CMS Region 7 Updates – 01/12/2018

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ACA/Marketplace Updates

Reminder: Health Plan Coverage Effectuation

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

How to Assist Consumers with their First Premium Payment

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

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

What happens if a consumer misses a payment?

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

Under current rules, marketplace plan issuers must:

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

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

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

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

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

Frequently Asked Questions (FAQ) by Assisters:

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

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

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

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

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

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

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

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

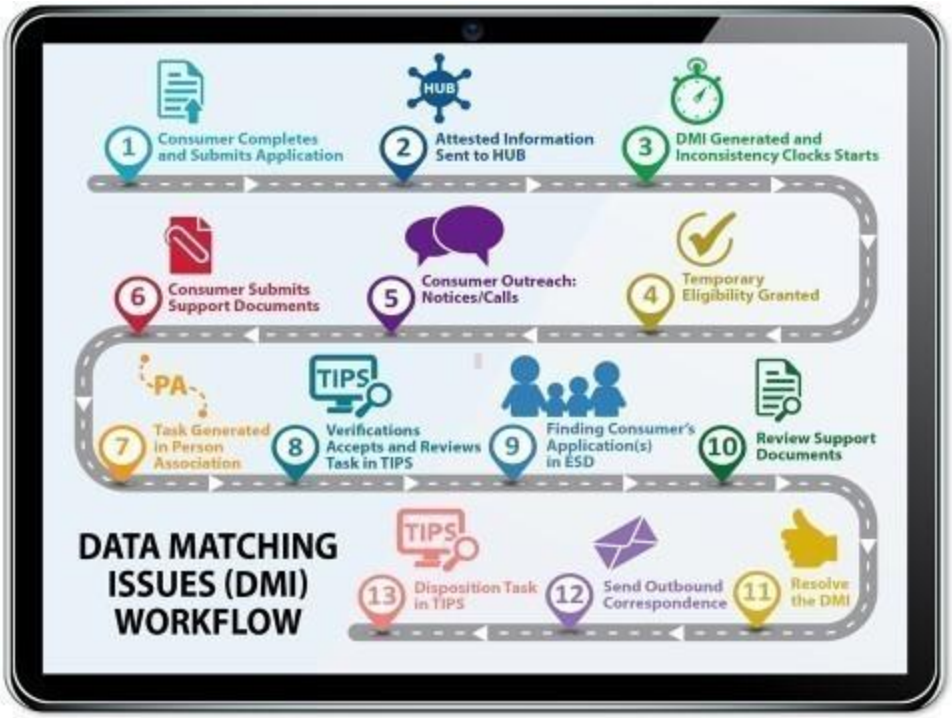
TIP: We also encourage assisters to see **this Tip Sheet on Helping Consumers Affected by Grace Periods Related to Non-Payment of Premiums**, and SOP-9 of the **Standard Operating Procedures Manual for Assisters in the Individual Federally-facilitated Marketplaces**.

###

Reminder: Help Consumers Resolve their DMIs

A) Resolving Data Matching Issues (DMIs)

Now that open enrollment for 2018 coverage is over, it's important for assisters to understand how to reduce potential data matching issues (DMIs). Similarly, it's crucial for consumers to know how and when to submit requested information and the timeline to do so in order to resolve the DMI and avoid having their coverage terminated.

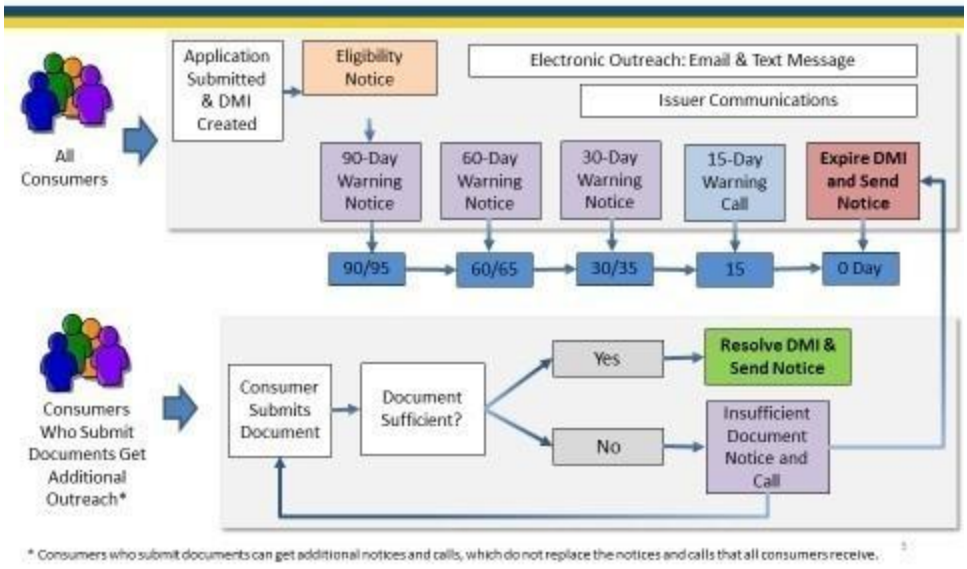


After submitting a Marketplace application, the system verifies the consumer's information to determine eligibility. But in some cases, the information the applicant provides does not match existing records from trusted data sources (TDSs) such as Internal Revenue Service (IRS), Social Security Administration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

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

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

Consumer Outreach



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

Impact of DMI Expiration

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

B) Steps to Help Resolve DMIs

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

1. A consumer failed to provide a Social Security Number (SSN) on the application.

2. A consumer failed to provide all household income on the application.

3. A consumer's name as entered in the application differs from how it appears in his or her citizenship document or other document.

4. A consumer failed to provide his or her immigration documents and ID numbers.

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

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

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

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

###

Refresher: Marketplace Appeals

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

- Consumers can submit an appeal request by mailing an appeal request form, mailing an appeal request letter, or faxing the form or letter. See the different ways consumers can **request an appeal** (also available in **Spanish**).

- Different states have different appeals request forms. Find **Appeal Request Forms** that apply for the consumer's state (also available in **Spanish**).

- Help consumers learn how to request an **expedited appeal** (also available in **Spanish**) if the time needed for the standard appeal process would jeopardize the consumer's life, health, or ability to attain, maintain, or regain maximum function.

- Some consumers will file certain appeals through the Marketplace or through their State Medicaid or CHIP agency; depending on their state and eligibility result. Make sure to review consumers' eligibility notices for directions. Find out what **eligibility notices** look like.

- Encourage consumers to include a copy of their eligibility notice when they file an appeal. Find **information** on what to do if a consumers submits and appeal request and the Marketplace Appeals Center tells them their appeal is "invalid." They might need to take certain actions to get their request considered.

- Check out this presentation to learn about the **Marketplace eligibility appeals process**.

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

###

Loss of Qualifying Health Coverage SEP

Consumers may qualify for a Special Enrollment Period (SEP) if they (or anyone in your household) lost qualifying health coverage (or "minimum essential coverage"). Some examples of qualifying coverage include:

1. Loss of Qualifying Health Coverage (Coverage through a job, or through another person's job)
2. Medicaid or Children's Health Insurance Program (CHIP) Coverage (Includes pregnancy-related coverage and medically needy coverage)
3. Medicare
4. COBRA (Consumers who selected COBRA may qualify for a Loss of Qualifying Coverage SEP if an employer stops making payments toward part of the consumer's COBRA premium)
5. Individual or group health plan coverage that ends during the year
6. Coverage under your parent's health plan (if you're on it) If you turn 26 and lose coverage, you can qualify for this Special Enrollment Period

Remember: Under Marketplace rules, consumers are not eligible for a SEP based on loss of minimum essential coverage (MEC) if they:

- Voluntarily terminated their coverage
- Didn't pay their premiums
- Coverage was taken away because of fraud or intentional misrepresentation.

However, in cases when an employee terminates employer sponsored coverage (that meets the MEC standard) on behalf of a spouse or dependent, the spouse or dependent is considered an involuntary termination of coverage. This means that the spouse or dependent may be eligible for a SEP based on loss of qualifying coverage.

Note: Some consumers may not have been automatically re-enrolled in 2018 coverage because their former plan was discontinued for 2018 and the insurance company doesn't offer a similar plan, or their insurance company is no longer offering plans through the Marketplace for 2018. In these cases, the consumer may qualify for a loss of qualifying coverage SEP to enroll in a different plan for 2018.

To check if a consumer was re-enrolled in 2018 coverage, or see whether a consumer was re-enrolled into an alternate plan with a different insurance company, consumers can:

1. Log in and click "Start a new application or update an existing one." A blue box at the top of the next page will display, if they have been automatically enrolled in a plan. They can review plan details under "My Plans & Programs."
2. If a consumer was automatically enrolled, they would have received a notice. Log in and click "Messages" to view the notice.
3. If a 2018 application is marked "Status: Complete" in a consumer's Marketplace account, the consumer is enrolled in a plan for 2018.

For more information on Loss of Qualifying Coverage SEP, please refer to the following links:

1. "Understanding Special Enrollment Periods" – https://marketplace.cms.gov/outreach-and-education/special-enrollment-periods-available-to-consumers.pdf
2. "Special Enrollment Period (SEP): Overview for the Federally-facilitated Marketplace" - https://marketplace.cms.gov/technical-assistance-resources/sep-overview-session.pdf
3. "Complex Case Scenarios Preventing Gaps in Health Care Coverage Mini-Series: Transitioning from Employer-Sponsored Coverage to Other Health Coverage" - https://marketplace.cms.gov/technical-assistance-resources/transitioning-from-employer-coverage.pdf

"If you lose job-based health insurance" - https://www.healthcare.gov/have-job-based-coverage/if-you-lose-job-based-coverage/

###

"Pre-enrollment SEP Verification" Process

Summary: Last summer, CMS launched a pre-enrollment SEP Verification (SEPV) process to verify SEP eligibility for consumers newly enrolling in Marketplace coverage through the most common SEP types. Under the process, the Marketplace creates an SEP Verification Issue, referred to as an SVI, for new Marketplace applicants who submit an application and attest to information that qualifies them for an SEP. Consumers are required to submit documents to confirm their SEP eligibility before they can complete enrollment, make their first premium payment, and start using their Marketplace coverage.

Consumers newly enrolling in Marketplace coverage through any of the SEPs listed below will be required to submit documents to confirm their SEP eligibility before they can begin using their coverage. If consumers qualify for any of these SEPs, they will be asked in the **Eligibility Determination Notice (EDN)** to submit documents that prove their SEP eligibility. Assisters can download a model of the EDN that consumers will receive, which includes a list of documents they can submit. To do so, please click here, scroll down to "Eligibility Notice" and use the link below, "Special Enrollment Period Pre-Enrollment Verification (June 2017)."

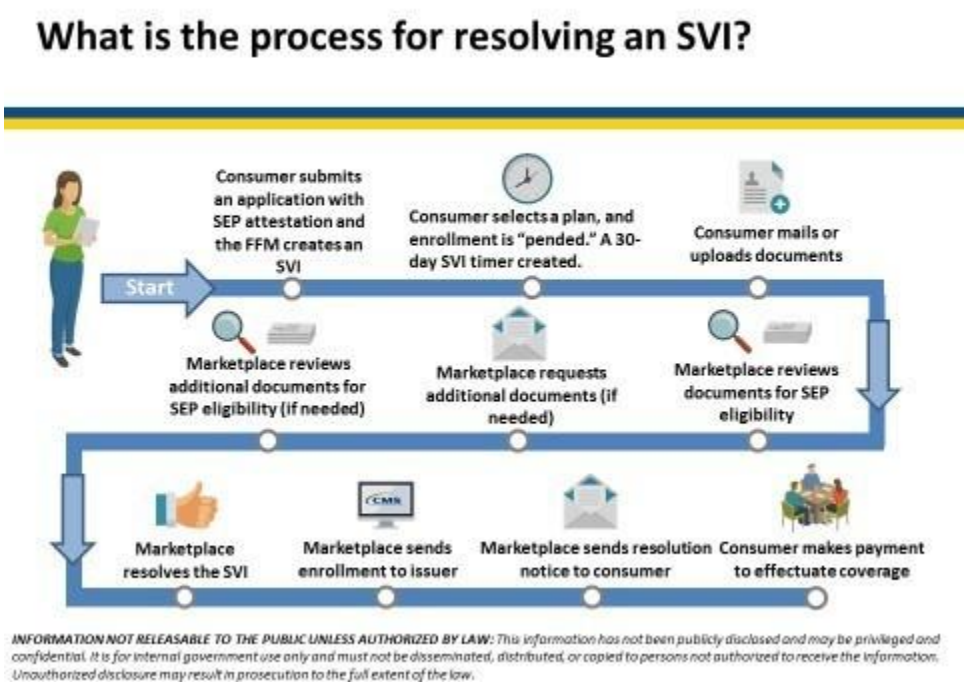
SEPs that Require Pre-enrollment Verification:

1. Loss of qualifying coverage
2. Move
3. Marriage
4. Gaining or becoming a dependent through adoption, placement for adoption, placement in foster care, or a child support or other court order
5. Medicaid/CHIP denial after applying for Medicaid/CHIP during Open Enrollment, or after applying for Marketplace coverage during Open Enrollment or following another SEP qualifying event.

Consumers with an SVI will be required to submit documents to confirm their SEP qualifying event before they can enroll, make their first premium payment, and start using their coverage. Consumers' coverage will start based on their SEP type and date they chose their plan.

- For example, a consumer who qualifies for a loss of coverage SEP and chooses a plan in January will have his or her coverage start either the first of the next month if they've already lost coverage and picked a plan, or will start the first of the month after the plan ends if they have a future end date. If he or she sends documents to resolve the SVI after the coverage starting date, once the SVI is resolved, coverage will be retroactively adjusted.

Consumers' deadline to submit documents is **30 days after they pick a plan.** Once they confirm their plan selection, consumers will receive a **pended plan selection notice** with this deadline. Like the EDN, this notice will also include a list of documents consumers can submit. Consumers' plan selections will be pended (put on hold) until the Marketplace confirms their SEP eligibility based on the documents they send. Consumers won't be able to use their coverage during this time, and should contact the Marketplace if they have questions. Consumers who don't send documents by their deadline could be found ineligible for this SEP and lose their opportunity to enroll in Marketplace coverage until the next annual open enrollment period, unless they experience another SEP qualifying event.



Frequently Asked Questions (FAQ) by Assisters:

Q: Can consumers who need to send documents to prove SEP eligibility pick a plan before they send documents, and before CMS reviews their documents?

A: Yes – consumers can pick a plan before sending the Marketplace documents to prove their eligibility. In fact, consumers **must** pick a plan before 60 days have passed from the time of their SEP qualifying event. However, consumers' plan selection will be pended (put on hold) until they send documents and the Marketplace confirms their SEP eligibility.

Q: How long will consumers have to submit documents to the Marketplace to prove their SEP eligibility?

A: Consumers have 30 days after they pick a plan to submit documents to prove their SEP eligibility. This deadline will appear in the notice consumers receive after they pick a plan.

Remember: This deadline is the date by which they must submit required documents to the Marketplace. That is, this deadline is not also the date by which the Marketplace must verify consumers' SEP eligibility.

Q: How do I help consumers upload documents to their online accounts?

A: More information about how consumers can upload documents online to prove their SEP eligibility is available here on HealthCare.gov.

Uploading documents to their Marketplace account is the fastest way to get documents to us. However, consumers may also mail copies of their documents to the Marketplace if they prefer; information on how to send copies of documents by mail is available here.

Remember: There is no option to fax documents or to send them by email.

Q: Is there anything consumers need to do after they submit documents to prove their SEP eligibility?

A: Once they've submitted documents to confirm their SEP eligibility, consumers should regularly check their Marketplace account, email, regular mail, and voicemail for more information from the Marketplace, because the Marketplace will follow up with more information on whether their documents successfully confirmed their SEP eligibility and, if not, information that they still need to confirm.

Consumers who have questions about the status of their documents can contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

Q: Will consumers' Eligibility Determination Notices (EDNs) include information on which member of a household needs to submit documents to prove their SEP eligibility?

A: Yes – consumers must submit documents to prove SEP eligibility for at least one household member on their application who experienced the SEP qualifying event. Consumers' EDN, Pended Plan Selection Notice, and other notices they receive related to their SEP will identify which member(s) of a household can submit information to prove their eligibility for the SEP.

Q: What happens if a consumer doesn't submit documents?

A: Consumers who don't respond to requests for documentation, or who don't provide sufficient documentation, could be found ineligible for their SEP and lose their opportunity to enroll in Marketplace coverage until the next annual open enrollment period or unless they experience another SEP qualifying event. If a consumer receives an EDN instructing him or her to submit documents to prove his or her eligibility for an SEP, it is critical that he or she submit the documents by the deadline listed in the Notice.

Remember: Consumers **have 30 days from when they choose a plan to submit documents that prove their SEP eligibility.** Consumers should read the EDN they get after they complete their application **and the notice they get after they pick a plan** carefully, and follow the instructions to resolve an SVI by their deadline.

Q: What if a consumer has a data matching issue (DMI) and also has to send documents to prove SEP eligibility?

A: If the consumer also has a data-matching issue (DMI, sometimes referred to as an "inconsistency") and therefore needs to submit other types of documents, their EDN will also include this information.

Consumers generally have 90/95 days from when they **complete their application** to submit documents to resolve a DMI, and 30 days **from when they pick a plan to submit documents to prove their SEP eligibility.**

If consumer has both a DMI and SVI then they'll need to resolve their SVI before they can begin using coverage. In some cases, this may occur before the DMI is resolved in which case the consumer could start using coverage prior to the DMI resolution. Visit HealthCare.gov/verify-information to learn more about how you can help consumers to resolve a DMI.

For more information on which types of documents consumers can submit to resolve an SVI, please refer to the following links:

- After you submit documents: https://www.healthcare.gov/verify-information/after-you-submit-documents/
- When the Marketplace asks for more documents: https://www.healthcare.gov/verify-information/
- Special Enrollment Periods Available to Consumers: https://marketplace.cms.gov/outreach-and-education/special-enrollment-periods-available-to-consumers.pdf
- Overview: Special Enrollment Period Pre-Enrollment Verification (SEPV): https://marketplace.cms.gov/technical-assistance-resources/sepv-session.pdf

- Special Enrollment Period Pre-Enrollment Verification (SEPV): Phase 2 Overview: https://marketplace.cms.gov/technical-assistance-resources/sepv-phase-2-overview.pdf

###

Final Weekly Enrollment Snapshot For 2018 Open Enrollment Period

Approximately 8.7M people selected or were automatically re-enrolled in plans using the HealthCare.gov platform during the 2018 open enrollment period. To access the snapshot, click here.

These snapshots provide point-in-time estimates of weekly plan selections, call center activity and visits to HealthCare.gov or CuidadoDeSalud.gov. The final snapshot reports new plan selections, active plan renewals and automatic enrollments. It does not report the number of consumers who paid premiums to effectuate their enrollment. This snapshot also does not include plan selections from State-based Exchanges, other than those using the HealthCare.gov platform.

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

###

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!

###

MACRA/Quality Payment Program (QPP) Updates

PY 2018 Medicare Shared Savings Program ACO Participants

CMS has released the 2018 participation data for the Accountable Care Organizations participating in the Medicare Shared Savings Program. 124 new ACOs and 65 renewing ACS have signed agreements or continue their participation in the program for the next three years. This brings the total number of Shared Savings Program ACOs to 561.

For more information, click here: https://data.cms.gov/browse?category=Special%20Programs%2FInitiatives%20-%20Medicare%20Shared%20Savings%20Program%20(MSSP)

###

SNF QRP- Full Confidential Feedback Reports- Now Available

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) Confidential Feedback Reports/Quality Measure Reports containing the assessment and claims-based IMPACT Act measures are now available via the Certification and Survey provider Enhanced Reports (CASPER) Reporting System.

For more information on these reports, please refer to the December 6, 2017 presentation and audio and transcript on the SNF QRP Training website.

Assessment-based quality measures:

- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)
- Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

Claims-based quality measures:

- Total Estimated Medicare Spending Per Beneficiary Measure
- Discharge to Community-Post Acute Care– SNF QRP
- Potentially Preventable 30-Day Post Discharge Readmission Measure

Please note- CMS has discovered an error in some of the MSPB measure calculations contained in the SNF October 2017 Confidential Feedback/QM reports. The error affects the risk adjustment of the measure. CMS has corrected this issue and the data has been loaded into the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. These facility level quality measures reports are on-demand, user-requested reports in your CASPER folder in QIES. Providers should request an updated version of the report to review the corrected MSPB measure calculation.

If you have questions about the information contained in your report, please contact the SNF QRP Help Desk at SNFQualityQuestions@cms.hhs.gov.

###

Now Available: Updated CY 2018 CMS QRDA I Schematron for Hospital Quality Reporting

The Centers for Medicare & Medicaid Services (CMS) has published an updated schematron for the 2018 CMS Quality Reporting Document Architecture (QRDA) Category I Implementation Guide (IG) for Hospital Quality Reporting. **This guidance is for electronic clinical quality measure (eCQM) submissions for calendar year (CY) 2018 and QRDA Category I files only.** QRDA Category I file submissions are for the following:

- Hospital Inpatient Quality Reporting (IQR) Program

- Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for Eligible Hospitals and Critical Access Hospitals

The updated schematron addresses an issue in the implementation of the QRDA I conformance statement CONF: CMS_0009, which states that a patient identifier other than the Medicare Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) must be present in the *recordTarget* element. Prior to the schematron update, a file submitted without an additional patient identifier would not be flagged in error.

This update ensures the presence of the additional patient identifier beyond HICN and MBI.

Please visit the Electronic Clinical Quality Improvement (eCQI) Resource Center QRDA page for the updated Schematron file.

Additional QRDA-Related Resources:

Additional QRDA-related resources, as well as current and past implementation guides, are found on the eCQI Resource Center QRDA page.

For questions related to this guidance, the QRDA Implementation Guides, or Schematrons, visit the ONC QRDA JIRA Issue Tracker.

###

CMS Launches Data Submission System for Clinicians in the Quality Payment Program

Website makes it easier for clinicians to submit data by offering one user-friendly site for all submissions

Today, the Centers for Medicare & Medicaid Services (CMS) announced that doctors and other eligible clinicians participating in the Quality Payment Program can begin submitting their 2017 performance data using a new system on the Quality Payment Program website (qpp.cms.gov). The data submission system is an improvement from the former systems under the CMS legacy programs, which required clinicians to submit data on multiple websites. Now, eligible clinicians will use the new system to submit their 2017 performance data for the Quality Payment Program during the 2017 submission period which runs from January 2, 2018 to March 31, 2018, except for groups using the CMS Web Interface whose submission period is January 22, 2018 to March 16, 2018.

"The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to implement the Quality Payment Program, and we are committed to doing so in the least burdensome way possible," said Seema Verma, Administrator of CMS. "The new data submission system makes it easier for clinicians to meet MACRA's reporting requirements and spend more time treating patients instead of filing paperwork."

Eligible clinicians will be required to log into the system. After logging in, the system will connect each eligible clinician to the Taxpayer Identification Number (TIN) associated with their National Provider Identifier (NPI). Eligible clinicians will report data either as an individual or a group.

There are multiple data submission options, including Qualified Clinical Data Registries (QCDRs), qualified registries, attestation, or the CMS Web Interface. Eligible clinicians can also submit data using a Health IT Vendor, which extracts data from certified EHR technology; however, in the spirit of flexibility and burden reduction, eligible clinicians can generate a non-certified report in either the new Quality Payment Program file format or QRDA III file format and manually upload the file into the submission system.

As data is entered into the system, eligible clinicians will see real-time initial scoring within each of the Merit-based Incentive Payment System (MIPS) performance categories based on their submissions. This scoring may change if new data is reported or quality measures that have not yet been benchmarked are used. Additionally, the performance category score will not initially take into account the user's Alternative Payment Model (APM) status, Qualifying APM Participant (QP) status, or other special status that may apply to clinicians.

Eligible clinicians are encouraged to log-in early and often to familiarize themselves with the system. Data can be updated at any time during the submission period. Once the submission period closes on March 31, 2018 (with the exception of the CMS Web Interface, which ends on March 16, 2018), we will calculate your payment adjustment based on your last submission or submission update.

Eligible clinicians who need assistance with the data submission system may contact the Quality Payment Program by email at qpp@cms.hhs.gov or toll free at 1-866-288-8292. Eligible clinicians have until March 31, 2018 to submit data for the 2017 transition year, unless they are part of a group reporting via the CMS Web Interface.

For a fact sheet on the Quality Payment Program data submission system, including more information for clinicians participating in APMs, please visit: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-2017-Data-Submission-Factsheet.pdf

###

Eligible Hospitals and CAHs: Remember to Use QualityNet for Attestation 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).

As of January 2, 2018, Medicare eligible hospitals and CAHs attesting to CMS for the EHR Incentive Program must use 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.

QNet Help Desk

Starting on January 2, 2018, you should **contact the QNet Help Desk** rather than the EHR Incentive Program Information Center if you need help with the registration and attestation process. The QNet Help Desk is available 8 a.m. - 8 p.m. ET, Monday through Friday:

E-mail: qnetsupport@hcqis.org

Phone: (866) 288-8912

TTY: (877) 715-6222

Fax: (888) 329-7377

###

CMS is Soliciting Stakeholder Recommendations for Potential Consideration of New Specialty Measure Sets and/or Revisions to the Existing Specialty Measure Sets for the 2019 Program Year of Merit-based Incentive Payment System (MIPS)

The Centers for Medicare & Medicaid Services (CMS) is accepting recommendations from stakeholders for potential consideration of new specialty measure sets and/or revisions to existing specialty measure sets for program year 2019 of the Merit-based Incentive Payment System (MIPS) program. Recommendations for new specialty sets or revisions to the 2018 specialty sets should be made based on the established 2018 quality measures. The CY 2018 quality measure specifications can be found here: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html.

In addition, recommendations will be accepted based on potential new MIPS measures that are being considered for implementation in the 2018 program year. These measures can be found in the List of Measures under Consideration for December 1, 2017 under the list for MIPS.

The current 2018 specialty measure sets are located in the Appendix measure tables of the CY 2018 Quality Payment Program final rule with comment period located at: https://www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-program-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme.

As established in the CY 2018 Quality Payment Program final rule, specialty measure sets currently exist for the following specialties:

- Allergy/Immunology
- Anesthesiology

- Cardiology
- Dentistry
- Dermatology
- Diagnostic Radiology
- Electrophysiology Cardiac Specialist (a subspecialty of Cardiology)
- Emergency Medicine
- Family Medicine
- Gastroenterology
- General Surgery
- Hospitalists
- Infectious Disease
- Internal Medicine
- Interventional Radiology
- Mental/Behavioral Health
- Nephrology
- Neurology
- Neurosurgical
- Obstetrics/Gynecology
- Oncology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine
- Plastic Surgery
- Podiatry
- Preventive Medicine
- Radiation Oncology
- Rheumatology
- Thoracic Surgery
- Urology
- Vascular Surgery

Each recommendation must include the following in order to be considered:

- The quality measure ID
- Measure title
- Supporting rationale and/or documentation that would support inclusion or exclusion of the current quality measure(s) from existing specialty sets or inclusion in new specialty sets.

Submissions of recommendations for a new specialty measure set and/or revisions to the current 2018 specialty measure sets should be sent to the PIMMS Quality Measures Support mailbox at PIMMSQualityMeasuresSupport@gdit.com.

Submissions of recommendations will be accepted from stakeholders up until Close of Business on Friday, February 9th, 2018.

All recommendations submitted by the aforementioned deadline will be considered and assessed for possible inclusion in rule making for the 2019 calendar year of the Quality Payment Program.

Note: *Submissions of recommendations for new specialty measure sets and/or revisions to the current 2018 specialty measure sets, does not guarantee that the recommendation will be accepted, proposed, or finalized during rule making for the 2019 calendar year of the Quality Payment Program. Determinations as to whether recommendations are accepted will not be communicated with stakeholders directly since they are being considered for the 2019 program year, but will be made evident through publications of the CY 2019 Quality Payment Program proposed and final rule.*

###

CMS announces new payment model to improve quality, coordination, and cost-effectiveness for both inpatient and outpatient care

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) announced the launch of a new voluntary bundled payment model called Bundled Payments for Care Improvement Advanced (BPCI Advanced). Under traditional fee-for-service payment, Medicare pays providers for each individual service they perform. Under this bundled payment model, participants can earn additional payment if all expenditures for a beneficiary's episode of care are under a spending target that factors in quality.

Bundled payments create incentives for providers and practitioners to work together to coordinate care and engage in continuous improvement to keep spending under a target amount. BPCI Advanced Participants may receive payments for performance on 32 different clinical episodes, such as major joint replacement of the lower extremity (inpatient) and percutaneous coronary intervention (inpatient or outpatient). An episode model such as BPCI Advanced supports healthcare providers who invest in practice innovation and care redesign to improve quality and reduce expenditures.

Of note, BPCI Advanced will qualify as an Advanced Alternative Payment Model (Advanced APM) under the Quality Payment Program. In 2015, Congress passed the Medicare Access and Chip Reauthorization Act or MACRA. MACRA requires CMS to implement a program called the Quality Payment Program or QPP, which changes the way physicians are paid in Medicare. QPP creates two tracks for physician payment – the Merit-Based Incentive Payment System or MIPS track

and the Advanced APM track. Under MIPS, providers have to report a range of performance metrics and then have their payment amount adjusted based on their performance. Under Advanced APMs, providers take on financial risk to earn the Advanced APM incentive payment.

"CMS is proud to announce this Administration's first Advanced APM," said CMS Administrator Seema Verma. "BPCI Advanced builds on the earlier success of bundled payment models and is an important step in the move away from fee-for-service and towards paying for value. Under this model, providers will have an incentive to deliver efficient, high-quality care."

In BPCI Advanced, participants will be expected to redesign care delivery to keep Medicare expenditures within a defined budget while maintaining or improving performance on specific quality measures. Participant bear financial risk, have payments under the model tied to quality performance, and are required to use Certified Electronic Health Record Technology. By meeting these requirements, the model qualifies as an Advanced APM. The 32 types of clinical episodes in BPCI Advanced add outpatient episodes to the inpatient episodes that were offered in the Innovation Center's previous bundled payment model (the Bundled Payments for Care Improvement initiative), including percutaneous coronary intervention, cardiac defibrillator, and back and neck except spinal fusion.

CMS designed this model taking into account rigorous evaluation results from previous CMMI models, industry experience with bundled payment, and stakeholder input from healthcare providers at acute care hospitals, physician group practices, and other providers and suppliers. BPCI Advanced seeks to support and encourage participants who are interested in:

- continuously redesigning and improving care,
- decreasing costs by eliminating care that is unnecessary or provides little benefit to patients,
- encouraging care coordination, and fostering quality improvement,
- participating in a payment model that tests extended financial accountability for the outcomes of improved quality and reduced spending,
- creating environments that stimulate rapid development of new evidence-based knowledge, and
- increasing the likelihood of better health at lower cost through patient engagement, education, and on-going communication between doctors and patients.

The Model Performance Period for BPCI Advanced starts on October 1, 2018 and runs through December 31, 2023. Like all models tested by CMS, there will be a formal, independent evaluation to assess the quality of care and changes in spending under the model.

For more information about the model and its requirements, or to download a Request for Applications document (RFA), the application template, and the necessary attachments, please visit: https://innovation.cms.gov/initiatives/bpci-advanced. Applications must be submitted via the Application Portal, which will close on 11:59 pm EST on March 12, 2018. Applications submitted via email will not be accepted.

The CMS Innovation Center will hold a Q&A Open Forum on Tuesday, January 30, 2018 from 12 pm – 1 pm EDT. This event is open to those who are interested in learning more about the model and how to apply. Please register in advance here - https://preaward.adobeconnect.com/e3cdwg6hgx9f/event/registration.html

###

Medicare and Medicaid Updates

CMS Announces Upcoming Low Volume Appeals (LVA) Settlement Option Details

Beginning February 5, 2018, CMS will start accepting Expressions of Interest (EOIs) for a limited settlement agreement option for Medicare Fee-For-Service providers, physicians, and suppliers (appellants) with fewer than 500 appeals pending at the Office of Medicare Hearing and Appeals (OMHA) and the Medicare Appeals Council (Council) at the Departmental Appeals Board.

Specifically, CMS will make available an administrative settlement process for appellants with fewer than 500 appeals pending at OMHA and the Council, combined, as of November 3, 2017, to settle the portion of their pending appeals that have total billed amounts of $9,000 or less per appeal in exchange for timely partial payment of 62% of the net Medicare approved amount.

Helpful weblinks:

- Low Volume Appeals Initiative Page: https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Appeals-Settlement-Initiatives/Low-Volume-Appeals-Initiative.html
- Appeals Initiative landing page: https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Appeals-Settlement-Initiatives/index.html

###

CMS announces new policy guidance for states to test community engagement for able-bodied adults

Will support states helping Medicaid beneficiaries improve well-being and achieve self-sufficiency

CMS today announced new guidance that will support state efforts to improve Medicaid enrollee health outcomes by incentivizing community engagement among able-bodied, working-age Medicaid beneficiaries. The policy responds to numerous state requests to test programs through Medicaid demonstration projects under which work or participation in other community engagement activities – including skills training, education, job search, volunteering or caregiving – would be a condition for Medicaid eligibility for able-bodied, working-age adults. This would exclude individuals eligible for Medicaid due to a disability, elderly beneficiaries, children, and pregnant women.
The new policy guidance sent to states is intended to help them design demonstration projects that promote the objectives of the Medicaid program and are consistent with federal statutory requirements. To achieve the objectives of Medicaid, state programs should be designed to promote better physical and mental health.

"Medicaid needs to be more flexible so that states can best address the needs of this population. Our fundamental goal is to make a positive and lasting difference in the health and wellness of our beneficiaries, and today's announcement is a step in that direction," said Seema Verma, CMS Administrator.

To date, CMS has received demonstration project proposals from 10 states that include employment and community engagement initiatives: Arizona, Arkansas, Indiana, Kansas, Kentucky, Maine, New Hampshire, North Carolina, Utah and Wisconsin.

"Our policy guidance was in response to states that asked us for the flexibility they need to improve their programs and to help people in achieving greater well-being and self-sufficiency," said Verma.

Announcement of the new guidance delivers on the commitment made by Administrator Verma in her address to state Medicaid directors last November, to "turn the page" in the Medicaid program and give states more freedom to design innovative programs that achieve positive results for the people they serve and to remove bureaucratic barriers that block states from achieving this goal.

Criteria and Parameters of the New Policy Guidance

CMS has identified a number of issues for states to consider in the development of proposals to promote work and other community engagement among working-age, non-pregnant Medicaid beneficiaries not eligible for Medicaid on the basis of a disability.

Meeting work and community engagement requirements should take into consideration areas of high unemployment or caregiving for young children or elderly family members. States will therefore be required to describe strategies to assist eligible individuals in meeting work and community engagement requirements and to link individuals to additional resources for job training, provided they do not use federal Medicaid funding to finance these services.

CMS will support state efforts to align Medicaid work and community engagement requirements with SNAP or TANF requirements, where appropriate, as part of this demonstration opportunity. Aligning requirements across these programs may streamline eligibility and reduce the burden on both states and beneficiaries and help beneficiaries succeed in meeting their work and community engagement responsibilities.

States must also fully comply with federal disability and civil rights laws and ensure that all individuals with disabilities have the necessary protections to ensure that they are not inappropriately denied coverage. States will be required to offer reasonable modifications to individuals with disabilities, and will be required to exempt individuals determined to be medically frail or who have an acute condition that a medical professional has determined will prevent them from complying with the requirements.

Administrator Verma cited the Administration's firm commitment to combat our nation's opioid crisis and the letter outlines that CMS will require states to make reasonable modifications for individuals with opioid addiction and other substance use disorders. These modifications may include counting time spent in medical treatment toward an individual's community engagement requirements or exempting individuals participating in intensive inpatient or outpatient medical treatment, as well as supporting other state efforts.

CMS also encourages states to consider a range of activities that could satisfy work and community engagement requirements. States should ensure that career planning, job training, referral, and volunteering opportunities considered to meet the community engagement requirement, and job support services offered in connection with the requirement, take into account people's employability and potential contributions to the labor market.

"States have the opportunity to help individuals improve and enhance the skills that employers truly value," said Verma. "People who participate in activities that increase their education and training are more likely to find sustainable employment, have higher earnings, a better quality of life, and, studies have shown, improved health outcomes."

Medicaid Demonstration Projects

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects determined by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. Demonstrations, which give states additional flexibility to design and improve their programs, are also designed to evaluate state-specific policy approaches and better serve Medicaid populations.

Administrator Verma also announced that CMS has updated Medicaid.gov to give states a clearer indication of how their reform strategies under section 1115 should align with a core objective of the Medicaid program: serving the health and wellness needs of the nation's vulnerable and low-income individuals and families. The revised website content signals a new, broader view of these demonstrations in which states can focus on evidence-based approaches that drive better health outcomes, and quality of life improvements, and support upward mobility and self-sufficiency.

On March 14, 2017, the Department of Health and Human Services and CMS issued a letter to the nation's governors affirming the federal government's partnership with states to improve the integrity and effectiveness of the Medicaid program for low-income people with Medicaid. The letter encourages states to bring forward proposals grounded in ideas that reflect the dynamics and culture of a state.

"This new guidance paves the way for states to demonstrate how their ideas will improve the health of Medicaid beneficiaries, as well as potentially improve their economic well-being," said Brian Neale, CMS Deputy Administrator and Director for the Center for Medicaid and CHIP Services.

To view a copy of the SMD letter # 18-002, please click here.

###

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

- CMS Launches Data Submission System for Clinicians in the Quality Payment Program
- CMS Updates Website to Compare Hospital Quality
- Patients over Paperwork: Get Updates on Burden Reduction
- Quality Payment Program: Qualified Registries and QCDRs
- Quality Payment Program Resources
- EHR Incentive Program Hospitals: Use QNet to Attest
- Medicare Diabetes Prevention Program Resources
- Post-Acute Care Quality Reporting Program Section GG Web-based Training
- Hospice Compare Update
- Are You Prepared for a Health Care Emergency?
- Get Your Patients Off to a Healthy Start in 2018
- New Payment Model to Improve Quality, Coordination, and Cost-effectiveness for Both Inpatient and Outpatient Care
- SNF Quality Reporting Program Confidential Feedback Reports
- Hospital Quality Reporting: Updated CY 2018 QRDA I Schematron
- January is Cervical Health Awareness Month

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities — Reminder
- Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims — Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Call — January 9
- ESRD QIP: Final Rule for CY 2018 Call — January 23
- New Medicare Card Project Special Open Door Forum — January 23
- ESRD QIP: Final Rule for CY 2018 Call — January 23

Medicare Learning Network Publications & Multimedia

- Dementia Care Call: Audio Recording and Transcript — New
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet — Revised
- Major Joint Replacement (Hip or Knee) Booklet — New
- Medicare-Required SNF PPS Assessments Educational Tool — Revised

###

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

###

National Medicare Education Program (NMEP) Meeting Save the Date- January 31, 2018

National Medicare Education Program (NMEP) Meeting

###

The Proposed Removal of Influenza Vaccination Measure from Home Health Quality of Patient Care Star Rating Webinar Materials are Now Available Online

On December 14, 2017, the Centers for Medicare & Medicaid Services (CMS) hosted a webinar for Medicare-certified home health agencies. CMS presented the rationale, comments received, timing, and impact of CMS' decision to remove the Influenza Vaccination Measure from the Quality of Patient Care Star Ratings (QoPC). If you were unable to attend this session or would like to review the information again, the webinar audio and transcript are now available for download here.

The updated methodology to compute the QoPC Star Ratings will be implemented in the April 2018 Home Health Compare refresh.

###

Governor proclaims January 2018 as Missouri Birth Defects Prevention and Awareness Month

JEFFERSON CITY, MO – The Missouri Department of Health and Senior Services (DHSS) and the office of Governor Greitens have proclaimed January 2018 as Missouri Birth Defects Prevention and Awareness Month in coordination with the National Birth Defects Network (NBDPN), the Centers for Disease Control and Prevention, the American Academy of Pediatrics, the March of Dimes, the Teratology Society and MothertoBaby. During the 2018 campaign "Prevent to Protect: Prevent Infections for Baby's Protection," special emphasis is focused on the importance of preventing infections before and during pregnancy that can increase the risk of having a baby with a birth defect.

DHSS is actively working to raise awareness of how common birth defects are and what steps can help to prevent them. In Missouri, approximately eight percent of all babies are born with a birth defect, and in 2014 approximately 19 percent of

infant deaths had birth defects as an underlying cause. Birth defects are the most common cause of death in the first year of life and the second most common cause of death in children aged one to four years.

Dr. Randall Williams, director of DHSS, said, "As an OB-GYN, healthy pregnancies, mothers and babies are something I care deeply about. I am excited that Governor Greitens has also made it a priority to do what he can to protect families and unborn children through awareness and prevention with Missouri's Birth Defects Prevention and Awareness Month in January."

Congenital heart defects are the leading cause of birth defect deaths and illness, with 17 per 100,000 babies born with critical congenital heart defects. These can be life threatening and require intervention during infancy.

Although not all birth defects can be prevented, many steps can be taken to increase a woman's chance of having a healthy baby. It is important to prevent those infections that can increase the risk of birth defects and other health problems for mothers and babies.

Here are some helpful tips for pregnant women or women who may become pregnant:

Practice Healthy Habits
- Take a multivitamin with 400 micrograms (mcg) of folic acid every day.
- Eat a healthy diet and be physically active.
- Seek prenatal care early in your pregnancy.

Get vaccinated.
- Get the flu shot and the whooping cough vaccine.
- Become up-to-date with all vaccines before getting pregnant.

Prevent insect bites.
- Use insect repellent.
- Wear long-sleeved shirts and long pants when outside.

Practice good hygiene.
- Wash your hands often with soap and water.
- Avoid putting a young child's cup or pacifier in your mouth.

Talk to your health care provider.
- Ask about how you can prevent infections, such as Zika virus.
- Discuss how to prevent sexually transmitted infections.

In addition to following these tips to prevent infections, all women capable of becoming pregnant should abstain from alcohol, tobacco and avoid secondhand smoke and other harmful chemicals, including illegal drugs. These steps can go a long way in promoting a healthy you and a healthy baby.

DHSS encourages you to be an active participant in National Birth Defects Prevention and Awareness Month. Additional materials and resources are available at http://health.mo.gov/living/families/genetics/birthdefects/index.php, www.CDC.gov/ncbddd, www.marchofdimes.org, www.healthychildren.org, www.MothertoBaby.org and www.Teratology.org.

###

Rural Matters Podcast

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.

###

Upcoming Webinar: Special Open Door Forum - New Medicare Card Project

CMS's Office of Information Technology (OIT) will host a Special Open Door Forum (ODF) to allow State Medicaid agencies, Medicaid providers, Managed Care Organizations (MCOs), Medicaid partners and other Medicaid stakeholders an opportunity to learn more about and ask questions regarding CMS's approach towards changing the Social Security

Number-based Health Insurance Claim Numbers (HICN) to the new Medicare Beneficiary Identifier (MBI). During this ODF we will cover the background of the New Medicare Card Project, the implementation of new Medicare numbers, the format of the new number, timeline & milestones, the transition period, outreach & education, and what you need to know to get ready for the new number.

For more information about the New Medicare Project, please visit our website: https://www.cms.gov/newcard

Feedback and questions on the New Medicare Card Project can be sent to: NewMedicareCardSSNRemoval@cms.hhs.gov

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

We look forward to your participation.

Special Open Door Participation Instructions:

Tuesday, January 23, 2018

2:00pm – 3:00pm Eastern Time

Conference Call Only

Please dial in at least 15 minutes prior to the start of the call

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

Conference ID #: 8259057

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

Encore: 1-855-859-2056; Conference ID: 8259057

Encore is an audio recording of this call that can be accessed by dialing 1-855-859-2056 and entering the Conference ID beginning 2 hours after the call has ended. The recording will expire January 31, 2018 at midnight Eastern Time.

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website at https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html for downloading. This New Medicare Card Project presentation is the same as the one presented on November 9th, 2017; we know that many could not participate and we are offering again. If this time is not convenient, please click below for that call's transcript and audio recording: Thursday, November 9, 2017 - Transcript & Audio File (Zip File) - New Medicare Card Project, Special Open Door Forum (SODF) [ZIP, 11MB]

###

CMS Measures Inventory Tool (CMIT) and the CMS Measures Inventory: Updates to the System and the Data

Date: January 17, 2018 **Time:** 2:00-3:00pm ET

Registration Link:
https://battellemms.webex.com/battellemms/onstage/g.php?MTID=ed809fe644fd164fd489bd319d7ab0716

Description: CMS has implemented the CMS Measures Inventory Tool (CMIT), as an innovative tool meant to improve the visibility and usability of the CMS portfolio of measures used within their programs. During the webinar, presenters will offer a demonstration of the new system, and provide information on how the data in CMIT is populated, updated, and validated. Participants will learn about all of the functionality of the system and how the system can be used to support measure development work. To register for this webinar, click here.

###

The Merit-based Incentive Payment System (MIPS): Annual Call for Measures and Activities

Date: February 5, 2018 **Time:** 2:30-3:30pm ET

Registration Link: https://engage.vevent.com/rt/cms/index.jsp?seid=997

Description: The Annual Call for Measures and Activities process allows clinicians and organizations, including but not limited to those representing eligible clinicians such as professional associations, and medical societies, and other stakeholders such as researchers and consumer groups to identify and submit for consideration:

- Quality measures for the quality performance category;
- EHR measures for the advancing care information performance category; and
- Activities for the improvement activities performance category.

###

CMS Administrator Joins AHA Webcast to Discuss Regulatory Relief

Wednesday, January 17, 2018 4:00 p.m. ET

AHA President and CEO Rick Pollack will be joined by Centers for Medicare & Medicaid Services Administrator Seema Verma to discuss the current regulatory landscape. Together they will discuss areas of priority and challenge for hospitals and health systems, as well as for CMS, and preview new efforts to reduce regulatory burden that will be rolled out this year.

Please click here to register and log-in http://windrosemedia.com/windstream/aha/011718/

Questions about the webcast or its contents? Call 1-800-424-4301. If you have any additional technical questions, please email: support@windrosemedia.com

###

Join CMS for the EHR Hospital Transition QualityNet Demonstration Webinar on 1/18

The Centers for Medicare & Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Program attestation for Medicare eligible hospitals and critical access hospitals (CAHs) has transitioned to a new platform. As of January 2, 2018, eligible hospitals and CAHs attesting to CMS for the EHR Incentive Program must submit their Calendar Year (CY) 2017 attestations through the QualityNet Secure Portal (QNet). Eligible hospitals and CAHs attesting to CMS must have an active and updated QNet account before submitting EHR Incentive Program attestations.

CMS is hosting a live demonstration webinar on **Thursday, January 18, 2018,** to walk through the registration, attestation, and objectives and measures submission process on QNet for the Medicare Hospital EHR Incentive Program. CMS will also provide an overview of the transition.

Webinar Details

Title: EHR Hospital Transition QualityNet Demonstration Webinar
Date: January 18, 2018
Time: 1:00-2:00 p.m. ET*

Registration Link:

https://meetingconnect.webex.com/meetingconnect/onstage/g.php?MTID=e8f12eb7eacf5bb679e8a881a9e203970

*Please note that the webinar will be from 1:00 to 2:00 p.m. **Eastern Standard Time.** The registration page sometimes displays information for a different time zone in error.

Due to technical limitations associated with the demonstration, only the first 1,000 attendees will be able to view the demonstration. For those who are unable to view the demonstration, a webinar recording will be posted on the Eligible Hospital Information page in the weeks following the webinar.

Attendees can submit their questions using the questions box. CMS will address questions at the end of the webinar as time allows.

Please note that the audio portion of this webinar will be broadcast through the web. You can listen to the presentation through your computer speakers. If you cannot hear audio through your computer speakers, please contact CMSQualityTeam@ketchum.com.

For More Information

- Review the EHR Hospital Transition Overview Fact Sheet
- Review the QualityNet Secure Portal Enrollment and Login User Guide
- Review the QualityNet User Role Management Guide
- Review the QualityNet Registration & Attestation User Guide
- Review the QualityNet Objectives and Clinical Quality Measures User Guide
- Visit the QNet webpage
- Visit the EHR Incentive Programs website
- Follow CMS on Twitter
- Subscribe to the EHR Incentive Programs listserv

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CMS Hospital/Quality Initiative Open Door Forum

Tuesday, January 16 2018 2:00pm-3:00pm Eastern Time (ET)

Please dial-in at least 15 minutes before call start time.

****This Agenda is Subject to Change****

I. Opening Remarks

Chair – Tiffany Swygert (Center for Medicare)

Moderator – Jill Darling (Office of Communications)

II. Announcements & Updates

- FY 2019 Wage Index Timeline
- New 'Communication About Pain' questions on the HCAHPS Survey, beginning January 2018: http://www.hcahpsonline.org/en/podcasts/
- Low Volume Settlement Opportunity Announcement: http://go.cms.gov/LVA

III. Open Q&A

DATE IS SUBJECT TO CHANGE

Next CMS Hospital/Quality Initiative Open Door Forum: TBD

ODF EMAIL MAILBOX: Hospital_ODF@cms.hhs.gov

This Open Door Forum is not intended for the press, and the remarks are not considered on the record. If you are a member of the Press, you may listen in but please refrain from asking questions during the Q & A portion of the call. If you have inquiries, please contact CMS at Press@cms.hhs.gov. Thank you.

Open Door Participation Instructions:

This call will be Conference Call Only.

To participate by phone:

Dial: 1-800-837-1935 & Reference Conference ID: 31068802

Persons participating by phone do not need to RSVP. TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

Encore: 1-855-859-2056; Conference ID: 31068802

Encore is an audio recording of this call that can be accessed by dialing 1-855-859-2056 and entering the Conference ID beginning 2 hours after the call has ended. The recording expires after 2 business days.

For ODF schedule updates and E-Mailing List registration, visit our website at http://www.cms.gov/OpenDoorForums/.

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

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

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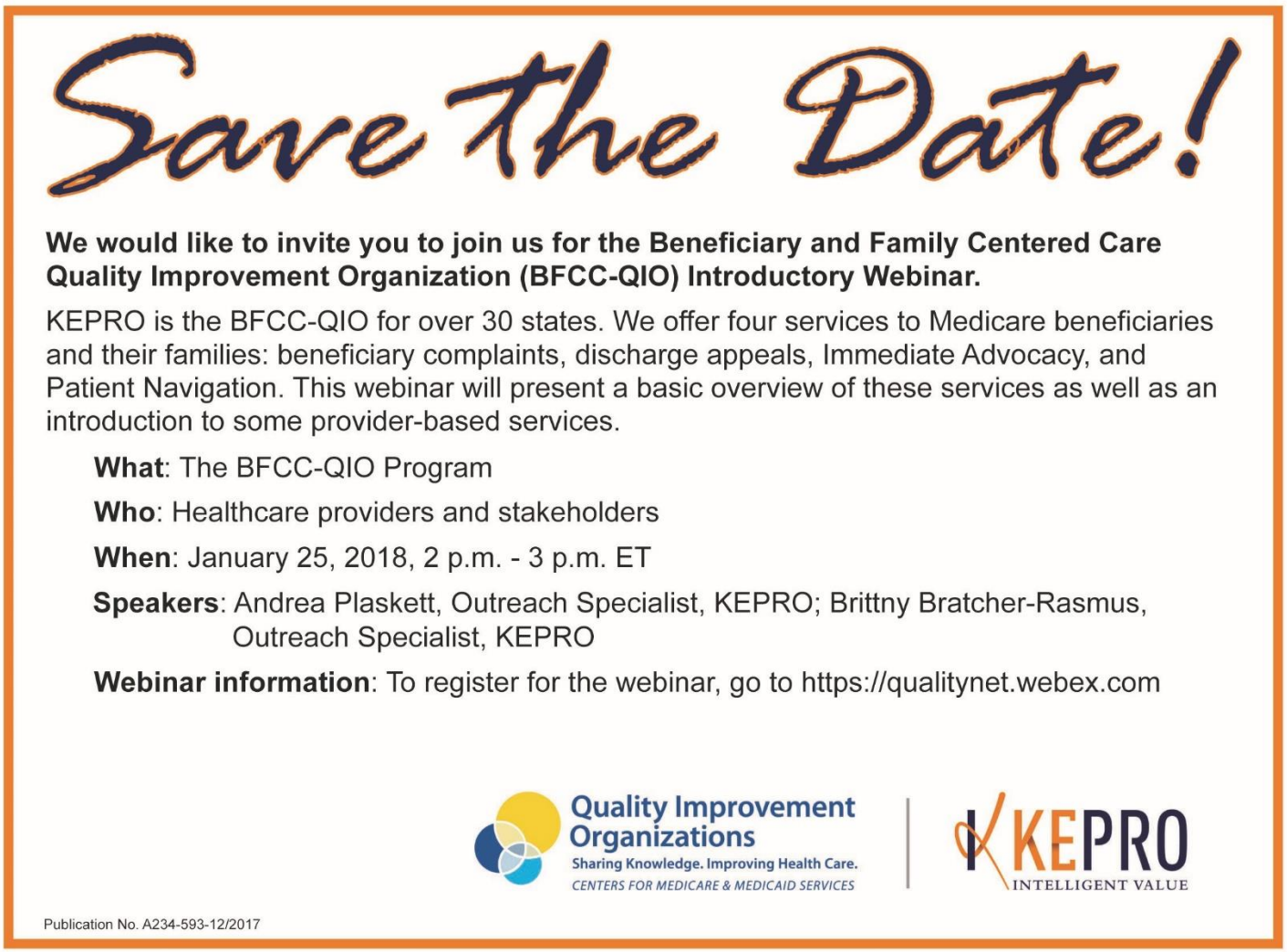
BFCC-QIO Program Webinar



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