of their transactions for compliance with adopted standards, code sets, unique identifiers, and operating rules. Reviews will be conducted beginning January 2018.

Volunteers will submit electronic transaction files for review and testing by HHS, as well as attest to compliance with operating rules. Transaction submission should take less than 10 hours total. Participants that are selected will be notified and will receive a compliance review package with step by step details of the process.

Upon completion, HHS will provide volunteers with a report that flags any issues that need to be addressed for full compliance. During the pilot, HHS will identify compliance issues and areas for optimization, and volunteers will develop a corrective action plan to remedy areas of noncompliance.

Volunteers that achieve successful reviews will receive a dated certificate to that effect from HHS. Volunteers may choose to share their certificate with potential business associates, the public, and other stakeholders.

This pilot will inform the rollout of the Administrative Simplification Optimization Program, where HHS will begin conducting proactive reviews of health plans and clearinghouses.

Health plans and clearinghouses that take part in the pilot project won't be subject to random selection for an assessment for one year following HHS's launch of the optimization program.

Volunteers for the pilot can send an email now to the HIPAAcomplaint@cms.hhs.gov mailbox. Any HIPAA-covered health plan or clearinghouse may volunteer.

HHS will choose volunteers from emails received by December 13, 2017. HHS will inform you by December 27, 2017, whether or not you're selected to be part of the pilot.

Sign up now to volunteer for our optimization project pilot. Write to HIPAAcomplaint@cms.hhs.gov today!

###

Now Available: Accredited Online Courses – Quality Payment Program 2017: Merit-Based Incentive Payment System (MIPS) Advancing Care Information (ACI) Performance Category Web-Based Training (WBT) Course and Quality Payment Program: Merit-based Incentive Payment System (MIPS) Participation in 2017 (November 2017) (Contact hours: 60 minutes) – New With Continuing Education Credit

Two new accredited online courses are now available.

A new Quality Payment Program 2017: Merit-Based Incentive Payment System (MIPS) Advancing Care Information (ACI) Performance Category Web-Based Training (WBT) course is available through the MLN LMS. Learn about:

- Base, performance, and bonus score reporting requirements for
- Advancing Care Information performance category of the Merit-based Incentive Payment System (MIPS)
- Identify the two Advancing Care Information performance category measure sets available for the 2017 transition year that vary depending on the edition of Certified Electronic Health Record Technology
- Identify the scoring and reweighting methodology for the Advancing Care Information performance category

This course is the seventh 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.

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.

A second new course, Quality Payment Program: Merit-Based Incentive Payment System Participation in 2017 Web-Based Training (WBT) course, is also available through the MLN LMS. Learn about:

- Participation in the 2017 Quality Payment Program Merit-based Incentive Payment System (MIPS), including recognizing who is a MIPS eligible clinician and who is exempt for 2017
- Pick Your Pace options and the difference between individual and group reporting
- Data submission methods, available resources, and where to go for help with the Quality Payment Program

This course is the eighth course in an evolving curriculum on the Quality Payment Program. 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 1 *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 November 1, 2020. *AMA PRA Category 1 Credit*™ is a trademark of the American Medical Association.

Accreditation Statements

Please click here for accreditation statements

###

Now Available: New Quality Payment Program Resources on CMS.gov

New Quality Payment Program Resources Available on CMS.gov

The Centers for Medicare & Medicaid Services (CMS) has posted the following new Merit-based Incentive Payment System (MIPS) resources on CMS.gov:

- **CMS Web Interface Resources**: Includes the new Excel template to use when uploading sample beneficiary data to the CMS Web Interface, as well as the corresponding user guide and instructional video on how to use the new Excel template.
- **Extreme and Uncontrollable Circumstances Fact Sheet:** Provides an overview of the Extreme and Uncontrollable Circumstances policy, established in the interim final rule with comment period, to support clinicians affected by the California wildfires and Hurricanes Harvey, Irma, and Maria.

- **MIPS 101 Guide:** Offers a basic overview of MIPS, including who is eligible to participate, the three ways to participate in MIPS in 2017, and the reporting requirements for the four MIPS performance categories.
- **MIPS Optometry Specialty Guide:** Highlights a non-exhaustive sample of measures and activities for the Quality, Improvement Activities, and Advancing Care Information performance categories that may apply to optometry in 2017.
- **MIPS Participation Infographic:** Details the three ways eligible clinicians can participate in MIPS in 2017.
- **QPP Frequently Asked Questions (FAQs):** Includes answers to nearly 40 questions about the Quality Payment Program in 2017.

In case you missed it, CMS recently posted the MIPS Scoring 101 Guide, MIPS specialty guides for radiologists and podiatrists, and the Virtual Groups Toolkit on CMS.gov.

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 QPP resources.

Questions?

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

###

Quality Payment Program Hardship Exception Application Deadline for the 2017 Transition Year Is Dec 31

Clinicians Need to Submit Quality Payment Program Hardship Exception Applications by December 31, 2017

The Centers for Medicare & Medicaid Services (CMS) would like to remind clinicians that the Quality Payment Program Hardship Exception Application for the **2017 transition year** is available on the Quality Payment Program website**.** The deadline for submitting a Quality Payment Program Hardship Exception Application is **December 31, 2017**.

MIPS eligible clinicians and groups may submit a hardship exception application for one of the following specified reasons:

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

Approved applications will result in the reweighting of the Advancing Care Information performance category to 0% of the final score.

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

About the Hardship Exception Application Process

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

To submit an application, you'll need:

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

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

- Disaster (e.g., a natural disaster in which the CEHRT was damaged or destroyed)
- Practice or hospital closure

- Severe financial distress (bankruptcy or debt restructuring)
- EHR certification/vendor issues (CEHRT issues)

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

Please note: CMS recently published an Interim Final Rule with Comment that provides guidance for MIPS eligible clinicians who live or practice in areas affected by Hurricanes Harvey, Irma, or Maria, or the Northern California wildfires. For more information, please review the Extreme and Uncontrollable Circumstances Policy for MIPS in 2017 Fact Sheet and the Interim Final Rule with Comment.

For More Information

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

###

Nomination Period Open for MACRA Measure Development Plan Technical Expert Panel

The Centers for Medicare & Medicaid Services (CMS) has contracted with Health Services Advisory Group, Inc. (HSAG) to develop and update the *CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)*. The *CMS Quality Measure Development Plan (MDP)* is mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and serves as a strategic framework for clinician quality measure development to support MIPS and advanced APMs, together known as the CMS Quality Payment Program.

HSAG is seeking nominations from representatives of the following stakeholder organizations, perspectives, and areas of expertise to participate in a Technical Expert Panel (TEP):

- Consumer/patient/family (caregiver) perspective
- Frontline clinicians with experience in: Emergency medicine, neurology, allergy/immunology, rheumatology, or physical medicine and rehabilitation
- Individual clinical practices, medical groups, or accountable care organizations
- Consumer or patient advocacy
- Personal experience receiving care for a neurological condition, a rheumatic disease, asthma or other allergic or immunological disorder, a musculoskeletal disorder, or emergency medical care
- Experience as a family member or caregiver of a person receiving such care
- Clinical quality measurement, including domains such as care coordination, patient safety, appropriate use, and population health and prevention
- Qualified clinical data registries (QCDRs)
- Health information technology

Under this contract, the TEP will provide clinical, scientific, and technical expertise related to clinician- and specialty-specific measure development for the Quality Payment Program. Specifically, the TEP will be asked to make recommendations regarding the development of a framework to quantitatively assess quality measures, the identification of quality measurement gaps among clinical specialties and CMS quality priorities, the outline and content of the annual progress report on CMS measure development for the Quality Payment Program, and future updates to the MDP.

We invite you to submit a nomination for an individual to serve on the panel by 11:59 p.m. (ET) December 20, 2017.

For more information about the project objectives, TEP time commitment, TEP requirements, and to download the TEP Nomination Form, go to the Quality Measures Call for Technical Expert Panel Members page at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Technical-Expert-Panels.html

1. Scroll down to the "Currently Accepting Nominations" section

2. Click: "CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)"

This work is conducted through the Impact Assessment of CMS Quality and Efficiency Measures contract (Contract Number: HHSM-500-2013-13007I; Task Order Number: HHSM-500-T0002). If you have any questions or require technical assistance, email MACRA-MDP@hsag.com.

###

Extreme and Uncontrollable Circumstances Policy for MIPS Clinicians in 2017

Many clinicians have been affected by the Northern California wildfires and Hurricanes Harvey, Irma, and Maria—all of which happened in 2017, the transition year for the Merit-based Incentive Payment System (MIPS). The Centers for Medicare & Medicaid Services (CMS) understands that if you live or practice where these disasters took place, you may not be able to collect or submit data for a long time.

As part of the Quality Payment Program Year 2 final rule, which was released on November 2, 2017, CMS issued an interim final rule with comment period, which includes the Extreme and Uncontrollable Circumstances policy for the transition year of MIPS. This policy specifically addresses extreme and uncontrollable circumstances for the MIPS Advancing Care Information, Quality, and Improvement Activities performance categories in 2017. (It does not apply to the Cost performance category since it has a 0 percent weight in 2017.)

Who Does the Extreme and Uncontrollable Circumstances Policy Apply to?

Under this policy, if you're a MIPS eligible clinician who has been affected by Hurricanes Harvey, Irma, or Maria, or the Northern California wildfires:

- **You do not need to submit an application** to reweight the performance categories; CMS will be able to identify you based on the information in the Provider Enrollment, Chain and Ownership System (PECOS).
- **You will automatically receive a neutral MIPS payment adjustment**, unless you choose to submit data for any of the MIPS performance categories, in which case you will be scored based on the data you submitted.

Note, this automatic extreme and uncontrollable circumstances policy only applies to you if you're a MIPS eligible clinician in an affected area. It does not apply to MIPS eligible clinicians in MIPS Alternative Payment Models (MIPS APMs) in 2017 (such as the Medicare Shared Savings Program).

To learn more about the policy, view the interim final rule with comment period and the Extreme and Uncontrollable Circumstances Policy for MIPS in 2017 Fact Sheet.

###

"Guard Your Card" Drop-in Article: Fight Fraud: Guard Your Medicare Card

The article reminds about the importance of protecting your Medicare Number and warns about the types of scams that often occur.

If you have Medicare, you can protect your identity and help prevent health care fraud by guarding your Medicare card like you would a credit card.

Identity theft from stolen Medicare Numbers is becoming more common. Medicare's here to help by removing Social Security Numbers from Medicare cards and replacing them with a new, unique number for each person with Medicare. Medicare will mail new Medicare cards with the new numbers between April 2018 and April 2019.

Here are some important steps you can take to protect yourself from the identity theft that can lead to health care fraud:

- Don't share your Medicare Number with anyone who contacts you by telephone, email or in person, unless you've given them permission in advance. Medicare will NEVER contact you (unless you ask us to) for your Medicare Number or other personal information.
- Don't ever let anyone borrow or pay to use your Medicare Number.
- Review your Medicare Summary Notice to be sure you and Medicare are only being charged for actual items and services received.

If you're looking to enroll in a Medicare plan:

- Remember there are no "early bird discounts" or "limited time offers."
- Don't let anyone rush you to enroll by claiming you need to "act now for the best deal."
- Be skeptical of free gifts, free medical services, discount packages or any offer that sounds "too good to be true."

If someone calls you and asks for your Medicare Number or other personal information, hang up and call 1-800-MEDICARE (1-800-633-4227). To learn more about protecting yourself from identity theft and health care fraud, visit www.Medicare.gov/fraud or contact your local Senior Medicare Patrol (www.smpresource.org).

###

CMS releases its Measures under Consideration List for 2018 pre-rulemaking

Medicare and other payers are rapidly moving toward a healthcare system that rewards high quality care while spending more wisely. Foundational to the success of these efforts is having quality measures that are meaningful to patients, consumers, and providers alike. CMS recently announced the "Meaningful Measures" initiative to identify the most impactful areas for quality measurement and improvement and reflect core issues that are most vital to high quality care and better individual outcomes. Each year, CMS publishes a list of quality and cost measures that are under consideration for Medicare quality reporting and value-based purchasing programs, and collaborates with the National Quality Forum (NQF) to get critical input from multiple stakeholders, including patients, families, caregivers, clinicians, commercial payers and purchasers, on the measures that are best suited for these programs. Ultimately, these measures may help patients choose the nursing home, hospital, or clinician that is best for them, and can help providers to provide the highest quality of care across care settings.

I am happy to announce that CMS posted the Measures under Consideration (MUC) List for 2018 pre-rulemaking on the CMS website and has sent it to NQF in preparation for multi-stakeholder input.

This year's MUC List contains 32 measures that have the potential to drive improvement in quality across numerous settings of care, including clinician practices, hospitals, and dialysis facilities. CMS is considering new measures to help quantify healthcare outcomes and track the effectiveness, safety and patient-centeredness of the care provided. At the same time, CMS is taking a new approach to coordinated implementation of meaningful quality measures focused on the most critical, highly impactful areas for improvement while reducing the burden of quality reporting on all providers so they can spend more time with their patients. In addition to other factors, CMS evaluated the measures on the MUC list to ensure

that measures considered for adoption in a CMS program through rulemaking as necessary, focus on clearly defined, meaningful measure priority areas that safeguard public health and improve patient outcomes. For example, to generate this year's MUC list, CMS considered 184 measures submitted by stakeholders during an open call for measures. Considering the meaningful measurement areas, CMS narrowed the list to 32 measures (17% of the original submissions) which focus CMS efforts to achieve goals of high quality healthcare and meaningful outcomes for patients, while minimizing burden. CMS will continue to use the Meaningful Measures approach to strategically assess the development and implementation of quality measure sets that are the most parsimonious and least burdensome, that are well understood by external stakeholders, and are most likely to drive improvement in health outcomes.

This year, approximately 40% of measures on the MUC list are outcome measures, including patient-reported outcome measures, which will help empower patients to make decisions about their own healthcare and help clinicians to make continuous improvements in the care provided. In addition, this year there are eight episode-based cost measures proposed that were developed by incorporating the insight and expertise of clinicians and specialty societies. CMS is committed to working with clinicians, consumers, and other stakeholders on the development and use of measures that are most meaningful to patients and clinicians and our programs.

We invite you to review the MUC List in detail and to participate in the public process. We believe it is critical to hear a wide range of voices in the selection of quality and efficiency measures that are used for accountability and transparency purposes and look forward to another successful pre-rulemaking season. For more information regarding the NQF Measure Applications Partnership public stakeholder review meeting purpose, meetings, 2017 MUC List deliberations and voting, visit the NQF website at http://www.qualityforum.org/map/

###

Updated Medicare Part D Opioid Drug Mapping Tool Unveiled

Interactive tool adds extended-release opioid prescribing rates, county-level hot spots

The Centers for Medicare & Medicaid Services (CMS) released an updated version of the Medicare opioid prescribing mapping tool. This tool is an interactive, web-based resource that visually presents geographic comparisons of Medicare Part D opioid prescribing rates. The tool includes the addition of extended-release opioid prescribing rates and county-level hot spots and outliers, which may identify areas that warrant attention.

The mapping tool offers local communities greater transparency into opioid prescribing in the Medicare Part D program. Communities can use this resource to understand how this critical issue affects their area, examine regional variation, and make informed decisions about how to allocate resources. The underlying data that feeds this tool is also used by CMS to monitor and manage high risk use of opioids in the Part D program.

"Addressing the opioid epidemic and its impact on every state, county and municipality is a priority of the Trump Administration," said CMS Administrator Seema Verma. "This updated mapping tool gives providers, local health officials, and others data about their community's Medicare opioid prescription rate and information to help target resources and develop solutions for this problem plaguing our nation's neighborhoods."
Prescription opioids can be prescribed by doctors to treat moderate to severe pain. However, they also can have serious risks including addiction and overdose. The majority of drug overdose deaths involve opioids, and since 1999, the number of overdose deaths involving prescription opioids has quadrupled. In 2015, more than 15,000 people died from overdoses involving prescription opioids.

The data used in this mapping tool are from Medicare Part D prescription drugs prescribed by healthcare providers. In 2015, Medicare Part D spending on drugs was $137 billion, which reflects about 40% of U.S. retail prescription drug spending. In total, for Medicare Part D, there were approximately 80 million opioid claims for 111 distinct opioid products in 2015, accounting for $3.5 billion in spending. It is important to note that the information presented in the tool does not indicate the quality or appropriateness of opioid prescribing for an individual physician or in a given geographic region.

The updated version of the mapping tool presents Medicare Part D opioid prescribing rates for 2015 as well as the change in opioid prescribing rates from 2013 to 2015. New for this release is additional information on extended-release opioid prescribing rates. Extended-release opioids are formulated to release the active ingredient slower, over a longer period of time, and require less frequent administration. However, because extended-release drugs contain a large amount of the opioid, they have been associated with misuse, including both addiction and overdose deaths. In addition, this release includes county-level hot spots and outliers, which may identify areas that warrant attention.

The Medicare Part D Opioid Drug Mapping Tool can be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/OpioidMap.html

###

Reform of Requirements for Long-Term Care Facilities Phase 2

The Centers for Medicare & Medicaid Services (CMS) announced a new survey process for Long Term Care (LTC) facilities that will ensure national consistency while providing surveyors with the flexibility needed to make informed decisions based on experience and expertise.

To address concerns about the implementation of the new requirements and new LTC survey process, CMS will be making specific policy and process adjustments to the enforcement system and results posted on Nursing Home Compare. A summary of these changes are described below:

- **Temporary moratorium on imposing certain enforcement remedies for specific Phase 2 requirements**: CMS will provide an 18 month moratorium on the imposition of certain enforcement remedies for specific Phase 2 requirements. This 18 month period will be used to educate facilities about specific new Phase 2 standards.

- **Freeze Health Inspection Star Ratings**: Following the implementation of the new LTC survey process on November 28, 2017, CMS will hold constant the current health inspection star ratings on the Nursing Home Compare (NHC) website for any surveys occurring between November 28, 2017 and November 27, 2018.

- **Availability of Survey Findings**: The survey findings of facilities surveyed under the new LTC survey process will be published on NHC, but will not be incorporated into calculations for the Five-Star Quality Rating System for 12 months. CMS will add indicators to NHC that summarize survey findings.

- **Methodological Changes and Changes in Nursing Home Compare**: In early 2018, NHC health inspection star ratings will be based on the two most recent cycles of findings for standard health inspection surveys and the two most recent years of complaint inspections.

For more detailed information and other changes to Nursing Home Compare listed above click here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html

SC18-04-NH Temporary Enforcement Delays for Certain Phase 2 F-Tags and Changes to *Nursing Home Compare*
SC18-05-NH Preparation for Launch of New Long-Term Care Survey Process (LTCSP)
For questions or concerns, please contact NHSurveyDevelopment@cms.hhs.gov

###

2018 Medicare Costs - CMS Product No. 11579 Revised December 2017

Medicare Part A (Hospital Insurance) Costs

Part A Monthly Premium
Most people don't pay a Part A premium because they paid Medicare taxes while working. If you don't get premium-free Part A, you pay up to $422 each month.

Hospital Stay

In 2018, you pay
- $1,340 deductible per benefit period
- $0 for the first 60 days of each benefit period
- $335 per day for days 61–90 of each benefit period
- $670 per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime)

Skilled Nursing Facility Stay

In 2018, you pay
- $0 for the first 20 days of each benefit period
- $167.50 per day for days 21–100 of each benefit period
- All costs for each day after day 100 of the benefit period

Medicare Part B (Medical Insurance) Costs

Part B Monthly Premium
The standard Part B premium amount in 2018 is $134 or higher depending on your income. However, most people who get Social Security benefits pay less than this amount ($130 on average). Social Security will tell you the exact amount you'll pay for Part B in 2018.

You pay the standard premium amount (or higher) if:
- You enroll in Part B for the first time in 2018.
- You don't get Social Security benefits.
- You're directly billed for your Part B premiums.
- You have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of $134 in 2018.)
- Your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount.

If you're in 1 of these 5 groups, here's what you'll pay:

If your yearly income in 2016 was			**You pay (in 2018)**
File individual tax return	**File joint tax return**	**File married & separate tax return**	
$85,000 or less	$170,000 or less	$85,000 or less	$134
above $85,000 up to $107,000	above $170,000 up to $214,000	N/A	$187.50
above $107,000 up to $160,000	above $214,000 up to $320,000	N/A	$267.90
above $160,000 up to $214,000	above $320,000 up to $428,000	above $85,000 up to $129,000	$348.30
above $214,000	above $428,000	above $129,000	$428.60

If you have questions about your Part B premium, call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. If you pay a late enrollment penalty, these amounts may be higher.

Part B Deductible—$183 per year

Medicare Advantage Plans (Part C) and Medicare Prescription Drug Plans (Part D) Premiums

Visit Medicare.gov/find-a-plan to get plan premiums. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. You can also call the plan or your State Health Insurance Assistance Program (SHIP). To get the most up-to-date
SHIP phone numbers, visit shiptacenter.org or call 1-800-MEDICARE.

Part D Monthly Premium

The chart below shows your estimated prescription drug plan monthly premium based on your income. If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium.

If your yearly income in 2016 was			**You pay (in 2018)**
File individual tax return	**File joint tax return**	**File married & separate tax return**	
$85,000 or less	$170,000 or less	$85,000 or less	Your plan premium
above $85,000 up to $107,000	above $170,000 up to $214,000	not applicable	$13.00 + your plan premium
above $107,000 up to $133,500	above $214,000 up to $267,000	not applicable	$33.60 + your plan premium
above $133,500 up to $160,000	above $267,000 up to $320,000	not applicable	$54.20 + your plan premium
above $160,000	above $320,000	above $85,000	$74.80 + your plan premium

2018 Part D National Base Beneficiary Premium — $35.02

This figure is used to estimate the Part D late enrollment penalty and the income-related monthly adjustment amounts listed in the table above. The national base beneficiary premium amount can change each year. See your Medicare & You handbook or visit Medicare.gov for more information.

For more information about Medicare costs, visit Medicare.gov.

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CMS Office of the Actuary Releases 2016 National Health Expenditures

In 2016, overall national health spending increased 4.3 percent following 5.8 percent growth in 2015, according to a study by the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS) published as a Web First by *Health Affairs*. Following Affordable Care Act (ACA) coverage expansion and significant retail prescription drug spending growth in 2014 and 2015, health care spending growth decelerated in 2016. The report concludes that the 2016 expenditure slowdown was broadly based as growth for all major payers (private health insurance, Medicare, and Medicaid) and goods and service categories (hospitals, physician and clinical services, and retail prescription drugs) slowed in 2016.

During 2014 and 2015, the health spending share of the economy increased 0.5 percentage point from 17.2 percent in 2013 to 17.7 percent in 2015. The increases in the health spending share of the economy in 2014 and 2015 were largely due to coverage expansion that contributed to 8.7 million individuals gaining private health insurance coverage and 10.2 million gaining Medicaid coverage over the period and to significant growth in retail prescription drug spending. Health care

spending grew 1.5 percentage points faster than the overall economy in 2016, resulting in a 0.2 percentage-point increase in the health spending share of the economy – from 17.7 percent in 2015 to 17.9 percent in 2016.

Additional highlights from the report:

- **Private health insurance** spending increased 5.1 percent to $1.1 trillion in 2016, which was slower than the 6.9 percent growth in 2015. The deceleration was largely driven by slower enrollment growth in 2016 after two years of faster enrollment growth due to ACA coverage expansion.
- **Medicare** spending grew 3.6 percent to $672.1 billion in 2016, which was slower growth than the previous two years when spending grew 4.8 percent in 2015 and 4.9 percent in 2014. The slower growth in 2016 was due to slower growth in spending for both Medicare fee-for-service (2.2 percent in 2015 compared to 1.8 percent in 2016) and Medicare Advantage (11.1 percent in 2015 compared to 7.4 percent in 2016).
- **Medicaid** spending growth slowed in 2016, increasing 3.9 percent to $565.5 billion. State and local Medicaid expenditures grew 3.2 percent in 2016, while federal Medicaid expenditures increased 4.4 percent in 2016. The slower overall growth in Medicaid spending was much lower than in the previous two years, when Medicaid spending grew 11.5 percent in 2014 and 9.5 percent in 2015. The higher growth in 2014 and 2015 was due in part to the initial impacts of the ACA's expansion of Medicaid enrollment during that period.
- **Out-of-pocket** spending includes direct consumer payments such as copayments, deductibles, and spending not covered by insurance. Out-of-pocket spending grew 3.9 percent to $352.5 billion in 2016, faster than the 2.8 percent growth in 2015. Additionally, 2016 was the fastest rate of growth since 2007 and was higher than the average annual growth of 2.0 percent during 2008-15. The faster growth in 2016 was due in part to a continued shift towards enrollment in high-deductible health plans, which was somewhat offset by a continued decrease in the number of uninsured in 2016.
- **Retail prescription drug** spending slowed in 2016, increasing 1.3 percent to $328.6 billion. The slower growth in 2016 follows two years of significant growth in 2014 and 2015, 12.4 percent and 8.9 percent, respectively. This significant growth in 2014 and 2015 was largely attributable to increased spending on new medicines and price growth for existing brand-name drugs, particularly for drugs used to treat hepatitis C. Growth slowed in 2016 primarily due to fewer new drug approvals, slower growth in brand-name drug spending as spending for hepatitis C drugs declined, and a decline in spending for generic drugs as price growth slowed.
- In 2016, the federal government and households accounted for the largest shares of spending (28 percent each) followed by private businesses (20 percent), state and local governments (17 percent), and other private revenue (7 percent). After two consecutive years of rapid growth (10.9 percent in 2014 and 8.9 percent in 2015), federal government spending for health care slowed, increasing 3.9 percent in 2016. The primary reason for the deceleration in federal spending growth in 2016 was federal Medicaid spending, which grew more slowly in 2016 as a result of less Medicaid enrollment growth.

The CMS Office of the Actuary's report will appear on the CMS website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

An article about the study is also being published by *Health Affairs* as a Web First (http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1299) and will also appear in the journal's January 2018 issue.

###

Extension of Prior Authorization for Repetitive Scheduled Non-Emergent Ambulance Transports (CMS-6063-N3)

The Centers for Medicare & Medicaid Services (CMS) announced that it is extending the Medicare Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transport Model for one additional year. The model was originally scheduled to end for all states on December 1, 2017. The model has been extended one additional year and will now end for all states on December 1, 2018. This is being extended to allow time for additional evaluation and analyses. Claims data for the first two years of the model show substantial reductions in repetitive scheduled non-emergent ambulance transport spending.

For additional information click here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-of-Repetitive-Scheduled-Non-Emergent-Ambulance-Transport-.html

Extension of Prior Auth…. (CMS-6063-N3) at *Federal Register*: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-26759.pdf and on 12/12/2017 will be available online at https://federalregister.gov/d/2017-26759

Frequently Asked Questions (FAQs)- https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Downloads/AmbulancePriorAuthorization_ExternalFAQ_120417.pdf

Questions can be sent to: AmbulancePA@cms.hhs.gov.

###

Upcoming Webinars and Events and Other Updates

New Medicare Card Webinars

The Centers for Medicare & Medicaid Services (CMS) Kansas City Regional Office invites you to attend the **New Medicare Card Webinars**. Recent legislation requires CMS to remove Social Security Numbers from all Medicare cards to address the current risk of beneficiary medical identity theft, and to replace the cards with a unique number for each Medicare beneficiary. These webinars will address the new card design, the timeframe of the mailings and scenarios, what Medicare beneficiaries should do to ensure they receive their new card, and partner resources to help with education.

The goal of these **free** webinars is to educate those who serve people with Medicare and their caregivers so they can be a valuable resource on this initiative.

There are multiple webinars so you can choose one that best works with your schedule. All webinars will provide the same information. CMS will host separate webinars and informational sessions for people with Medicare and their caregivers.

Register:

January 30, 2018 11:00 AM – 12:00 PM
https://newmedicarecard013018.eventbrite.com

February 8, 2018 12:00 PM – 1:00 PM
https://newmedicarecard020818.eventbrite.com

February 16, 2018 10:00 AM – 11:00 AM
https://newmedicarecard021618.eventbrite.com

February 21, 2018 1:00 PM CST – 2:00 PM CST
https://newmedicarecard022118.eventbrite.com

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

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

###

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

###

Register for December 14 Webinar on Proposed Removal of Influenza Vaccination Measure from Home Health Quality of Patient Care Star Rating

On Thursday, December 14, at 2 p.m. ET, the Centers for Medicare & Medicaid Services (CMS) will host a webinar for Medicare-certified home health agencies.

Following the 10/10/2017 MLN call describing proposed changes to the Quality of Patient Care (QoPC) star ratings and a one-month comment period, CMS is finalizing the proposal to remove the Influenza Vaccination Measure from the QoPC Star Ratings. The updated methodology to compute the QoPC Star Ratings will be implemented in the April 2018 Home Health Compare refresh.

During this webinar, CMS will present the rationale, comments received, timing, and impact of this change. A question and answer session will follow the presentation.

Webinar Details

Title: Proposed Removal of Influenza Vaccination Measure from Home Health Quality of Patient Care Star Rating
Date: Thursday, December 14, 2017
Time: 2-3 p.m. ET
Target Audience: Medicare-certified Home Health Agencies

Presenters:

- Alan Levitt, CMS
- Betty Fout, Abt Associates
- Sara Galantowicz, Abt Associates

Event Registration: https://engage.vevent.com/rt/cms/index.jsp?seid=983

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Medicare Learning Network

News & Announcements

- QRDA III Implementation Guide for CY 2018 Performance Period
- DMEPOS: Traveling Beneficiary Clarification
- Hospice Compare Search Function
- World AIDS Day is December 1
- First Breakthrough-Designated Test to Detect Extensive Number of Cancer Biomarkers
- CMS Finalizes Comprehensive Care for Joint Replacement Model Changes, Cancels Episode Payment Models & Cardiac Rehabilitation Incentive Payment Model
- Updated Medicare Part D Opioid Drug Mapping Tool
- Quality and Cost Measures under Consideration: CMS Releases List for 2018 Pre-rulemaking
- Hospice Provider Preview Reports: Review by December 30
- Quality Payment Program Hardship Exception Application Deadline: December 31
- IRF and LTCH Provider Preview Reports: Review by January 3
- New PEPPER Available for Short-term Acute Care Hospitals
- Quality Payment Program Resources
- Extreme and Uncontrollable Circumstances Policy for MIPS Clinicians in 2017
- Targeted Probe and Educate Limits MAC Medical Record Reviews
- Medical Record Documentation: Helpful Clinical Templates and Data Elements
- Qualified Medicare Beneficiary: HETS and Remittance Advice
- National Influenza Vaccination Week: December 3 through 9
- National Handwashing Awareness Week: December 3 through 9

Provider Compliance

- Billing for Stem Cell Transplants — Reminder
- Hospital Discharge Day Management Services CMS Provider Minute Video — Reminder

Claims, Pricers & Codes

- January 2018 Average Sales Price Files Available

Upcoming Events

- Medicare Diabetes Prevention Program Model Expansion Orientation Webinar — December 13
- National Partnership to Improve Dementia Care and QAPI Call — December 14
- Home Health QRP: Proposed Removal of Influenza Vaccination Measure from Home Health Quality of Patient Care Star Rating Webinar — December 14

Medicare Learning Network Publications & Multimedia

- Quality Payment Program 2017: MIPS ACI Performance Category Web-Based Training Course — New
- SNF Value-Based Purchasing Program Call: Audio Recording and Transcript — New
- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — Updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — Updated
- SBIRT Services Booklet — Reminder
- DMEPOS Quality Standards Educational Tool – Revised
- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — Revised
- Medicare Advance Written Notices of Noncoverage Booklet — Revised
- How to Use the Searchable Medicare Physician Fee Schedule Booklet — Revised
- Long-Term Care Hospital Prospective Payment System Booklet — Revised
- Power Mobility Devices Booklet — Revised

###

New / Updated CMS Publications

- Helping People Understand Their Explanation of Benefits
- Apply for Medicaid & CHIP through the Health Insurance Marketplace
- Report Life Changes to the Marketplace After You Enroll in Coverage
- About the SHOP Marketplace
- Medicare & the Health Insurance Marketplace
- 2018 Medicare Costs

###

Newly Posted Training Materials

- Medicare 101 (Spanish version)
- Medicare Open Enrollment Period: Review, Compare, Enroll (Revised November 2017)

###

National Plan and Provider Enumeration System (NPPES) data breach

CMS is committed to protecting private information of its stakeholders and has worked to contain and correct a recent data breach on the evening of October 17, 2017 until the morning of October 18, 2017 (approximately 15 hours). Personal information was inadvertently publicly exposed through the National Plan and Provider Enumeration System (NPPES). While we have no reason to believe information was compromised or misused, since the incident involves social security numbers (SSN) and date of births (DoB), there is a risk of identity theft, and we want providers to know about the protective actions they can take.

CMS steps taken to resolve the issue

- Provide free identity monitoring services for those providers who had their data exposed;
- Mail notification letters starting on December 6, 2017 to the providers and
- Respond to inquiries from those providers with exposed data.

###

Unsubscribe

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.