CMS Region 7 Updates – 12/29/2017

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ACA/Marketplace Updates

Weekly Enrollment Snapshot: Week Six

Week 6, Dec 3- Dec 9, 2017

In week six of Open Enrollment for 2018, 1,073,921 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 6 Dec 3 – Dec 9	Cumulative Nov 1- Dec 9
Plan Selections	1,073,921	4,678,361
New Consumers	388,984	1,378,476
Consumers Renewing Coverage	684,937	3,299,885
Consumers on Applications Submitted	1,318,767	7,286,855
Call Center Volume	1,001,594	4,363,201
Calls with Spanish Speaking Representative	79,756	324,666
HealthCare.gov Users	3,489,194	13,985,130
CuidadoDeSalud.gov Users	137,570	486,404
Window Shopping HealthCare.gov Users	270,072	1,386,829
Window Shopping CuidadoDeSalud.gov Users	7,277	28,651

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 9
Alaska	10,633
Alabama	92,652
Arkansas	32,189

Arizona	87,687
Delaware	11,553
Florida	1,021,576
Georgia	246,270
Hawaii	10,187
Iowa	28,585
Illinois	168,663
Indiana	79,230
Kansas	53,043
Kentucky	47,474
Louisiana	50,995
Maine	40,608
Michigan	153,241
Missouri	133,021
Mississippi	45,954
Montana	25,191
North Carolina	271,301
North Dakota	11,830
Nebraska	54,186
New Hampshire	25,242
New Jersey	138,773
New Mexico	26,366
Nevada	46,156
Ohio	109,475
Oklahoma	73,147
Oregon	86,434
Pennsylvania	205,909
South Carolina	110,225
South Dakota	17,514
Tennessee	118,125
Texas	579,688
Utah	104,942
Virginia	203,441
Wisconsin	128,267
West Virginia	13,257
Wyoming	15,331

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Weekly Enrollment Snapshot: Week Seven: Dec 10- Dec 15, 2017

In the last week of Open Enrollment for 2018, 4,143,968 people selected plans using the HealthCare.gov platform or were automatically re-enrolled in a plan. As in past years, enrollment weeks are measured Sunday through Saturday.

This Open Enrollment snapshot covers the period from December 10, 2017, to 11:59PM Eastern Time on December 15, 2017. The plan selections reported in this snapshot are not final and do not include plan selections for consumers who enrolled in coverage through 3:00AM Eastern Time on December 16, 2017, or consumers who left their contact information at the call center due to high volume. 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. CMS plans to release an updated snapshot next week with the final enrollment data.

In addition, the week seven snapshot only reports new plan selections, active plan renewals, and automatic enrollments and does not report the number of consumers who have paid premiums to effectuate their enrollment. This snapshot does not include plan selections from State-based Exchanges, other than those using the HealthCare.gov platform. CMS plans to

release a detailed 2018 final enrollment report in March, including final plan selection data from State-based Exchanges that do not use the HealthCare.gov platform.

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

HealthCare.gov Platform Snapshot

HealthCare.gov Platform Snapshot	**Week 7 Dec 10 – Dec 15**	**Cumulative Nov 1- Dec 15**
Plan Selections	4,143,968	8,822,329
New Consumers	1,015,631	2,394,107
Consumers Renewing Coverage	3,128,337	6,428,222
Consumers on Applications Submitted	3,986,835	11,273,690
Call Center Volume	1,984,677	6,347,878
Calls with Spanish Speaking Representative	144,599	469,265
HealthCare.gov Users	5,596,225	18,358,032
CuidadoDeSalud.gov Users	226,432	679,996
Window Shopping HealthCare.gov Users	381,906	1,708,822
Window Shopping CuidadoDeSalud.gov Users	9,951	36,386

HealthCare.gov State-by-State Snapshot

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

State	**Cumulative Plan Selections Nov 1 - Dec 15**
Alaska	18,356
Alabama	170,023
Arkansas	68,642
Arizona	166,961
Delaware	24,860
Florida	1,731,275

Georgia	482,904
Hawaii	20,000
Iowa	53,548
Illinois	339,740
Indiana	168,223
Kansas	98,919
Kentucky	90,625
Louisiana	111,373
Maine	76,480
Michigan	298,999
Missouri	245,580
Mississippi	83,713
Montana	48,450
North Carolina	523,989
North Dakota	22,908
Nebraska	88,351
New Hampshire	50,275
New Jersey	278,881
New Mexico	50,539
Nevada	90,962
Ohio	233,345
Oklahoma	141,504
Oregon	157,537
Pennsylvania	396,725
South Carolina	218,435
South Dakota	30,090
Tennessee	230,493
Texas	1,130,594
Utah	195,121
Virginia	403,284

Wisconsin	227,572
West Virginia	28,164
Wyoming	24,889

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 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 Exchanges 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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Federal Exchange Open Enrollment for 2018 Coverage

The Centers for Medicare & Medicaid Services (CMS) announced that the fifth open enrollment period for the Health Insurance Exchange was the most cost effective and smooth enrollment experience for consumers, releasing data that shows the highest rates of consumer satisfaction to date at a lower cost. Similar to previous years, there was a surge in the number of consumers contacting the call center and visiting HealthCare.gov during the final days. Despite the increase in volume, both HealthCare.gov and the call center operated optimally and for the first time, a waiting room did not need to be deployed online during the final days of open enrollment. This provided consumers with exceptional site availability when the greatest number of consumers were making plan selections.

"Our goal from the beginning was to empower patients across the healthcare delivery system and make sure that Americans who chose to enroll in the Exchanges had a good customer experience while making enrollment more cost efficient, and the results show that we accomplished our goal," said CMS Administrator Seema Verma. "In a market that is experiencing soaring rates, I am proud of the hard work CMS put into making sure that our customers didn't experience the website failures that were commonplace with HealthCare.gov in previous open enrollment periods."

CMS cut wasteful spending and adjusted the open enrollment marketing budget this year to a level similar to what has proven to be effective for other major programs, like Medicare. CMS re-prioritized marketing tactics and focused funding and attention on the most strategic and efficient ways to reach consumers, including targeted digital advertising and email. This year, CMS spent only $10 million on marketing and outreach, which is just over $1 per enrollee all while improving the ease and quality of customer service. In comparison, last year CMS spent a total of $100 million, nearly $11 per enrollee.

The primary goal of this open enrollment period was to provide a seamless experience for consumers. While HealthCare.gov was scheduled for a total of 60 hours of regular maintenance during open enrollment, the site only used 21.5 hours. This meant consumers were able to shop and pick a plan with little interruption throughout the entire enrollment period. Data from the call center shows that the consumer satisfaction rate remained at an all-time high – averaging 90 percent – throughout the entire open enrollment period. This is up from 85 percent last year.

This year CMS also focused on building new partnerships with the private sector—as a way to begin to shift away from the government selling a private product, similar to Medicare and the successful growth of Medicare Advantage. To empower patients to take ownership of their healthcare decisions, CMS leveraged the capabilities of the private sector to help consumers through the selection process, including increasing opportunities for consumers to connect with agents and brokers. Agents and brokers are licensed professionals who help guide consumers through the complex task of choosing and utilizing health coverage. Many brokers are independent business people who live and work in the communities they serve and have years of experience in assisting clients.

This open enrollment period successfully realigned the Exchange with standard employer and Medicare open enrollment periods and with the calendar year, which offers a single effective date for coverage—January 1st, 2018—for all of the individuals and families who signed up for coverage. Open Enrollment for 2018 coverage ended with approximately 8.8 million people enrolling in coverage using the HealthCare.gov platform.

To read the week 7 enrollment snapshot, visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-12-21.html

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First Half of 2017 Average Effectuated Enrollment Report

Effectuated Enrollment Analysis

According to data as of September 15, 2017, an average of 10.1 million individuals had effectuated their coverage through June 2017, meaning that they selected a plan and paid their premium. This is approximately 200,000 fewer effectuated individuals compared to the effectuated report for the first half of 2016 and about 2.1 million below the number of plan selections at the end of 2017 open enrollment.

Looking historically at Affordable Care Act trends from 2014 through 2017, we also see that a significant number of people who effectuate coverage do not stay in their plans for the full year. By June, 9.9 million individuals remained in coverage compared to the 12.2 million who selected plans. On average since 2014, more than a million enrollees per year dropped their coverage before the end of the plan year.

This report also shows that the proportion of the population that enrolls on Federal and State-Based Exchanges and qualifies for financial assistance in the form of advance premium tax credits (APTC) or cost-sharing reduction (CSR) has remained relatively stable, but the average amount of APTC per eligible individual has risen by nearly 29% when compared with the 2016 average APTC per eligible enrollee. In addition, the average amount of APTC per eligible enrollee has risen slightly (from $371.49 to $373.37) when compared with the February 2017 snapshot average APTC per eligible enrollee. This indicates that individuals who effectuated after February 2017 and who remained covered were more likely to have or receive more APTC.

Background Information

The primary source for the first half of 2017 average effectuated enrollment are payment and enrollment data. Effectuated enrollment is the average number of individuals who had an active policy from January through June of 2017, and who paid their premium (thus effectuating their coverage) as of September 15, 2017. This data includes effectuated enrollment from both State-Based and Federally-Facilitated individual market Exchanges.

APTC enrollment is the average number of individuals who had an active policy from January through June of 2017, who paid their premium, and who received an APTC subsidy. APTC is generally available if a consumer's household income is between 100 and 400 percent of the federal poverty level and certain other criteria are met. A consumer was defined as having an APTC if the applied APTC amount was greater than $0; otherwise, a consumer was classified as not having APTC.

CSR enrollment is the average number of individuals who had an active policy from January through June 2017, who paid their premium, and received CSRs. A CSR is generally available if a consumer is eligible for APTC, has a household income between 100 percent and 250 percent of the federal poverty level, and the individual chooses a health plan from the silver plan category. Those who qualify have reduced out-of-pocket costs. American Indians and Alaskan Natives are eligible for CSRs under different criteria.

Total Average Effectuated Enrollment and Financial Assistance by State for the First Half of 2017

State	Total Enrollment	APTC Enrollment	Percentage of Enrollment with APTC	CSR Enrollment	Percentage of Enrollment with CSR
Total	10,142,056	8,561,695	84%	5,814,266	57%
AK	14,954	13,782	92%	6,157	41%
AL	154,156	144,301	94%	117,454	76%
AR	56,846	48,830	86%	32,887	58%
AZ	142,502	123,391	87%	80,064	56%
CA	1,346,226	1,153,203	86%	658,766	49%
CO	143,509	93,403	65%	38,424	27%
CT	96,438	73,193	76%	41,289	43%
DC	18,349	877	5%	605	3%
DE	22,433	18,841	84%	10,524	47%
FL	1,407,434	1,296,661	92%	1,046,493	74%
GA	400,469	358,239	89%	284,246	71%
HI	16,502	13,728	83%	9,937	60%
IA	44,901	38,952	87%	23,655	53%
ID	84,737	74,808	88%	56,680	67%
IL	295,176	241,296	82%	142,949	48%
IN	144,459	106,407	74%	68,001	47%

Total Average Effectuated Enrollment and Financial Assistance by State for the First Half of 2017					
State	**Total Enrollment**	**APTC Enrollment**	**Percentage of Enrollment with APTC**	**CSR Enrollment**	**Percentage of Enrollment with CSR**
KS	85,227	73,661	86%	47,904	56%
KY	72,588	56,276	78%	36,578	50%
LA	109,877	98,729	90%	62,168	57%
MA	236,177	174,818	74%	147,513	62%
MD	133,317	101,577	76%	76,151	57%
ME	69,992	60,776	87%	37,649	54%
MI	274,887	227,209	83%	135,556	49%
MN	86,108	63,505	74%	11,061	13%
MO	211,238	185,343	88%	120,354	57%
MS	65,475	61,076	93%	52,334	80%
MT	45,848	39,863	87%	19,634	43%
NC	455,412	426,575	94%	306,309	67%
ND	19,940	16,883	85%	9,298	47%
NE	73,855	68,862	93%	41,268	56%
NH	46,341	29,410	63%	16,668	36%
NJ	243,760	193,240	79%	126,694	52%
NM	44,271	32,376	73%	20,981	47%
NV	74,993	63,377	85%	42,207	56%
NY	211,504	117,945	56%	33,400	16%
OH	202,747	153,276	76%	91,881	45%
OK	120,985	112,466	93%	76,910	64%
OR	133,363	100,132	75%	52,601	39%
PA	359,673	300,481	84%	204,950	57%
RI	29,374	22,989	78%	16,268	55%
SC	181,600	165,456	91%	131,622	72%
SD	26,560	24,409	92%	15,764	59%
TN	197,360	174,163	88%	117,543	60%
TX	942,891	819,321	87%	607,779	64%
UT	172,022	149,490	87%	105,610	61%
VA	354,344	293,980	83%	213,621	60%
VT	28,538	22,354	78%	11,770	41%
WA	182,596	113,808	62%	71,812	39%
WI	211,025	173,959	82%	107,942	51%
WV	27,160	24,012	88%	14,135	52%
WY	21,922	19,989	91%	12,205	56%
Source: September 15, 2017 CMS					

Average APTC per month is the total amount of APTC for the month for all consumers who received APTC divided by the number of consumers who received APTC, by state and total.

Average Advanced Premium Tax Credit by State, 2017	
(For individuals receiving APTC)	
State	**Average APTC per Month**
Total	**$373.37**
AK	$965.53
AL	$518.58
AR	$274.95
AZ	$541.26
CA	$348.44

Average Advanced Premium Tax Credit by State, 2017 (For individuals receiving APTC)	
State	**Average APTC per Month**
CO	$380.79
CT	$439.98
DC	$252.70
DE	$421.20
FL	$365.31
GA	$359.94
HI	$356.86
IA	$425.13
ID	$352.10
IL	$369.17
IN	$263.35
KS	$378.32
KY	$292.95
LA	$437.21
MA	$177.05
MD	$316.72
ME	$414.11
MI	$265.91
MN	$431.95
MO	$400.54
MS	$382.03
MT	$480.91
NC	$593.70
ND	$288.14
NE	$509.97
NH	$250.42
NJ	$350.75
NM	$285.78
NV	$288.85
NY	$232.46
OH	$268.25
OK	$553.58
OR	$347.36
PA	$426.82
RI	$246.44
SC	$422.52
SD	$444.19
TN	$535.05
TX	$335.40
UT	$234.08
VA	$318.58
VT	$323.96
WA	$252.92
WI	$402.91
WV	$565.94
WY	$505.45
Source: September 15th, 2017 CMS	

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Maine Windstorms

CMS recognizes that certain exceptional circumstances, including a natural disaster such as a severe wind-storm, can prevent an individual from enrolling in coverage before an open enrollment period expires. In these cases, the Marketplace has the authority to provide a special enrollment period (SEP) to give these consumers more time to enroll in a health plan. Individuals who were unable to timely enroll in coverage during Open Enrollment due to the impacts of the severe wind-storms and resulting power outages across Maine should qualify for an exceptional circumstances SEP that will provide them more time to enroll in coverage.

Therefore, Maine residents who were unable to complete enrollment during Open Enrollment due to the wind-storms should contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) to speak with a Marketplace representative. Maine residents who are affected by the wind-storm should provide detailed information about their situation so the Marketplace representative can appropriately assist them. Additional SEP information related to natural disasters is available on HealthCare.gov at https://www.healthcare.gov/sep-list/ .

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1095As: How Assisters Can Help Consumers Prepare for Tax Season

During Open Enrollment (OE), assisters can help consumers by taking steps to increase the likelihood that the Form 1095-A consumers receive during tax season is accurate. Many consumers are unaware that their enrollment application affects their taxes. Mistakes on the application may lead to inaccuracies on Form 1095-A and may mean consumers have to refile their taxes in the future. Assisters can help to mitigate this risk by ensuring certain data fields are correct.

Assisters should talk to consumers about:

- Updating prior year mailing addresses
- Double checking that their demographic information is accurate
- Confirming their household structure and any dependents the tax filer will claim. Consumers may not realize that their household structure for tax filing should be reflected on their Marketplace application. For example, if parents share custody of a child, the parent who will claim the child on their taxes should also be the parent who applies for APTC on the child's behalf.

In particular, assisters should ask consumers if their mailing addresses have changed. *If so, it's important that their mailing address is updated on prior year applications as well as for the current year to ensure that consumers receive their Form 1095-As. The Marketplace uses the last known address on consumers' Marketplace applications to mail Form 1095-As to taxpayers and other responsible adults. If consumers update their mailing address on their PY 2018 application, their mailing address will not update on prior year applications, so it is important that consumers update their address on their PY2017 application, too.*

For more information about how Marketplace coverage will affect consumers' taxes, assisters should visit: HealthCare.gov/taxes/ or call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325). If consumers have questions about their taxes, need their Form 8962 or 8965, or want to learn more about the fee for not having health coverage, they should visit IRS.gov.

###

Application Spotlight: Employer Sponsored Coverage

During our November 17th webinar, we reviewed the Employer-Sponsored Coverage (ESC) section of the Marketplace application. We highlighted how assisters can help consumers answer questions regarding employer-sponsored coverage, including COBRA and retiree coverage. We also discussed how to help consumers determine whether their offer of ESC is deemed affordable by the Marketplace.

Affordability and Minimum Value

A consumer may be eligible for financial help through the Marketplace if their ESC is either unaffordable (by Marketplace standards) or doesn't meet the minimum value (MV) standard. Determining whether someone has access to ESC is one component for determining eligibility for advance payments of the premium tax credit (APTCs) and cost-sharing reductions

(CSRs). Consumers are not eligible for financial assistance through the Marketplace if an offer of ESC is considered affordable and meets minimum value.

A health plan meets the minimum value standard if it's designed to pay at least 60% of the total cost of medical services for a standard population and the benefits include coverage of physician and inpatient hospital services.

Affordability is calculated by comparing the employee's share of the annual premium for self-only coverage to the employee's annual household income. A health plan is considered affordable if the employee's required contribution for self-only coverage does not exceed 9.56 percent (in 2018) of the employee's household income for the year. The Marketplace does not consider the cost of coverage for other family members when determining whether the coverage is affordable for the family.

When helping consumers answer questions on the application about employer sponsored coverage, assisters should encourage consumers to accurately report whether they are enrolled in or eligible for ESC, including the cost of the lowest-cost self only plan offered by the employer and whether the ESC meets the minimum value standard.

In order to evaluate the offer of employer-sponsored coverage, consumers may complete or ask their employers to fill out the **"Employer Coverage Tool"** worksheet. Consumers offered coverage will be asked to provide the Marketplace with the employer's name, Employer Identification Number (EIN), phone number, and address. The EIN is displayed on consumers' W-2, or consumers can ask the employer to provide it to them. This worksheet is available at https://www.healthcare.gov/downloads/employer-coverage-tool.pdf

Consumers may also ask for a copy of the Summary of Benefits and Coverage (SBC) of the employer plan, which indicates whether the coverage meets minimum value requirements. Here's an example of what an SBC may look like: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SBC-Sample-Completed-MM-508-fixed-4-12-16.pdf

IRS Decreases the ACA Affordability Percentages for 2018:

For plan years **beginning in 2018**, employer-sponsored coverage will be considered affordable if the employee's required contribution for self-only coverage does not exceed:

- **9.56 percent** (in 2017, it was 9.69%) of the employee's household income for the year, for purposes of both the pay or play rules and premium tax credit eligibility; and
- **8.05 percent** (in 2017, it was 8.16%) of the employee's household income for the year, for purposes of an individual mandate exemption (adjusted under separate guidance).

COBRA and Retiree Coverage

A consumer is not eligible for APTCs or CSRs if he or she is enrolled in COBRA or retiree coverage. . A consumer who has an offer of COBRA or retiree coverage but has not yet enrolled may still be eligible for APTC or CSRs. Minimum value and affordability standards don't apply to consumers with an offer of COBRA or retiree coverage – as long as these consumers are not enrolled in that coverage, they may be eligible for financial help through the Marketplace, if otherwise eligible.

During the Marketplace Open Enrollment period and any applicable special enrollment period (SEP), consumers can voluntarily drop their COBRA coverage and enroll in Marketplace coverage instead, even if their COBRA hasn't expired. If a spouse or dependent loses ESC through a family member's employer, the spouse or dependent also may be eligible for an SEP. If a consumer decides to drop their COBRA coverage or not pay the premiums, they are not eligible for an SEP for loss of minimal essential coverage (MEC). These consumers would have to wait until they qualify for another SEP or the next Open Enrollment period.

Resources

For more information on ESC, visit:

- www.healthcare.gov/have-job-based-coverage/

For more information on COBRA, visit:

- https://www.healthcare.gov/unemployed/cobra-coverage/

For more resources from the Internal Revenue Service (IRS) on minimum value and affordability, visit:

- www.irs.gov/Affordable-Care-Act

###

Key Dates for 2018 / Draft Letter to Issuers / Draft Rate Filing Timelines

Proposed Key Dates for 2018: CMS is releasing a timeline intended to be an easy reference document for issuers and states. It consolidates the proposed key dates in 2018 related to Qualified Health Plan (QHP) certification, rate review, and risk adjustment.

Click here: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Proposed-Key-Dates-for-Calendar-Year-2018.pdf

Draft Letter to Issuers: CMS released the draft 2019 Annual Issuer Letter that provides guidance to issuers on technical policy and operational matters related to QHPs, including stand-alone dental plans (SADPs), seeking to be certified or recertified for offer through the Federally-facilitated Marketplace (FFM).

- The 2019 Draft Letter to Issuers (LTI) is available here:https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2019-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf
- Fact Sheet for LTI https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/2019-Draft-Annual-Letter-to-Issuers-for-2019.html

Draft Bulletin: Proposed Timing of Submission of Rate Filing Justifications for the 2018 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2019: CMS is releasing a draft bulletin that proposes the deadline for health insurance issuers to submit rate filing justifications for single risk pool coverage in the individual and small group markets. The bulletin also proposes the dates CMS will post proposed and final rate changes for single risk pool coverage for the 2019 plan year. Click here:

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-2018-filing-timeline-bulletin.pdf

###

Don't Forget! Weekly Enrollment Snapshots

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 Marketplaces, the State Partnership Marketplaces, and some State-based Marketplaces. 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.

Weekly Enrollment Snapshot- Week 6: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-12-13.html

First Half of 2017 Average Effectuated Enrollment Report: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-12-13-2.html.

###

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.

###

Request an Eligibility Appeal Webinar

The Friday, December 1 webinar with presentations on Resolving Data Matching Issues, and Frequently Asked Questions on Marketplace Eligibility Appeals & Review of the Standard Operating Procedures Manual for Assisters, Chapter 10: Request an Eligibility Appeal is available at: https://goto.webcasts.com/starthere.jsp?ei=1155604&tp_key=8ccce53d17.

###

MACRA/Quality Payment Program (QPP) Updates

Eligible Hospitals and CAHs: Remember to Use a QualityNet Account to Attest to CMS in 2018

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

Starting January 2, 2018, Medicare eligible hospitals and CAHs must attest to CMS for the EHR Incentive Program through QNet. The change applies to calendar year (CY) 2017 attestations, as well as future reporting periods. QNet is the same system Medicare eligible hospitals and CAHs currently use for clinical quality measure (CQM) reporting.

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

Attestations from prior years will be view only on the Registration and Attestation System for Medicare eligible hospitals and CAHs after December 31, 2017.

Create or Update Your QNet Account

New user enrollment is now open on the QNet portal. You can take one of two actions:

- **If you don't have an account on QNet** already from previous CQM submissions, you'll need to create a new one before you attest.
- **If you—or the person/department at your hospital who usually submits EHR Incentive Program data—already has an account**, you'll need to update that existing account by adding the "meaningful use" role before attestation. If your organization's account has several users associated with the account, you may not have permission to make the change. The account's designated "Security Administrators" can make the "meaningful use" role update.

The QNet Enrollment and Login User Guide offers step-by-step guidance for the enrollment process.

For More Info

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

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

CMS will distribute more information on this transition as it becomes available. In the meantime, don't forget to review the 2017 Modified Stage 2 and Stage 3 EHR Incentive Program requirements to ensure you are ready to attest in 2018.

###

REMINDER: 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.

###

Quality Payment Program Early Login Release

To prepare for the January 2, 2018 opening of the data submission period for the 2017 performance year, CMS has launched an Early Login of the qpp.cms.gov website. This Early Login launch will allow users to log into the qpp.cms.gov website using their established Enterprise Identity Management (EIDM) credentials to verify their authorized roles. CMS will be able to verify that the import of EIDM credentials and roles was completed correctly and, address any users' issues or questions.

Helpful Weblinks:
Updated QPP Home Page: https://qpp.cms.gov/

###

Sign in to Quality Payment Program and Verify Your Credentials

Ready to sign in to the Quality Payment Program for Performance Year 2017?

Good news! You can now:

1. Use your Enterprise Identity Management (EIDM) credentials to sign in to the Quality Payment Program.
2. Verify your account information. If needed, update your account information in the CMS Enterprise Portal.

Sign in to the Quality Payment Program to report data when the submission window opens on January 2, 2018.

The CMS Web Interface submission window opens on January 22, 2018.

For questions or problems signing in to the Quality Payment Program:

- Email the Quality Payment Program Service Center at QPP@cms.hhs.gov
- Call 1-866-288-8292; TTY: 1-877-715-6222

Interested in Quality Payment Program usability evaluations?

CMS is looking for Medicare clinicians, practice managers, administrative staff, or EHR and Registry vendors, to participate in user research activities to validate current and future Quality Payment Program website functionality. We value your suggestions and recommendations. If you're interested in any upcoming user studies, please email Partnership@cms.hhs.gov.

###

NOTICE: Deadline extended for the MACRA Measure Development Plan Call for TEP

This is a notice that the deadline for the Call for Technical Expert Panel for the MACRA Measure Development Plan has been extended to 11:59 p.m. ET on **January 8, 2018**.

Health Services Advisory Group, Inc. (HSAG), Measure & Instrument Development and Support contractor to the Centers for Medicare & Medicaid Services (CMS), is seeking nominations for representatives of the following 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
- Health information technology

This TEP will provide expertise related to measure development for the Quality Payment Program. Nominations close at 11:59 p.m. ET on **January 8, 2018**.

For more information about the project and to download the TEP Nomination Form, go to the Technical Expert Panels page at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Technical-Expert-Panels.html and click: "Currently Accepting Nominations (this includes the Panel Call, the Nomination form and the TEP Charter)."

1. For information, click: "CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)."

2. To download the TEP Nomination Form, scroll to the "Downloads" section at the bottom of the page and click: "CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) [ZIP]."

For questions or technical assistance, please email to MACRA-MDP@hsag.com.

Sincerely,

MACRA MDP Project Team

Health Services Advisory Group, Inc.

###

Merit-based Incentive Payment System Improvement Activities Category Call for TEP

This is a notice regarding a current call for nominations for the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) Improvement Activities (IA) Technical Expert Panel (TEP).

As part of its improvement activity development process, CMS is seeking feedback from a group of stakeholders, consumers, patients and experts who can contribute direction and thoughtful input on the improvement activities during development and maintenance. HealthInsight is a subcontractor on this project, and is working to convene a TEP around the effectiveness and accuracy of the improvement activities (IAs) included in year 1 of the Quality Payment Program under the Merit-based Incentive Payment System's (MIPS) Improvement Activities performance category.

We are seeking a TEP of approximately 10-12 clinicians and individuals with the following perspectives and areas of expertise:

- Subject matter/clinical expertise with IAs
- Consumer/patient/family (non-medical caregiver)
- Healthcare disparities
- Performance measurement
- Quality improvement

The nomination period closes at **5:00 pm PST** on **January 12, 2018**.

For more information, or to download the TEP Nomination Form, review the full posting on the Technical Expert Panels page at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/TEP-Currently-Accepting-Nominations.html#456.

###

Medicare and Medicaid Updates

CMS Updates Website to Compare Hospital Quality

Agency continues to incorporate feedback to ensure reliable information is reported

The Centers for Medicare & Medicaid Services (CMS) updated data on the *Hospital Compare* website and on data.medicare.gov to provide patients, families and all stakeholders with the information they need to compare the performance of hospitals where they seek medical care. Along with data on quality measures, CMS will also update the Overall Hospital Star Rating.

"CMS is committed to empowering beneficiaries by providing transparent, comprehensive, and reliable information," Verma said.

Hospital Compare (https://www.medicare.gov/hospitalcompare/search.html) reports information on quality measures for over 4,000 hospitals nationwide, including Veterans Administration (VA) Medical Centers and military hospitals. The website provides information for patients and caregivers on how well hospitals deliver care and encourages hospitals to improve the quality of care they provide. Users can compare performance across many common conditions.

For this update, CMS will respond to stakeholder concerns by updating several existing measures and the Overall Star Rating. The Overall Star Rating has been revised to use an enhanced methodology to assign ratings to hospitals, based on Technical Expert Panel recommendations and public input "We continue to refine the Star Ratings and look forward to an ongoing dialogue with hospitals and patients and their families on how we can provide beneficiaries useful information," Verma said.

CMS's Overall Hospital Quality Star Rating on *Hospital Compare* was first displayed in July 2016, and we intend to update the rating twice per year, in July and December. CMS is committed to working with stakeholders in a transparent manner to evaluate and update the Overall Star Rating.

As a proven healthcare consumer tool, the Overall Hospital Quality Star Rating summarizes data from existing measures on *Hospital Compare* for each hospital to allow its users to easily compare hospital facilities. In addition, with data.medicare.gov, users can explore and download hospital data, as well as data on ambulatory surgical centers, inpatient psychiatric facilities, and some cancer hospitals.

As part of the December update, CMS will post supporting documents related to the Star Ratings on the *QualityNet* website:

- **Quarterly Specifications** – Provides updates on various national distributions of the Star Ratings: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775959066
- **Comprehensive Methodology** – Provides several enhancements to the Overall Star Rating methodology: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775957165
- **SAS Pack** – Provides materials to calculate individual Star Ratings: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775958130

CMS will post the summary of comments from the public comment period on the Technical Expert Panel recommendations on cms.gov in the Public Input Summary Report, which provides stakeholders with results of public input collected last fall. The public input period was intended to draw comments on several enhancements to the Star Ratings recommended by a Technical Expert Panel and other stakeholders. CMS will post this report on cms.gov at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Public-Comments.html.

###

Long-Term Care Hospital (LTCH) Compare Website – New Measures Added

This fact sheet contains information about the Long-Term Care Hospital (LTCH) Compare website that was refreshed with new quality measures added on December 12, 2017.

I. Background
Why is this information being released?

Section 3004(a) of the Affordable Care Act established the LTCH Quality Reporting Program (QRP) and requires the Secretary of Health and Human Services to establish procedures for making quality data submitted by LTCHs available to the public. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) also requires public reporting

of provider performance two years following the specified application date (the date data collection began). Historically, new items are added to the programs in the fall. This Compare refresh release contains data from over 400 LTCHs.

What new measures were added to LTCH Compare?

1. Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccination (NQF #0680)

- Data Collection Period: July 1, 2015 – June 30, 2016 (displayed as October 1, 2015 – March 31, 2016)
    - Measure suppressed by CMS due to measure calculation error

2. Influenza Vaccination among Healthcare Personnel (NQF #0431)

- Data Collection Period: July 1, 2015 – June 30, 2016 (displayed as October 1, 2015 – March 31, 2016)

3. National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)

- Data Collection Period: January 1, 2016 – December 31, 2016

4. National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717)

- Data Collection Period: January 1, 2016 – December 31, 2016

What measures are currently displayed on LTCH Compare?

1. Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF # 0678)

- Data Collection Period: January 1, 2016 – December 31, 2016

2. National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF # 0138)

- Data Collection Period: January 1, 2016 – December 31, 2016

3. National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139)

- Data Collection Period: January 1, 2016- December 31, 2016

4. All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge From Long-Term Care Hospitals (NQF #2512)

- Data Collection Period: January 1, 2014 – December 31, 2015

What is the source of this new publicly reported data?

- Data for NQF #0680 is based upon patient assessments and were collected and submitted to CMS by LTCH providers via the Long-Term Care Hospital Continuity Assessment Record & Evaluation (LTCH CARE) Data Set.
- Data for NQF #0431, #1716, and #1717 was collected and submitted to CMS by LTCH providers via the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN).

What is the source of this new publicly reported data?

- Data for NQF #0680 is based upon patient assessments and were collected and submitted to CMS by LTCH providers via the Long-Term Care Hospital Continuity Assessment Record & Evaluation (LTCH CARE) Data Set.
- Data for NQF #0431, #1716, and #1717 was collected and submitted to CMS by LTCH providers via the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN).

How is the data on the LTCH Compare site relevant to consumers? How will they use the site?

LTCH Compare takes quality measure data and puts them into a readily useful format for the public to get a snapshot of the quality of care provided by each hospital.

II. Summary of Findings for New Measures

LTCH Measure Name and Description	National Rate of Quality Measure Performance (CY2016)
Patients assessed and given influenza vaccination *Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccination (NQF #0680)*	***
Influenza Vaccination Coverage Among Healthcare Personnel *Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)*	77%**
Methicillin-resistant Staphylococcus aureus (MRSA) Bacterial Infection *National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)*	0.909*
Clostridium difficile Infection (CDI) *National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)*	0.846*

**Reported as National Standardized Infection Ratio (SIR)*
*** NQF #0680 and NQF #0431 are calculated based on July 1, 2015 through June 30, 2016 (displayed as October 1, 2015 – March 31, 2016)*
**** Data for the NQF #0680 measure is suppressed for the December refresh due to errors in the measure calculations*
The Standardized Infection Ratio (SIR) is the primary summary measure used by the National Healthcare Safety Network (NHSN) to track healthcare associated infections (HAIs).

II. Summary of Findings for Current Measures

LTCH Measure Name and Description	National Rate of Quality Measure Performance (CY2015)	National Rate of Quality Measure Performance (CY2016)
Patients with New or Worsened Pressure Ulcers Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF # 0678)	1.8%	1.9%
Catheter-Associated Urinary Tract Infection (CAUTI) National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure (NQF # 0138)	0.994*	0.960*
Central Line-Associated Bloodstream Infection (CLABSI)	0.980*	0.943*

National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection Outcome Measure (NQF #0139)		
30 Days All-Cause Unplanned Readmission All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge From Long-Term Care Hospitals (NQF #2512)	24.61%**	24.96%**

**Reported as National Standardized Infection Ratio (SIR)*
***NQF #2512 is calculated based on two years of data. In the chart above CY2015 = January 1, 2013 through December 31, 2014 and CY2016 = January 1, 2014 through December 31, 2015*
The Standardized Infection Ratio (SIR) is the primary summary measure used by the National Healthcare Safety Network (NHSN) to track healthcare associated infections (HAIs).

III. Resources Available to Providers

Where can I find more information about LTCH Compare?

- Visit the LTCH Quality Public Reporting webpage for more information on LTCH Compare.
- Visit the LTCH Quality Reporting Data Submission Deadlines webpage for more information on submitting LTCH data to CMS.
- For more information on SIRs, view the NHSN SIR Guide.

Help Desks

- For questions about the LTCH QRP payment reduction for failure to report required quality data, contact the CMS Reconsiderations and Exception and Extension helpdesk at LTCHQRPReconsiderations@cms.hhs.gov
- For general questions about data submission, including questions about the LTCH CARE Data Set, email LTCHQualityQuestions@cms.hhs.gov
- For questions about LTCH quality data submitted to CMS via CDC's NHSN, or NHSN Registration, email NHSN@cdc.gov
- For questions about LTCH Public Reporting, email LTCH Public Reporting helpdesk: LTCHPRquestions@cms.hhs.gov
- Subscribe to the Post-Acute Care Quality Reporting Program (PAC QRP) listserv for the latest LTCH Quality Reporting Program information including but not limited to training, stakeholder engagement opportunities, and general updates about reporting requirements, quality measures, and reporting deadlines.

IV. Additional Compare Sites

- Hospital Compare
- Physician Compare
- Nursing Home Compare
- Dialysis Compare
- Home Health Compare
- Inpatient Rehabilitation Facility (IRF) Compare
- Hospice Compare

###

Inpatient Rehabilitation Facility (IRF) Compare Website - New Measures Added

This fact sheet contains information about the Inpatient Rehabilitation Facility (IRF) compare website that was refreshed with new quality measures added on December 12, 2017.

I. Background
Why is this information being released?

Section 3004(b) of the Affordable Care Act established the IRF Quality Reporting Program (QRP) and requires the Secretary of Health and Human Services to establish procedures for making quality data submitted by IRFs available to the public. The

Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) also requires public reporting of provider performance two years following the specified application date (the date data collection began). Historically, new items are added to the programs in the fall. This Compare refresh contains data from over 1,100 IRFs.

What new measures were added to IRF Compare?

1. Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccination (NQF #0680)

- Data Collection Period: July 1, 2015 – June 30, 2016 (displayed as October 1, 2015 – March 31, 2016)

2. Influenza Vaccination among Healthcare Personnel (NQF #0431)

- Data Collection Period: July 1, 2015 – June 30, 2016 (displayed as October 1, 2015 – March 31, 2016)

3. National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)

- Data Collection Period: January 1, 2016 – December 31, 2016

4. National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717)

- Data Collection Period: January 1, 2016 – December 31, 2016

What measures are currently displayed on IRF Compare?

1. Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)

- Data Collection Period: January 1, 2016 – December 31, 2016

2. National Healthcare Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)

- Data Collection Period: January 1, 2016 – December 31, 2016

3. All Cause Unplanned 30 day post IRF Discharge Readmission Measure (NQF #2502)

- Data Collection Period: January 1, 2014 – December 31, 2015

What is the source of the new publicly reported data?

- Data for NQF #0680 is based upon patient assessments and were collected and submitted to CMS by IRF providers via the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI).
- Data for NQF #0431, #1716, and #1717 were collected and submitted to CMS by IRF providers via the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN).

How is the data on the IRF Compare site relevant to consumers? How will they use the site?

IRF Compare takes quality measure data and puts them into a readily useful format for the public to get a snapshot of the quality of care provided by each hospital.

II. Summary of Findings for New Measures

IRF Measure Name and Description	National Rate of Quality Measure Performance (CY2016)
Patients assessed and given influenza vaccination *Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccination (NQF #0680)*	91%**
Influenza Vaccination Coverage Among Healthcare Personnel *Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)*	84%**
Methicillin-resistant Staphylococcus aureus (MRSA) Bacterial Infection *National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)*	1.18*
Clostridium difficile Infection (CDI) *National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)*	1.16*

**Reported as National Standardized Infection Ratio (SIR)*
*** NQF #0680 and NQF #0431 are calculated based on July 1, 2015 through June 30, 2016 (displayed as October 1, 2015 – March 31, 2016)*
The Standardized Infection Ratio (SIR) is the primary summary measure used by the National Healthcare Safety Network (NHSN) to track healthcare associated infections (HAIs).

II. Summary of Findings for Current Measures

IRF Measure Name and Description	National Rate of Quality Measure Performance (CY2015)	National Rate of Quality Measure Performance (CY2016)
Patients with New or Worsened Pressure Ulcers Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF # 0678)	0.8%	0.6%
Catheter-Associated Urinary Tract Infection (CAUTI) National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure (NQF # 0138)	1.007*	1.097*
30 Days All-Cause Unplanned Readmission All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge From Long-Term Care Hospitals (NQF #2502)	13.06%**	13.39%**

**Reported as National Standardized Infection Ratio (SIR)*
***NQF #2502 is calculated based on two years of data. In the chart above CY2015 = January 1, 2013 through December 31, 2014 and CY2016 = January 1, 2014 through December 31, 2015*
The Standardized Infection Ratio (SIR) is the primary summary measure used by the National Healthcare Safety Network (NHSN) to track healthcare associated infections (HAIs).

III. Resources Available to Providers

Where can I find more information about IRF Compare**?**

- Visit the IRF Quality Public Reporting webpage for more information on IRF Compare.
- Visit the IRF Quality Reporting Data Submission Deadlines webpage for more information on submitting IRF quality data to CMS.
- For more information on SIRs, view the NHSN SIR Guide.

Help Desks

- For questions about IRF-PAI data submissions or status of data submissions via CASPER reports, call 1-800-339-9313 or email help@qtso.com.
- For questions about IRF quality data submitted to CMS via CDC's NHSN, or NHSN Registration, email NHSN@cdc.gov.
- For questions about IRF Public Reporting, email IRF Public Reporting helpdesk: IRFPRquestions@cms.hhs.gov.
- Detailed guidance on how to run and interpret IRF-PAI provider reports can be found in Section 3 of the CASPER Reporting User's Manual.
- For questions about quality measure calculation, data submission deadlines, or data items contained within the Quality Indicator section of the IRF-PAI, email IRF.Questions@cms.hhs.gov.
- Subscribe to the Post-Acute Care Quality Reporting Program (PAC QRP) listserv for the latest IRF Quality Reporting Program information including but not limited to training, stakeholder engagement opportunities, and general updates about reporting requirements, quality measures, and reporting deadlines.

###

Physician Compare Annual Measure Release – Introduction of Star Ratings

Overview

The Centers for Medicare & Medicaid Services (CMS) has added new quality information to the Physician Compare website.

The Affordable Care Act required the establishment of the Physician Compare website. The goal of the website is to help patients and caregivers make informed choices about the Medicare physicians and other clinicians they see; publicly reporting both new and updated 2016 performance information will help further that goal. The first quality measures were added to Physician Compare in February 2014. Since then, CMS has continued a phased approach to public reporting.

2016 Performance Information on Physician Compare

As the next step in CMS's phased approach to public reporting, starting in December 2017 CMS is publicly reporting certain 2016 performance information on Physician Compare. The information was designated as available for public reporting in the 2016 Physician Fee Schedule final rule.

Data are available for public reporting on public-facing profile pages and/or via the Physician Compare Downloadable Database available on data.medicare.gov. Because of the different primary audiences, CMS publicly reports information differently in the Downloadable Database than on profile pages.

The primary audience for profile pages is patients and caregivers. On the profile pages, groups may have the following measures reported: a subset of 2016 Physician Quality Reporting System (PQRS) measures reported as star ratings; Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS summary survey measures; and/or non-PQRS Qualified Clinical Data Registry (QCDR) measures.

The 2016 non-PQRS QCDR measures, available for both groups and individual clinicians, and 2016 CAHPS for PQRS measures available for only groups, are being reported as a percent – not as star ratings – on the relevant profile pages.

Group CAHPS for PQRS summary survey measures are reported as top-box scores on Physician Compare. The top-box score is the percentage of responses in the most positive response categories. Based on testing with patients and caregivers and the recommendation from the Agency for Healthcare Research and Quality (AHRQ), Physician Compare publicly reports top-box scores to ensure patient experience data is interpreted correctly.

The Downloadable Database is mainly intended as a resource for clinicians and group representatives, as well as third-party data users. Groups may have 2016 PQRS measures, CAHPS for PQRS summary survey measures, and/or non-PQRS QCDR measures included in the Downloadable Database. Individual clinicians may have 2016 PQRS and non-PQRS QCDR measures, as well as 2015 utilization data reported in the Downloadable Database. The final 2016 data will be available for download in late spring or early summer of 2018 once the informal review process has been completed. At this time, the most current general information (updated every two weeks) and performance information for 2015 is available for download.

The measures now included on Physician Compare profile pages represent a variety of types of clinical care by groups representing many different specialties. The 2016 PQRS performance information is divided into eight different categories, ranging from general care to more specialized care.

The categories include:

- Preventive care: General health
- Preventive care: Cancer screening
- Patient safety
- Care planning
- Diabetes
- Heart disease
- Respiratory diseases
- Behavioral health

In addition to the measures being reported for groups and individual clinicians, 2016 data for the Shared Savings Program, Pioneer, and Next Generation Accountable Care Organizations (ACOs) are now also publicly reported on Physician Compare. ACO measures are reported as percent performance rates. CAHPS for ACO summary survey measures are reported as means. In this way, the CAHPS for ACO performance scores are the average of all responses available for each summary survey measure.

Physician Compare also now includes information about group ACO affiliation. If a group is part of an ACO, there will be a link to that ACO's Physician Compare profile page from the group profile page.

The criteria for public reporting require that the measures must be statistically valid, reliable, accurate, and comparable across reporting mechanisms, and meet the minimum reliability threshold, to be included in the Physician Compare Downloadable Database. To be included on public facing profile pages, the data must also prove to resonate with patients and caregivers.

Star Ratings on Physician Compare

When public reporting performance information began in 2014, CMS started with a small subset of group-level Web Interface measures. Now with the use of star ratings, CMS is restarting its phased approach for the use of star ratings with just a small subset of group-level measures. For the first time this year as part of the continued phased approach to public reporting, CMS has publicly reported a small subset of 2016 PQRS group-level measures on group profile pages as star ratings.

Since star ratings are new to Physician Compare this year, it is important to understand how the star rating is constructed.

After extensive research and outreach, and hearing what stakeholders wanted to see in a benchmark and understanding the concerns and cautions raised, CMS proposed an item-level (or measure-level) benchmark using the Achievable Benchmark of Care (ABC™) methodology. This benchmark was finalized in the CY 2016 Physician Fee Schedule final rule (80 FR 71128 through 71129). The ABC™ benchmark is the "5-star rate," serving as the anchor for the star rating methodology.

As discussed in the CY 2018 Quality Payment Program final rule (82 FR 53827 through 53829), the process for choosing a star rating attribution method built upon CMS's work in choosing the ABC™ benchmark methodology. After reviewing feedback, conducting extensive statistical analysis, and consulting with the TEP, the equal ranges method was chosen. The equal ranges method for assigning star ratings is intuitive for patients and caregivers to interpret, and reflects the true performance on the measure rather than forcing a distribution. Additionally, CMS expects star rating assignments based on the equal ranges method to be more stable across years, allowing clinicians to better assess their performance year-to-

year. The equal ranges method also provides a more reliable and meaningful classification, ensuring that a 4-star performance is statistically better than and distinct from a 3-star performance on a measure, for example.

The ABC™ methodology for the benchmark and the equal ranges method for assigning star ratings were chosen because together they allow the public reporting of a statistically sound and easy-to-interpret set of data. They also give a point of comparison to help patients and caregivers interpret the performance information on Physician Compare. For more information about star ratings, visit the CMS Physician Compare Initiative page.

More Information on Physician Compare

For more information on Physician Compare, please visit the website at http://www.medicare.gov/physiciancompare. You can also go to www.medicare.gov and click on "Find doctors & other health professionals". Clinicians can visit the CMS Physician Compare Initiative page for information on keeping their general information current and troubleshooting problems, and to learn more about public reporting.

If you have questions about public reporting on Physician Compare or keeping your information current, contact the Physician Compare support team at PhysicianCompare@Westat.com.

###

Phase-out of expenditure authority for Designated State Health Programs (DSHP) in Section 1115 Demonstrations

The Centers for Medicare & Medicaid Services (CMS) has approved a number of demonstration projects, under the authority of section 1115 of the Social Security Act (section 1115 demonstrations) that include providing federal funding for state expenditures for designated state health programs (DSHP) that were previously funded entirely by the state, without federal funds.

After reviewing the practice of DSHP funding, CMS has determined it will no longer accept state proposals for new or renewing section 1115 demonstrations that rely on federal matching funds for Designated State Health Programs (DSHP).

State Medicaid Director Letter (SMD# 17-005)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850
SMD# 17-005

RE: Phase-out of expenditure authority for Designated State Health Programs (DSHP) in Section 1115 Demonstrations

December 15, 2017

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) has approved a number of demonstration projects, under the authority of section 1115 of the Social Security Act (section 1115 demonstrations) that include providing federal funding for state expenditures for designated state health programs (DSHP) that were previously funded entirely by the state, without federal funds. One stated purpose of federal DSHP funding was to ensure the continuation of these beneficial state programs while the state was incurring additional expenditures for health service delivery reform or expansion under the demonstration project. However, the result has been that many states are not contributing state funds toward these delivery system reform efforts. Instead, these states are primarily relying on dollars freed up by the federal Medicaid contribution to DSHP to draw down additional federal Medicaid matching expenditures to support delivery system reforms.

After reviewing the practice of DSHP funding, CMS has determined that it will no longer accept state proposals for new or renewing section 1115 demonstrations that rely on federal matching funds for DSHP. Federal DSHP funding has raised oversight concerns about its consistency with the federal-state financial partnership established under the Medicaid statute. Moreover, current demonstrations have not made a compelling case that federal DSHP funding is a prudent federal investment. Authority for DSHP in current demonstrations will continue until the end of the state's current demonstration period but will not be extended or renewed. CMS is available to consult with affected states interested in identifying other options to support innovative state section 1115 demonstrations that promote the objectives of Medicaid.

Background
Designated State Health Programs (DSHP) are existing state-funded health programs that have not previously qualified for federal funding, including Medicaid. DSHPs existed in the state prior to the section 1115 demonstration. As part of the demonstration, CMS historically allowed the state to count certain expenditures for the program as expenditures under the demonstration that qualify for federal matching funds, allowing the state to use the "freed up" state dollars towards its Medicaid demonstration. Unlike traditional Medicaid matching funds, which are tied to claims for specific services provided to Medicaid beneficiaries, federal matching funds provided to support DSHP have not necessarily been tied to the extent to which the DSHP serves Medicaid beneficiaries. Since 2005, HHS has authorized several states to draw federal Medicaid matching funds for DSHP under the authority of section 1115(a)(2) of the Act.

DSHP Raises Oversight Concerns and Increases Federal Expenditures
Several states have been authorized to obtain federal Medicaid matching funds for DSHP through section 1115 demonstrations that provide for expanded health coverage and delivery system reforms. The stated purpose of federal DSHP funding under these demonstrations was typically to ensure the continuation of important state programs while the state was making investments in Medicaid delivery system reform or coverage expansion. However, current demonstrations have not made a compelling case that federal DSHP funding is necessary to support the continuation of important programs previously operated by the state, and federal DSHP funding is inconsistent with the overall federal-state financial relationship under the Medicaid statute.

Federal DSHP funding has appeared to serve primarily as a financing mechanism for the state, rather than being an integral part of the delivery system or coverage reforms under the approved section 1115 demonstrations. In most approved demonstrations, the amount of DSHP funding is tied to expenditures under the demonstration for delivery system reform activities, so that the federal DSHP funding frees up state dollars that the state can expend to obtain additional federal match. This, in effect, results in increased federal expenditures without a comparable increase in the state's investment in its demonstration.

CMS has been working to increase internal controls related to documenting that approved DSHPs are likely to assist in promoting the objectives of Medicaid. The use of demonstration authority to match state DSHP expenditures has also been of interest to Congressional oversight committees, and the Government Accountability Office (GAO). As part of these efforts, CMS began requesting additional documentation of demonstration purposes being served by federal DSHP funding in demonstration proposals. CMS also began requiring states to submit claiming protocols to ensure only allowable DSHP costs were matched with federal Medicaid funds.

In general, this documentation has confirmed that federal DSHP funding is primarily used by states to obtain additional federal funds without state match, and not as an integral part of a Medicaid delivery system or coverage reform demonstration. For example, one state's approved DSHP includes an immunization program and tobacco use prevention that previously were funded entirely by the state, without federal Medicaid matching funds, and do not appear integral to the state's section 1115 demonstration supporting delivery system reform. Another state received DSHP for a child growth and nutrition program and for a renal disease program, which were not integral to the state's 1115 demonstration for delivery system reform and coverage expansion.

Other Programmatic and Financing Mechanisms Available
CMS is committed to working with states to help identify other strategies to support innovation and improvement to their Medicaid programs. Delivery system reform and coverage expansion approaches that are effective and efficient should advantage the local, state, and federal governments while maintaining the integrity of the statutory funding structure. CMS is available to consult with states interested in identifying options to support innovative state section 1115 demonstrations that promote the objectives of Medicaid.

Next Steps
In addition to this letter, the Centers for Medicaid and CHIP Services (CMCS) will conduct direct outreach to states with existing DSHPs to emphasize that the authority for DSHP will not be extended beyond the currently approved demonstration period. CMS will work with states with pending demonstration proposals that include DSHP as a funding mechanism to identify other options to support innovative state section 1115 demonstrations that promote the objectives of Medicaid.

Questions and comments regarding this policy may be directed to Judith Cash, Acting Director, State Demonstrations Group, CMCS, at 410-786-9686.
Sincerely,
/s/
Brian Neale
Director

cc:

National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
National Conference of State Legislatures
American Public Human Services Association
Association of State and Territorial Health Officials
Council of State Governments

###

Comprehensive End-Stage Renal Disease Care (CEC) Model: Performance Year 1 Annual Evaluation Report

The Comprehensive ESRD Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD). Through the CEC Model, CMS is partnering with dialysis facilities and nephrologists that form ESRD Seamless Care Organizations (ESCOs), which are specialty-based Accountable Care Organizations. The Performance Year 1 Annual Evaluation Report contains impact estimates for the CEC Model on quality of care, quality of life, utilization, and cost outcomes in the first performance year of the model, which lasted from October 2015 to December 2016. It also presents descriptive information about ESCOs and their reasons for participating in the CEC Model.

For more information on the Comprehensive ESRD Care (CEC) Model Year 1 Annual Report click here: https://innovation.cms.gov/Data-and-Reports/index.html

###

CMS strengthens federal support to California residents affected by wildfires

Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma announced that the agency has taken immediate steps and is monitoring conditions in support of California residents displaced and recovering from the wildfires ravaging southern portions of the state. On Dec.11, 2017, Acting Health and Human Services Secretary Eric D. Hargan declared a public health emergency (PHE) in the state of California retroactive to Dec. 4, 2017. The PHE allows CMS to waive or modify certain Medicare, Medicaid and Children's Health Insurance Program (CHIP) requirements if necessary to provide health services.

"While the lives and homes of southern Californians remain at risk from dangerous wildfires, CMS is taking the necessary steps to provide flexibilities that help meet the medical needs of the individuals and families affected," said Administrator Verma. "Our work will continue as long as the people impacted work to recover, rebuild their lives, and access care for themselves and their families."

The agency has taken the following steps to support the state of California and those residents impacted by wildfires:

- **Waivers for Skilled Nursing Facilities and Assistance for Hospitals and other Healthcare Facilities:** CMS issued a blanket Skilled Nursing Facility waiver, described on the website below; and the Regional Office has provided numerous technical assistance responses to the state, California Hospital Association and providers on specific types of CMS and other HHS program flexibilities that were available with and without waivers. These program flexibilities and waivers work to provide continued access to care for beneficiaries. For more information on the waivers CMS granted, visit https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html

- **Special Enrollment Opportunities and Medicare Flexibilities:** CMS is providing beneficiaries affected by the California wildfires a Special Enrollment Period (SEP) that gives them an additional opportunity through March 31, 2018 to add, drop or change their Medicare health and prescription drug plan in the event they are eligible for an SEP and were unable to make an election during the fall open enrollment period or another election period for which they were eligible. For more information on these special enrollment periods, visit: https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Extension-SE-Period-PR-VI-CA-Wildfire.pdf. When a public health emergency is in effect, Medicare Advantage Organizations in affected areas are required to waive prior authorization and other gatekeeper requirements and to allow care to be provided by

non-contracted providers and facilities. In addition, Part D plan sponsors are expected to lift certain limit for drug benefits.

- **Dialysis Care:** Dialysis patients who are unable to receive dialysis services at their usual facility and who need assistance to locate a facility where they can be dialyzed, should call the NW 18 (Southern California) Patient Hotline (800) 637-4767 for assistance. The following large dialysis organization hotline numbers are also available for patients: DaVita *Emergency* Dialysis Services: (800) 400-8331, *Fresenius* Kidney Care *Emergency Hotline:* (800) 626-1297, Dialysis Clinic Inc. (DCI) Emergency Command Center: (866) 424-1990, and U.S. Renal Care Emergency Hotline: (866) 671-USRC (8772).

- **Healthcare Provider Hotline:** CMS established a toll-free hotline servicing Medicare's Part B providers and suppliers in California. The hotline is intended to assist non-certified Part B suppliers, physicians and non-physician practitioners helping with recovery efforts enroll in federal health programs and receive temporary Medicare billing privileges. CMS is temporarily waiving the application fee, finger print-based criminal background checks, site visits, and in-state licensure requirements usually required for providers to access Medicare billing privileges. The toll-free hotline telephone number is (855) 259-2396.

We encourage people with federal benefits and providers and suppliers of healthcare equipment and services that have been impacted by the California wildfires, to seek help by visiting CMS' emergency webpage (www.cms.gov/emergency).

To read updates regarding HHS activities related to the California wildfires, visit https://www.phe.gov/emergency/events/ca-wildfires2017/Pages/default.aspx

###

2019 Medicare Advantage Part I Advance Notice – Risk Adjustment

The Centers for Medicare & Medicaid Services (CMS) released Part I of the 2019 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part D Payment Policies (the Advance Notice), which contains key information about proposed updates to the Part C Risk Adjustment Model and the use of encounter data.

The 2019 Advance Notice is being published in two parts this year due to requirements in the 21st Century Cures Act, which mandated certain changes to the Part C risk adjustment model and a 60 day comment period for these changes. Changes to other payment methodologies proposed for the following calendar year that are typically contained in the Advance Notice only require a 30 day comment period and will be released in accordance with that statutory deadline. The payment policies for 2019, proposed in both in Part I and Part II of the Advance Notice, will be finalized in the annual Rate Announcement. To be assured consideration, comments on the proposals announced today should be submitted by March 2, 2018.

2019 Part C Risk Adjustment Model proposal

The 21st Century Cures Act amended the Social Security Act by, in part, requiring CMS to make improvements to risk adjustment for 2019 and subsequent years. In response to these requirements, we are proposing changes to the CMS-HCC Risk Adjustment model that is used to pay for aged and disabled beneficiaries enrolled in Medicare Advantage plans. These proposals reflect changes to risk adjustment required by the 21st Century Cures Act, including an evaluation of adding mental health, substance use disorder, and chronic kidney disease conditions to the risk adjustment model and making adjustments to take into account the number of conditions an individual beneficiary may have, as well as a variety of additional technical updates. Further, the 21st Century Cures Act requires that CMS fully phase in the required changes to the risk adjustment model by 2022. We are therefore proposing to begin the phase in of this new model in 2019, starting with a blend of 75% of the risk adjustment model used for payment in 2017 and 2018 and 25% of the new risk adjustment model proposed.

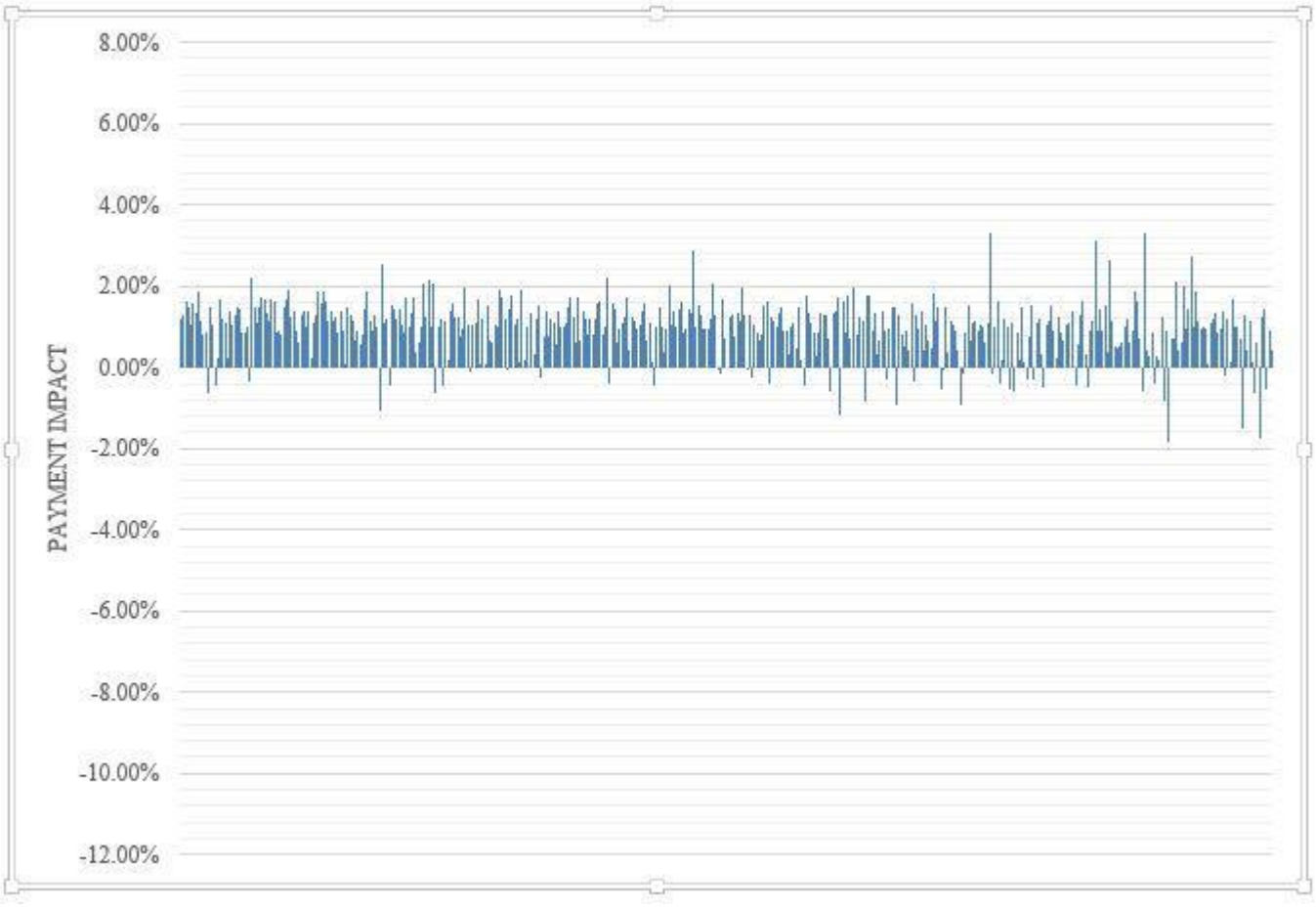
For 2019, CMS is proposing a model that includes additional mental health, substance use disorder, and chronic kidney disease conditions in the risk adjustment model.

With respect to taking into account the number of conditions an individual beneficiary has, in Part 1 of the Advance Notice we describe a proposed new risk adjustment model and discuss an alternative model. The model we are proposing – the "Payment Condition Count model" – takes into account the number of conditions that a beneficiary has, only among the

conditions that are included in the payment model. The model discussed as an alternative – the "All Condition Count model" – takes into account all conditions that a beneficiary has, including both those in the payment model and those not in the model.

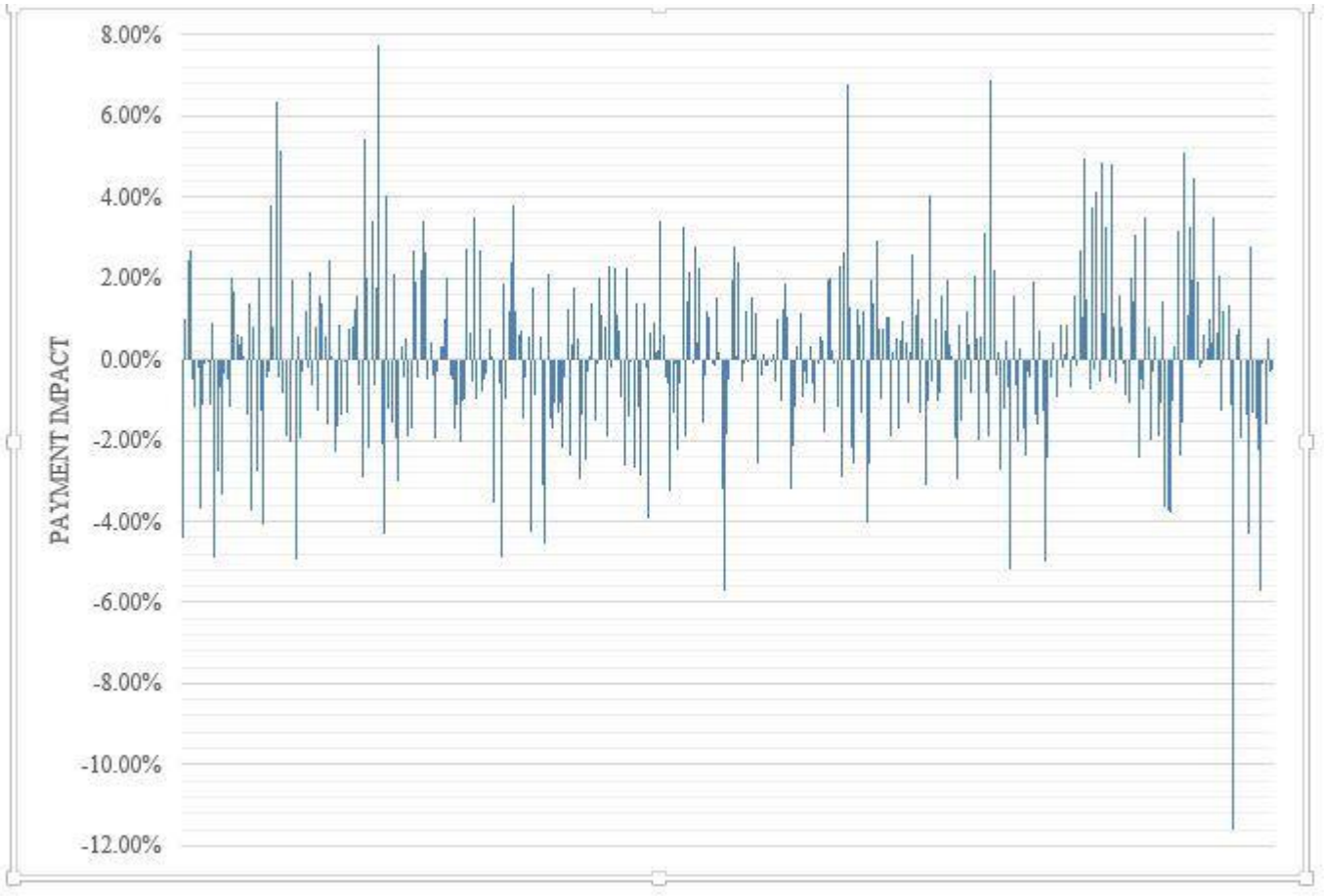
The charts below indicate the range of contract-level impacts of each of these CMS-HCC Risk Adjustment models on Medicare Advantage risk scores. Overall, while the experience of individual plans would vary, the Payment Condition Count model is projected to increase MA risk scores by 1.1%, while the All Condition Count model would decrease MA risk scores by -0.28%. Under the Payment Condition Count model, the change in MA contracts' risk scores is generally positive and less varied than the All Condition Count model. The change in MA contracts' risk scores under the All Condition Count model is more varied, with both negative and positive changes.

Payment Condition Count model – Percent change in MA contract-level risk scores



This graph displays the estimated percent change in payment for 446 Medicare Advantage contracts. Each line indicates the Payment Condition Count model's estimated impact on payment for 1 contract.

All Condition Count model – Percent change in MA contract-level risk scores



This graph displays the estimated percent change in payment for 446 Medicare Advantage contracts. Each line indicates the All Condition Count model's estimated impact on payment for 1 contract.

Using Encounter Data

The model we are proposing in Part 1 of the Advance Notice also makes technical updates, including calibrating the model with more recent data, selecting diagnoses with the same method used for encounter data, and supplementing encounter data used in payment with inpatient data submitted to the historical risk adjustment data collection system (the Risk Adjustment Processing System (RAPS)).

CMS calculates risk scores using diagnoses submitted by Medicare FFS providers and by Medicare Advantage organizations. Historically, CMS has used diagnoses submitted into CMS' RAPS by Medicare Advantage organizations. In recent years, CMS began collecting encounter data from Medicare Advantage organizations, which also includes diagnostic information. In 2016, CMS began using diagnoses from encounter data to calculate risk scores, by blending 10% of the encounter data-based risk scores with 90% of the RAPS-based risk scores. For 2017 and 2018, CMS continued to use a blend to calculate risk scores, by calculating risk scores with 25% encounter data and 75% RAPS in 2017, and 15% encounter data and 85% RAPS in 2018. For 2019, CMS proposes to calculate risk scores by adding 25% of the risk score calculated using diagnoses from encounter data and FFS diagnoses with 75% of the risk score calculated with diagnoses from RAPS and FFS diagnoses. CMS is also proposing to implement the phase-in of the new risk adjustment model by calculating the encounter data-based risk scores exclusively with the new risk adjustment model, while maintaining use of the current 2018 risk adjustment model for calculating risk scores with RAPS data.

Process

Comments on the proposals set forth in Part I of the proposed Advance Notice must be submitted by Friday, March 2, 2018. The final 2019 Rate Announcement will be published by Monday, April 2, 2019.

To submit comments or questions electronically, go to www.regulations.gov, enter the docket number "CMS-2017-0163" in the "search" field , and follow the instructions for ''submitting a comment.''

The Advance Notice and Draft Call Letter may be viewed through: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html and selecting "Announcements and Documents."

###

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.

###

Medicare Learning Network

News & Announcements

- New Medicare Card: Less Than Four Months until Transition Begins
- IRF and LTCH Compare Quarterly Refresh: New Measures Added
- Hospice Compare Quarterly Refresh
- MACRA Measure Development Plan Technical Expert Panel: Submit Nominations by December 20
- Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests: Request for Nominations
- QRDA I Conformance Statement Resource
- Provider Enrollment Application Fee Amount for CY 2018
- 2018 Medicare EHR Incentive Program Payment Adjustment for Eligible Clinicians
- Physician Compare: 2016 Performance Information Available

Provider Compliance

- Payment for Outpatient Services Provided to Beneficiaries Who Are Inpatients of Other Facilities
- Bill Correctly for Device Replacement Procedures
- Medicare Hospital Claims: Avoid Coding Errors — Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Call — January 9

Claims, Pricers & Codes

- If You Submit Paper Claims: Avoid Crossover Issues

Medicare Learning Network Publications & Multimedia

- IRF Medical Review Changes MLN Matters Article — New
- IRF Reference Booklet — New
- Quality Payment Program Call: Audio Recording and Transcript — New
- Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims MLN Matters Article — Updated
- Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims MLN Matters Article — Updated
- December 2017 Catalog — Revised
- IRF Prospective Payment System Booklet — Revised
- DMEPOS Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers Fact Sheet — Revised
- DMEPOS Competitive Bidding Program Traveling Beneficiary Fact Sheet — Revised
- Medical Privacy of Protected Health Information Fact Sheet — Reminder
- Behavioral Health Integration Services Fact Sheet — Reminder
- Medicare Basics: Commonly Used Acronyms Educational Tool — Reminder
- Evaluation and Management Services Web-Based Training Course — Reminder
- Medicare FFS Response to the 2017 Southern California Wildfires MLN Matters Article — New
- Medicare Diabetes Prevention Program Model Call: Audio Recording and Transcript — New
- Hospice Payment System Booklet — Revised
- Ambulance Fee Schedule Fact Sheet — Revised
- Medicare Overpayments Fact Sheet — Revised

###

Join us for the CMS National Training Program Learning Series Webinar

January 11, 2018 1:00 – 2:30 pm ET

This webinar will provide an overview of when people can enroll in or change Medicare coverage, including the following:

- Initial Enrollment Period
- Open Enrollment Period
- General Enrollment Period
- Special Enrollment Periods (Qualifying events, Part B Special Enrollment Period, 5-Star Special Enrollment Period)
- Unique opportunities to make coverage decisions
- Helpful Resources

###

To register for this event, visit https://goto.webcasts.com/starthere.jsp?ei=1176499&tp_key=917070c070

FCC Proposals for the Rural Health Care Program Request for Comments

The Federal Communications Commission (FCC) is seeking public comment on possible changes to the Rural Health Care Program (RHC). This program provides up to $400 million every year to support telecommunications for health care delivery in rural and underserved areas of the country. The FCC is seeking input on the viability of the $400 million cap and alternative options to meet the needs of rural health care providers who take part in the program. **FORHP will soon be**

scheduling a webinar to discuss this Notice of Proposed Rulemaking (NPRM) in more detail, as well as some of the key issues to consider for rural hospitals, clinics and telehealth providers. Once the NPRM is formally published in the Federal Register, the FCC will open a 30-day window for public comment. Watch this space for more information about these issues.

###

Rural Matters Podcast

Tom Morris, Associate Administrator for the Federal Office of Rural Health Policy, spoke with John White in the December 12th edition of the Rural Matters podcast. The focus of the conversation was the sobering fact borne out by research that rural Americans are dying at an earlier age and at a higher rate than urban Americans. Some of the conditions that are leading to the higher rate of death in rural, including certain chronic diseases and opioid addiction, could be prevented through timely intervention, education, and better access to health care. Rural Matters is a biweekly, 30-minute podcast about rural education, business, and health. Guests include rural education decision-makers, rural business owners and entrepreneurs and rural health care representatives.

###

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.