CMS Region 7 Updates – 02/16/2018

Table of Contents

ACA/Marketplace Updates

IRS Statement on Health Care Reporting Requirement

For the upcoming 2018 filing season, the IRS will not accept electronically filed tax returns where the taxpayer does not address the health coverage requirements of the Affordable Care Act. The IRS will not accept the electronic tax return until the taxpayer indicates whether they had coverage, had an exemption or will make a shared responsibility payment. In addition, returns filed on paper that do not address the health coverage requirements may be suspended pending the receipt of additional information and any refunds may be delayed.

To avoid refund and processing delays when filing 2017 tax returns in 2018, taxpayers should indicate whether they and everyone on their return had coverage, qualified for an exemption from the coverage requirement or are making an individual shared responsibility payment. This process reflects the requirements of the ACA and the IRS's obligation to administer the health care law.

Taxpayers remain obligated to follow the law and pay what they may owe at the point of filing. The 2018 filing season will be the first time the IRS will not accept tax returns that omit this information. After a review of its process and discussions with the National Taxpayer Advocate, the IRS has determined identifying omissions and requiring taxpayers to provide health coverage information at the point of filing makes it easier for the taxpayer to successfully file a tax return and minimizes related refund delays.

Click here for more information about the individual shared responsibility provision.

https://www.irs.gov/tax-professionals/aca-information-center-for-tax-professionals

###

Getting Ready for Tax Season

Information on 1095-As

Like last year, assisters can help consumers who enrolled in coverage through the Health Insurance Marketplaces and received advance payments of the premium tax credit (APTC) understand the Form 1095-A that they receive from the Marketplace. Consumers must use the Form 1095-A to complete Form 8962 when they file their 2017 taxes. These forms allow consumers to reconcile the total APTC they received during 2017 with the amount of premium tax credit (PTC) for which they are eligible based on their final 2017 income and household information.

Forms should be received within the first few months of 2018. Consumers should receive a hard copy of this form in the mail, but can also access the form directly through their healthcare.gov account in the tax form section. If consumers do not have online accounts, they can create one to view their Form 1095-A. Depending on changes that may have occurred to consumers' coverage over the course of 2017, such as changing Marketplace plans during the year, **some consumers may receive more than one Form 1095-A.**

Please remember that as an assister, you are prohibited from helping consumers with filing their taxes, unless you are also a licensed tax professional.

Let consumers know that the monthly enrollment premium listed on their Form 1095-A (Part III, Column A) may be different from their plan's full monthly premium amount. This does not always mean there are errors that need to be corrected. The monthly premium on the Form 1095-A may be different from what is expected for several reasons that are addressed here. If consumers identify errors on their Form 1095-A, direct them to notify the Marketplace by calling the Marketplace Call Center at 1-800-318-2596. Below are some helpful resources to share with consumers as you help them understand how using APTCs for their Marketplace coverage affects their taxes. Click the hyperlink to access the resource:

- Complete guide to 2017 health coverage & your tax status
- Health Coverage Tax Tool

- How to Use Form 1095A
- How to Reconcile PTC

Information on Form 1095-B and Cs

This year, some consumers will receive Forms 1095-B or 1095-C. Like Form 1095-A, Forms 1095-B and C will provide consumers with information about their health coverage during the prior year. Consumers who have health coverage through the Marketplace and receive a Form 1095-A might also receive a Form 1095-B or Form 1095-C, if they or members of their household had coverage in 2017 through other programs or plans outside of the Marketplace, like Medicaid or private health insurance. **Individuals who have questions about a Form 1095-B or 1095-C should contact the entity that provided them with the form.**

Forms 1095-C will be provided to consumers by certain large employers. Forms 1095-B will be provided to consumers by health insurance providers, such as health insurance companies and government agencies including Medicare, Medicaid or CHIP. Insurance issuers and carriers aren't required to file Form 1095-B to report coverage in individual market qualified health plans that individuals enroll in through Health Insurance Marketplaces. This coverage generally is reported by Marketplaces on Form 1095-A. However, health insurance issuers will file Form 1095-B to report on coverage for employees obtained through the Small Business Health Options Program (SHOP).

IRS Extends Deadline to Provide 1095-B and Cs

The IRS extended the 2018 due date for certain employers and health coverage providers to send 2017 health coverage information forms to individuals. The following organizations now have until March 2, 2018, to provide Forms 1095-B or 1095-C:

- Insurers
- Self-insuring employers
- Other coverage providers
- Applicable large employers

The March 2nd date is a 30-day extension from the original due date of January 31st.

This 30-day extension is automatic. Employers and providers do not have to request it. The due dates for filing 2017 information returns with the IRS are not extended. For 2018, the due dates to file information returns with the IRS are:

- Feb. 28 for paper filers
- April 2 for electronic filers

Because of these extensions, individuals may not receive their Forms 1095-B or 1095-C by the time they are ready to file their 2017 individual income tax return. While information on these forms may assist in preparing a return, taxpayers are not required to have these forms to file. Taxpayers can prepare and file their returns using other information about their health coverage.

More information on the 1095-A extension can be found here.

###

CMS Announces Additional Special Enrollment Periods to help Individuals Impacted by Hurricanes in Puerto Rico and the U.S. Virgin Islands

Agency provides extended special enrollment periods for 2018 Medicare and Exchange coverage

En Española

The Centers for Medicare & Medicaid Services (CMS) announced additional opportunities for individuals affected by the 2017 hurricanes in Puerto Rico and the U.S. Virgin Islands to enroll in Medicare health and drug plans and health coverage

through the Federal Health Insurance Exchange. CMS is providing these special enrollment periods so that certain individuals and families who were impacted can access health coverage on the Exchange and have additional time to join, drop, or switch Medicare health and prescription drug plans. CMS announced initial special enrollment period opportunities in September, this extends these opportunities through March 31, 2018.

CMS established the following special enrollment periods to support individuals impacted by the 2017 hurricanes in Puerto Rico and the U.S. Virgin Islands:

- **Federal Health Insurance Exchange special enrollment period:** Individuals affected by the 2017 hurricanes in Puerto Rico and the U.S. Virgin Islands who relocated to a state that uses the Federal Health Insurance Exchange, but were unable to enroll during the 2018 Annual Open Enrollment Period or any other special enrollment period, are eligible for an exceptional circumstance special enrollment period to enroll in 2018 Exchange coverage. Individuals in this situation may request this special enrollment period through March 31, 2018. These individuals should contact the Exchange Call Center at 1-800-318-2596 to request enrollment using this special enrollment period.
- **Medicare special enrollment period extension:** This special enrollment period will allow individuals affected by the 2017 hurricanes in Puerto Rico and the U.S. Virgin Islands to enroll, dis-enroll or switch Medicare health or prescription drug plans through March 31, 2018. This special enrollment period can be used even if the beneficiary made a choice during Medicare's fall open enrollment period. The special enrollment period can also be used for those who left Puerto Rico and would like to enroll in a local Medicare Advantage or Medicare prescription drug plan that would better meet their healthcare needs. Beneficiaries who change their permanent residence, rather than temporarily relocate, and no longer reside in their plan service area, are eligible to join a Medicare Advantage or prescription drug plan offered in the new area in which they reside through the existing residence change special enrollment period. Individuals who were displaced and return to Puerto Rico or the U.S. Virgin Islands are also eligible for the residence change special enrollment period. Individuals in these situations may contact 1-800-MEDICARE to request enrollment using this special enrollment opportunity.

For more information on special enrollment periods for the Federal Health Insurance Exchange, visit: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Territories-SEP-Guidance.pdf

For more information on special enrollment period extension for Medicare, visit: https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Extension-SE-Period-PR-VI-CA-Wildfire.pdf

###

Canceling vs. Terminating a Consumers Coverage

There are various reasons consumers may want to end their health care coverage; however, it is important for assisters and consumers to understand the difference between canceling and terminating coverage. A consumer would proceed with ***terminating*** coverage if the consumer has enrolled and paid at least one month's premium or her coverage has been effectuated. The Marketplace requires 14 days' notice before terminating coverage. However, if the consumer is terminating coverage for some but not all the household members on the application, in most cases the coverage will end immediately for the family member(s) being terminated. Consumers should report a life change to the Marketplace Call Center in order to remove someone from an application while keeping others covered. More information can be found here: https://www.healthcare.gov/reporting-changes/how-to-report-changes/

A consumer could end their coverage by ***cancelling*** if the consumer's start date has not passed or the consumer has not made their first month's premium. When coverage is cancelled, there is no advance notice required; but the cancellation must be done prior to the policy start date.

Important Reminders

- Consumers can cancel their coverage by logging into their HealthCare.gov account and clicking "End (Terminate) All Coverage" prior to the policy effective date or by not paying their first month's premium.
- Terminating coverage generally requires a 14-day notice and cannot take place earlier than the policy start date. When ending coverage for some but not all family members or reporting changes to the consumer's household, the applicant will receive a new eligibility determination notice.
- Remind consumers to come back to report changes throughout the year.

- Note: The Marketplace Appeals Center does not review appeals for termination disputes that are not appealable (i.e., a consumer who wants a retroactive termination). Retro terminations due to Marketplace error or technical issue may be reviewed by caseworkers and evaluated, but if the retro termination is denied, there are no appeal rights.
- See https://www.healthcare.gov/how-to-cancel-a-marketplace-plan/ for more information.
- Call the Marketplace Call Center for help: 1-800-318-2596.

It's important for consumers to have coverage in place before terminating or cancelling their coverage on the Marketplace. Once consumers Marketplace coverage has ended, they will not be able to re-enroll until next open enrollment period unless they qualify for a special enrollment period.

For more information: https://www.healthcare.gov/apply-and-enroll/change-after-enrolling/

###

Consumer Action Needed

Initial warning notices have been sent to consumers who are receiving financial help with their Marketplace coverage and may also be enrolled in Medicaid or CHIP (also called Medicaid/CHIP Periodic Data Matching)

Key Takeaway**:** Consumers determined eligible for minimum essential coverage (MEC)[1] Medicaid or CHIP are not eligible for advance payments of the premium tax credit (APTC) or for income-based cost-sharing reductions (CSRs) to help pay for their Marketplace plan premium and covered services. The Marketplace has identified consumers who may be dually-enrolled in Marketplace coverage with APTC/CSRs and in MEC Medicaid/CHIP and has sent them notification of their dually-enrolled status. This spring, the Marketplace will end APTC/CSRs for dually-enrolled consumers who do not take action in response to the Medicaid/CHIP PDM initial warning notice; these consumers will remain enrolled in a Marketplace plan at full cost. Assisters can help affected consumers understand the notice(s) and complete the necessary next steps.

Overview

Consumers who are determined eligible for or are enrolled in MEC Medicaid or CHIP are ineligible for APTC and CSRs to help pay for the cost of their Federally-Facilitated Marketplace (Marketplace) [2] plan premium and covered services.[3], [4]

Medicaid/CHIP Periodic Data Matching (PDM) is the process the Marketplace uses to identify, notify, and reduce the number of consumers who are enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP (i.e. "dually-enrolled" consumers).

This month, the Marketplace sent an initial warning notice to the household contact for dually-enrolled[5] consumers, stating that if they do not take action by the date in the notice, the Marketplace will end any APTC/CSRs being paid on behalf of affected consumers, and those consumers' Marketplace coverage will continue without financial help. [6]

The notice tells the household contact (and provides instructions) to do one of the following by a specified date:

- end affected consumers' Marketplace coverage with APTC/CSRs; or
- update their Marketplace application to tell the Marketplace that affected consumers are not enrolled in Medicaid/CHIP.

In Spring 2018, at least 30 days following the initial notice, the Marketplace will send a final notice to the household contact for applications with affected consumers who did not respond to the initial warning notice by the specified date. This notice will let consumers know that they are still enrolled in a Marketplace plan but will no longer receive financial help (APTC/CSRs). Consumers who choose to remain in full-cost Marketplace coverage should notify their state Medicaid/CHIP agency of their Marketplace enrollment. If they choose to remain enrolled in full-cost Marketplace coverage, they may no longer be eligible for CHIP, but could continue to receive CHIP coverage, if otherwise eligible, by ending their Marketplace enrollment.

For anyone else on the application who is still enrolled in a Marketplace plan, their coverage will continue and eligibility for APTC/CSRs, if applicable, will be redetermined. Dually-enrolled consumers who do not want to pay full cost for their share of the Marketplace plan premium and covered services should end their Marketplace coverage immediately. The final notice

includes instructions for next steps, such as ending Marketplace coverage, confirming whether or not someone is enrolled in Medicaid/CHIP, and appealing the Marketplace's decision; it also includes the date that the changes to financial assistance become effective. The Marketplace will also send an updated Eligibility Determination Notice (EDN).

Q&A: How to help consumers who receive the notice(s)

Q1: When and how are these notices being sent to consumers?

A1: The Marketplace sent initial warning notices in February 2018 to the household contact for Marketplace applications with one or more dually-enrolled consumers. In Spring 2018, the Marketplace will send a final notice to the household contact for Marketplace applications with consumers who did not take action by the date in the initial warning notice. The Marketplace will also send an updated EDN for all consumers in the household. All notices are mailed to the household contact and/or posted to their Marketplace accounts, depending on what they selected as their communication preference.

Q2: How will consumers identify the Medicaid/CHIP PDM notices, and what do the notices say?

A2: The subject of the initial warning notice reads "Warning: Members of your household may lose financial help for their Marketplace coverage." The initial warning notice:

- Lists the dually-enrolled consumers;
- Provides instructions to either end their Marketplace coverage with APTC/CSRs, or update their Marketplace application to tell the Marketplace that they're not enrolled in Medicaid or CHIP;
- Gives them a date by which they must take action; and
- Provides instructions for consumers who want more information about Medicaid or CHIP, who aren't sure if their Medicaid or CHIP coverage qualifies as MEC, or who aren't sure whether they're enrolled in or have been determined eligible for Medicaid or CHIP.

The subject of the final notice reads "IMPORTANT: Members of your household are still enrolled in a Marketplace plan but will no longer get financial help for it." The final notice:

- Lists the dually-enrolled consumers who did not take action by the date in the initial warning notice;
- Tells them the date that Marketplace coverage without financial assistance becomes effective;
- Alerts them that they should to take immediate action to end their Marketplace coverage if they don't want to pay full cost for their share of the Marketplace plan premium and covered services;
- Provides instructions for consumers who want more information about Medicaid or CHIP, who aren't sure if their Medicaid or CHIP coverage qualifies as MEC, or who aren't sure whether they're enrolled in Medicaid or CHIP;
- Tells them what financial help consumers on the policy who are not dually enrolled will get; and
- Directs the consumer to the forthcoming EDN for more information on how to submit an appeal to the Marketplace if a consumer believes his or her financial assistance was ended incorrectly.

Copies of both notices will be available in English and Spanish, with instructions on how to get the help in other languages.

Q3: As an assister, why might consumers contact me?

A3: Consumers who receive either/both of the Medicaid/CHIP PDM notices may contact assisters:

- For help understanding the notice(s);
- For help ending Marketplace coverage with APTC/CSRs;
- For help updating their Marketplace application to tell the Marketplace they're not enrolled in Medicaid/CHIP;
- If they don't think they're enrolled in Medicaid or CHIP;

- If they aren't sure if they're enrolled in Medicaid or CHIP; or
- If they want more information about whether their Medicaid or CHIP coverage qualifies as MEC.

Q4: Where can I learn about what these consumers have to do?

A4: Look at the Medicaid/CHIP PDM User Interface Guide: www.healthcare.gov/downloads/marketplace-medicaid-chip-guide.pdf. It explains the steps consumers should to take depending on their situation. You can share this guide with consumers as well.

Q5: How can I help these consumers?

A5: Help consumers understand the notice(s). Explain that the Marketplace has sent this notice to them because the Marketplace has identified members of their household as being enrolled in both Marketplace plan with financial help **and** Medicaid or CHIP. This is important because consumers who've been determined eligible for MEC Medicaid or CHIP are not eligible for a Marketplace plan with APTC/CSRs. Consumers who receive the notices should take immediate action.

For consumers who **are** eligible for or enrolled in MEC Medicaid or CHIP:

- Encourage them to take immediate action to end their Marketplace coverage with APTC/CSRs or be prepared to pay all the costs of the Marketplace plan. Explain the potential financial impact of not ending Marketplace coverage. Consumers who choose to remain in full-cost Marketplace coverage should notify their state Medicaid or CHIP agency of their Marketplace enrollment. If they choose to remain enrolled in full-cost Marketplace coverage, they may no longer be eligible for CHIP, but could continue to receive CHIP coverage, if otherwise eligible, by ending their Marketplace enrollment.
- If they decide to end their Marketplace coverage, help them follow the instructions on HealthCare.gov for consumers who wish to end Marketplace with APTC/CSRs coverage when he or she has Medicaid or CHIP: https://www.healthcare.gov/help/end-marketplace-plan/.
- If they decide to keep their Marketplace plan **without** financial help in addition to their Medicaid or CHIP coverage, help them notify their Medicaid/CHIP agency.

For consumers who **are not** enrolled in Medicaid or CHIP:

- Help them to update their Marketplace application accordingly. They should report a "life change" on their Marketplace application and tell the Marketplace they're not enrolled in Medicaid or CHIP that counts as qualifying coverage. The Medicaid/CHIP PDM User Interface Guide explains the steps to do this.

Q6: What should I do if the consumers think they're not enrolled in Medicaid or CHIP, aren't sure if they're enrolled in Medicaid or CHIP, or aren't sure if their Medicaid or CHIP benefits qualify as MEC?

A6: Inform these consumers that they should contact their state Medicaid or CHIP agency to confirm their enrollment status. (Instructions for doing so are in the notices).

- If the state agency confirms that the consumer is not eligible for or enrolled in MEC Medicaid or CHIP coverage, he or she should update his or her Marketplace application to tell the Marketplace that he or she is not enrolled in Medicaid or CHIP by reporting a life change. The Medicaid/CHIP PDM User Interface Guide www.healthcare.gov/downloads/marketplace-medicaid-chip-guide.pdf explains the steps to do this.
- If the state agency confirms that the consumer is enrolled in MEC Medicaid or CHIP coverage, the consumer should immediately end his or her Marketplace coverage with APTC/CSRs.

Advise consumers who want more information about Medicaid or CHIP to contact their state Medicaid or CHIP agency:

- For Medicaid: Visit https://www.healthcare.gov/medicaid-chip/ scroll down to "Apply for Medicaid and CHIP 2 Ways" and select your state from the drop-down menu under the second option to apply for coverage, "Through your state agency". Once the state is selected, there will be a link to the Medicaid agency website for further assistance.

- For CHIP: Visit https://www.insurekidsnow.gov/ or call 1-877-543-7669 for more information and assistance.

Q7: What if a consumer is enrolled in Medicaid or CHIP that counts as qualifying coverage and Marketplace coverage with APTC/CSRs, but believes they are actually eligible to remain enrolled in Marketplace coverage with APTC/CSRs?

A7: A consumer who's enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP that counts as qualifying coverage may believe they are eligible to remain enrolled in Marketplace coverage with APTC/CSRs if they experienced a change in household income or family size that makes them no longer eligible for Medicaid/CHIP that counts as qualifying coverage. The consumer should contact the state Medicaid/CHIP agency to inform them of these circumstances. If the state Medicaid or CHIP agency informs the consumer that they are no longer eligible for Medicaid or CHIP that counts as qualifying coverage, the consumer should update their Marketplace application to state that they are not enrolled in Medicaid or CHIP that counts as qualifying coverage; they can remain in their Marketplace coverage with APTC/CSRs, if otherwise eligible.

Q8: How soon after the final notice is sent will the Marketplace end APTC/CSRs on behalf of affected consumers?

A8: The Medicaid/CHIP PDM final notice will include the date on which changes to financial assistance will become effective for the affected enrollees.

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[1] Most Medicaid is considered qualifying health coverage (also known as minimum essential coverage, or MEC). Some forms of Medicaid cover limited benefits (like Medicaid that only covers emergency care, family planning or pregnancy-related services) and aren't considered MEC. (For more information on which Medicaid programs are considered MEC, visit HealthCare.gov/medicaid-limited-benefits/). Most CHIP coverage is considered qualifying coverage.

[2] References to the "Marketplace" throughout refer to the Federally-Facilitated Marketplace and State-Based Marketplaces using the federal eligibility and enrollment platform.

[3] Generally, a consumer who is eligible for income-based CSRs will also be eligible for APTC. However, not all consumers who are eligible for APTC will be eligible for income-based CSRs.

[4] In accordance with recent guidance from the Internal Revenue Service (IRS), if a Marketplace makes a determination or assessment that an individual is ineligible for Medicaid or CHIP and eligible for APTC when the individual enrolls in Marketplace coverage, the individual is treated as not eligible for Medicaid or CHIP for purposes of the premium tax credit while they are enrolled in Marketplace coverage for that year.

For more information, visit: https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Premium-Tax-Credit, question 29.

[5] Due to technical limitations, dually-enrolled consumers in Ohio will not receive notices in this round of Medicaid/CHIP PDM. Consumers in this state will not be affected by this round of Medicaid/CHIP PDM.

[6] If a consumer still wants a Marketplace plan after having been determined eligible for MEC Medicaid or CHIP, he or she will have to pay full price for his or her share of the Marketplace plan premium and covered services, without APTC or income-based CSRs, if otherwise eligible. Consumers who choose to remain in full-cost Marketplace coverage should notify their state Medicaid or CHIP agency of their Marketplace enrollment. If they choose to remain enrolled in full-cost Marketplace coverage, they may no longer be eligible for CHIP, but could continue to receive CHIP coverage, if otherwise eligible, by ending their Marketplace enrollment.

###

New Resources for Assisters

Assisters are encouraged to check out Marketplace.cms.gov for new resources that are helpful for assisters. New/Updated resources available on the site include:

- Sample Applications, forms and notices
- Fact Sheets and outreach materials

- Technical Assistance Resources like Webinar Presentations & Assister Newsletters

There's lots of helpful information to support your work as an assister as well as reference information to lean on regarding marketplace complex cases, policy and operations. This website is updated often so be sure to check back periodically for new content.

###

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

- 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, and Labor Day. CACs and Navigators should call their dedicated phone lines so the Call Center can better track the needs of assisters. The dedicated Assister Line can also help with password resets and can help with access to non-application SEPs. Contact your Navigator Project Officer (for Navigators) or your designated organization leadership (for CACs) for more information on the Assister Line.

Navigator Marketplace Call Center line: 1-855-868-4678

CAC Marketplace Call Center line: 1-855-879-2683

General consumer Call Center line: 1-800-318-2596 (TTY: 1-855-889-4325).

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

###

Stay in Touch

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

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

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

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

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

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

###

MACRA/Quality Payment Program (QPP) Updates

Advancing Care Information Improvement Activities Bonus for 2017 CMS QRDA III

The Centers for Medicare & Medicaid Services (CMS) has identified an additional advancing care information identifier for use with the 2017 CMS Quality Reporting Document Architecture Category III (QRDA III) Implementation Guide (IG) Version 1.0 for Eligible Clinicians and Eligible Professionals Programs.

The identifier, ACI_IACEHRT_1 for Advancing Care Information Improvement Activities Bonus, should be used when submitting for an advancing care information bonus for the use of certified electronic health record technology (CEHRT) for an improvement activity. An updated version of the 2018 CMS QRDA III IG will be published to reflect the addition of this identifier.

This announcement is for vendors and data submitters about the additional identifier missing from the table 'Advancing Care Information Objectives and Measures Identifiers'.

- **Identifier**: ACI_IACEHRT_1
- **Description**: Advancing Care Information Improvement Activities Bonus
- **Reporting Metric**: Yes/No

If you have **not** yet submitted QRDA III data to the Quality Payment Program (QPP) for 2017 and need to account for the ACI_IACEHRT_1, you can simply include this measure identifier as part of your advancing care information section of your submission file.

If you have already submitted QRDA III data to QPP for 2017 and need to include the ACI_IACEHRT identifier, you can either:

- Submit a full QRDA III submission which includes all the data previously submitted, plus the ACI_IACEHRT_1 measure, or
- Submit a QRDA III for only the advancing care information category which includes all the data previously submitted for advancing care information, plus the ACI_IACEHRT_1 measure.

Additional QRDA-Related Resources:

You can find additional QRDA related resources, as well as current and past implementation guides, on the eCQI Resource Center. For questions related to the QRDA Implementation Guides and/or Schematrons, visit the ONC QRDA JIRA Issue Tracker.

For questions related to QPP/Merit-based Incentive Payment System data submissions, visit the QPP website or contact us by phone 1-866-288-8292, TTY: 1-877-715-6222 or email QPP@cms.hhs.gov

###

Register for Upcoming 2017 MIPS Submission Question and Answer Sessions

CMS Will Answer Questions about MIPS Submission Feature During "Office Hours" Sessions

Deadlines are fast approaching to submit data for the 2017 Merit-based Incentive Payment System (MIPS) performance period. The 2017 submission period runs **through March 31, 2018 with two exceptions**:

1. Groups using the CMS Web Interface have until **March 16, 2018** at 8pm ET to submit data.

2. Individual Eligible Clinicians submitting quality data via claims, must submit claims by **March 1, 2018**.

To help individual eligible clinicians and groups prepare for submission, CMS will be hosting "Office Hours" sessions over the next several weeks. CMS subject matter experts will answer commonly asked questions about the submission feature on qpp.cms.gov, as well as answer attendees' questions live. Registrants will also have the opportunity to email their questions prior to the sessions.

Review the Office Hour topics and register below. Please note that Qualified Registries, Qualified Clinical Data Registries and Web Interface Reporters should utilize their support calls for data submission support.

Date: February 28, 3-4pm ET

Title: Quality Payment Program Data Submission Office Hours: MIPS Quality Data Submission

Register: https://meetingconnect.webex.com/meetingconnect/onstage/g.php?MTID=e48f0bf615c2b96b0d46afa2990f71cf5

Date: March 14, 3-4pm ET

Title: Quality Payment Program Data Submission Office Hours: MIPS Attestation for Advancing Care Information and Improvement Activities

Register:
https://meetingconnect.webex.com/meetingconnect/onstage/g.php?MTID=e91c195e7ad08aa6bf083477491616247

Please note: Space for these sessions is limited. Register now to secure your spot. The audio portion of the sessions will be broadcast through the web. You can listen to the presentation through your computer speakers.

For More Information

For step-by-step instructions on how to submit MIPS data, check out this video and fact sheet. Questions about your participation status or MIPS data submission? Contact the Quality Payment Program Service Center by:

- Email: qpp@cms.hhs.gov
- Phone: 1-866-288-8292 (TTY: 1-877-715-6222)

###

Join CMS at a 2018 QCDR Measures Workgroup to Learn More about 2019 QCDR Measure Development, Processes, and Expectations

On Tuesday, February 27, 2018 at 2:00 p.m. ET, the Centers for Medicare & Medicaid Services (CMS) will host a webinar that will provide an overview of QCDR measures development, processes and expectations. This webinar is intended to assist with the measure development of QCDR measures for future program years of MIPS. Please know that CMS is not accepting additional QCDR measure submissions for 2018.

Webinar Details

Title: 2018 QCDR Measures Workgroup
Date: Tuesday, February 27, 2018
Time: 2:00-4:00 p.m. ET
Description: On Tuesday, February 27, 2018 at 2:00 p.m. ET, the Centers for Medicare & Medicaid Services (CMS) will host a webinar that will provide an overview of the development, criteria, and evaluation of QCDR Measures. Among the topics to be presented during the webinar, CMS will provide information regarding:

- How to identify meaningful quality actions (numerators)
- How to construct QCDR measures that will align with the goals and priorities of the Merit-based Incentive Payment System (MIPS) program
- How to understand the structure of multi-strata measures
- How to appropriately apply measure analytics

Audience: Current and Prospective Qualified Clinical Data Registries

Event Registration: https://engage.vevent.com/rt/cms/index.jsp?seid=1003

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. Phone lines will be available for the Q&A portion of the webinar.

For More Information
Visit qpp.cms.gov to learn more about the QCDRs.

###

Alternative Payment Models (APMs) Table Published

The Centers for Medicare and Medicaid Services (CMS) published a table displaying the Alternative Payment Models (APMs) that CMS operates. In the table CMS identifies which of those APMs CMS has determined to be MIPS APMs or

Advanced APMs. We will modify this list based on changes in the designs of APMs or the announcement of new APMs. The table displays the APMs that CMS operates. In the table CMS identifies which of those APMs CMS has determined to be MIPS APMs or Advanced APMs. We will modify this list based on changes in the designs of APMs or the announcement of new APMs.

See the table here: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Comprehensive-List-of-APMs.pdf

###

MIPS Reporting Deadlines Fast Approaching: 10 Things to Do and Know

Deadlines are fast approaching if you plan to submit data for the 2017 Merit-based Incentive Payment System (MIPS) performance period. Don't wait until the last minute to submit your data. Submit early and often. The two key dates are:

- **March 16 at 8 pm Eastern time** for group reporting via the CMS web interface
- **March 31** for all other MIPS reporting, including via qpp.cms.gov

Now is the time to act. Here are the top 10 things you need to do and know if you are an eligible clinician. This list focuses on reporting via the qpp.cms.gov data submission feature, **not** on group reporting on via the CMS Web Interface and **not** on individual reporting on Quality measures via claims submission data.

Note: If you're not sure if you are required to report for MIPS, enter your National Provider Identifier (NPI) in the MIPS Lookup Tool to find out whether you need to report. Additionally, if you know you are in a MIPS APM or Advanced APM, you can use the APM Lookup Tool.

1. Visit qpp.cms.gov and click on the "Sign-In" tab to use the data submission feature.
2. Check that your data are ready to submit. You can submit data for the Quality, Improvement Activities, and Advancing Care Information performance categories.
3. Have your CMS Enterprise Identity Management (EIDM) credentials ready, or get an EIDM account if you don't have one. An EIDM account gives you a single ID to use across multiple CMS systems.
4. Sign in to the Quality Payment Program data submission feature using your EIDM account.
5. Begin submitting your data early. This will give you time to familiarize yourself with the data submission feature and prepare your data.
6. The data submission feature will recognize you and connect your NPI to associated Taxpayer Identification Numbers (TINs).
7. Group practices:

1. A practice can report as a group or individually for each eligible clinician in the practice. You can switch from group to individual reporting, or vice versa, at any time.
2. The data submission feature will save all the data you enter for both individual eligible clinicians and a group, and CMS will use the data that results in a higher final score to calculate an individual MIPS-eligible clinician's payment adjustment.

1. You can update your data up to the March 31 deadline. The data submission feature doesn't have a "save" or "submit" button. Instead, it automatically updates as you enter data. You'll see your initial scores by performance category, indicating that CMS has received your data. If your file doesn't upload, you'll get a message noting that issue.
2. You can submit data as often as you like. The data submission feature will help you identify any underperforming measures and any issues with your data. Starting your data entry early gives you time to resolve performance and data issues before the March 31 deadline.
3. For step-by-step instructions on how to submit MIPS data, check out this video and fact sheet.

If you are in an ACO or other APM, make sure you are working with your ACO or APM to make sure they have any patient information they need to report. Remember you need to report on Advancing Care Information measures on your own.

Questions about your participation status or MIPS data submission? Contact the Quality Payment Program Service Center by:

- Email: qpp@cms.hhs.gov

- Phone: 1-866-288-8292 (TTY: 1-877-715-6222)

###

2016 Medicare Electronic Health Record (EHR) Incentive Program Payment Adjustment Fact Sheet for Critical Access Hospitals

The American Recovery and Reinvestment Act (ARRA) was enacted into law in 2009. It established incentive payments for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) to promote the adoption and meaningful use of Certified Electronic Health Record Technology (CEHRT). Meaningful use is a term defined in the authorizing legislation and by CMS in regulation and describes the use of CEHRT that furthers the goals of information exchange among health care professionals and hospitals.

As part of ARRA, Congress mandated that critical access hospitals (CAHs) that are not meaningful users of certified electronic health record (EHR) technology receive downward payment adjustments for cost reporting periods beginning in Federal fiscal year (FY) 2015 or a subsequent year.

Overview of the Program

CAHs will be subject to a downward adjustment to their Medicare reimbursement for inpatient services unless they demonstrate meaningful use under the Medicare or Medicaid EHR Incentive Program. CAHs must successfully demonstrate meaningful use of CEHRT for an EHR reporting period in calendar year (CY) 2016, or qualify for a significant hardship exception, to avoid a reduction in reimbursements for cost reporting periods beginning in FY 2016. For the FY 2016 payment adjustment year, the EHR reporting period is any continuous 90-day period within CY 2016.

How are Payment Adjustments Applied?

The adjustment applies to the Medicare reimbursement for inpatient services during the cost reporting period for which the CAH failed to demonstrate meaningful use. A CAH will receive a reduced rate of reimbursement for each FY for which it does not demonstrate meaningful use of CEHRT.

When do Payment Adjustments Begin?

Reduced Medicare payments for CAHs that do not successfully demonstrate meaningful use began with the cost reporting periods beginning in FY 2015 and will continue for each subsequent FY.

What are the Payment Adjustment Amounts for CAHs?

If a CAH did not demonstrate meaningful use of certified EHR technology for an applicable EHR reporting period, its reimbursement for a cost reporting period beginning in FY 2015 was reduced from 101 percent of its reasonable costs to 100.66 percent. For a cost reporting period beginning in FY 2016, its reimbursement was reduced to 100.33 percent of its reasonable costs. For a cost reporting period beginning in FY 2017 and for each subsequent fiscal year, its reimbursement will be reduced to 100 percent of reasonable costs. See the table below for an overview of reimbursement reductions:

Payment Adjustment Year	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020+
% of Reasonable Cost	100.66%	100.33%	100%	100%	100%	100%

###

Eligible Hospitals and CAHs: Get Help with Attestation on QNet

Medicare attestation for the CMS Electronic Health Record (EHR) Incentive Program for 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 now submit their Calendar Year (CY) 2017 attestations through the QualityNet Secure Portal (QNet).

- 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.

Attestation Resources

CMS has developed a series of user guides to help with the enrollment, registration, and attestation process:

- QNet Enrollment User Guide — a guide for creating and updating QNet accounts to prepare for Medicare attestation. The user guide includes step-by-step instructions for creating a new account on QNet.
- QNet User Role Management Guide — a guide for updating provider and administrator QNet accounts with the appropriate user account "roles" required for attestation.
- QNet Hospital Registration and Attestation User Guide — a guide for registering for attestation on QNet.
- QNet Hospital Objectives and Clinical Quality Measures User Guide — a guide for navigating the data submission process on QNet.

A video demonstration of the attestation process on QNet from a recent CMS webinar is also available. Slides from the demonstration webinar are available on the Eligible Hospital Information page.

QNet Help Desk

For help with registration and attestation on QNet, contact the QNet Help Desk rather than the EHR Incentive Program Information Center. 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 Accepting Proposals for New Measures for the Medicare EHR Incentive Program

The Centers for Medicare & Medicaid Services' (CMS) Annual Call for Measures for Eligible Hospitals and Critical Access Hospitals participating in the Medicare Electronic Health Record (EHR) Incentive Program is now open. Submit a measure proposal submission form by **June 29, 2018.**

CMS is encouraging stakeholders to identify and submit measures to be considered for inclusion in rulemaking in calendar year (CY) 2019. Measure implementation will be optional in CY 2020 but required beginning in CY 2021.

CMS is interested in adding measures that:

- Build on the advanced use of certified EHR technology (CEHRT) using 2015 Edition Standards and Certification Criteria;
- Increase health information exchange and interoperability;
- Continue improving program efficiency, effectiveness, and flexibility;
- Measure patient outcomes; and
- Emphasize patient safety.

Applicants should also consider the following:

- Would the proposed measure reduce reporting burden?
- Is the proposed measure duplicative of existing or previously removed objectives and measures?
- Would the proposed measure include an emerging certified health IT functionality or capability?

Submission Details

Proposals must be sent to CMSCallforMeasuresEHR@Ketchum.com. Applicants will receive email confirmations of their submission.

Submission forms must be complete to be considered. Proposals that do not provide information for every field/section in the form will not be evaluated for consideration. Any information/field not applicable to the measure proposal must state "N/A" or "not applicable" or the proposal will not be considered.

Resources

- Medicare EHR Incentive Program Call for Measures Submission Form

For More Information

Visit the 2018 Call for Measures page on the EHR Incentive Programs website.

###

Updates to 2017 Extreme and Uncontrollable Circumstances Policy for MIPS Clinicians

The Centers for Medicare & Medicaid Services (CMS) has updated its Extreme and Uncontrollable Circumstances policy for the 2017 Merit-based Incentive Payment System (MIPS) transition year to include counties affected by Hurricane Nate and additional counties affected by the California wildfires. CMS understands that living in an area where these disasters took place may impact your resources to collect or submit data on time.

The data submission period for the 2017 transition year of MIPS is January 2- March 31, 2018. MIPS eligible clinicians in Federal Emergency Management Agency (FEMA) designated areas affected by Northern California wildfires and Hurricanes Harvey, Irma, Maria and Nate will be automatically identified. No action is required. However, if you are automatically identified but still choose to submit data on two or more MIPS performance categories (either as an individual or group), you'll be scored on those performance categories and your MIPS payment adjustment will be based on your final score.

MIPS eligible clinicians in these newly identified designated areas for Hurricane Nate and the California Wildfires are now covered by the Extreme and Uncontrollable Circumstances policy:

- **Alabama**: Autauga, Baldwin, Choctaw, Clarke, Dallas, Macon, Mobile, and Washington
- **Mississippi**: George, Greene, Hancock, Harrison, Jackson, and Stone
- **California**: Butte, Lake, Mendocino, Napa, Nevada, Orange, Santa Barbara, Solano, Sonoma, Ventura, and Yuba

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

Questions? The Quality Payment Program Service Center can be reached at 1-866-288-8292 (TTY 1-877- 715- 6222), Monday through Friday, 8:00 AM-8:00 PM Eastern time or by email at: QPP@cms.hhs.gov.

###

2017 Merit-based Incentive Payment System (MIPS) Claims Data

CMS has announced the ability to provide performance scores for MIPS Eligible Clinicians submitting quality data via claims. This is the first time that CMS is providing claims performance scores for any quality reporting or value-based program.

For more information, visit the QPP website: https://qpp.cms.gov/

###

Medicare and Medicaid Updates

CMS Medicare-Medicaid Coordination Office (MMCO) Enrollment Trends Data Brief

The Centers for Medicare & Medicaid Services (CMS), Medicare-Medicaid Coordination Office (MMCO) is pleased to announce the following updates:

- Data Analysis Brief: Managed Care Enrollment Trends
- Disability Competent Care Webinar Series Announcement (CE credits available)
- Disability Competent Care Assessment Tool and Webinar

Data Analysis Brief: Managed Care Enrollment Trends among Medicare-Medicaid Beneficiaries and Medicare-only Beneficiaries, 2006 through 2016
The Centers for Medicare & Medicaid Services (CMS), Medicare-Medicaid Coordination Office (MMCO) is pleased to announce the release of a brief report on managed care trends from 2006 through 2016. This report shows escalating proportions of individuals enrolled in managed care among all enrollment groups; however, the proportion of Medicare-Medicaid beneficiaries (33 percent) surpassed that of Medicare-only beneficiaries (31 percent) for the first time, beginning in 2015 and holding steady in 2016. Over the 11 years since 2006, these managed care enrollment proportions represent a tripling among Medicare-Medicaid beneficiaries (from 11 percent in 2006).

Individuals entitled to only partial Medicaid benefits have consistently had the highest Medicare managed care enrollment rates, even as compared to Medicare-only beneficiaries, though the proportion of full-benefit Medicare-Medicaid beneficiaries enrolled in managed care grew at a faster pace. Enrollment in Medicare-Medicaid Plan (MMPs) offered under the Financial Alignment Initiative capitated model demonstrations, which were implemented on a phase-in basis beginning in late 2013, correlates with recent enrollment growth in managed care among full-benefit Medicare-Medicaid beneficiaries. For additional information, please find the report at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ManagedCareEnrollmentTrends2006-2016Data.pdf

###

Evaluation of the Medicare Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport: Year 1 Annual Report

CMS has released the Year 1 Annual Report for the Evaluation of the Medicare Prior Authorization (PA) Model for Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT). This report, examines data from January 2012 through June 2016 for ESRD beneficiaries and RSNAT suppliers in model states. This is the first release of information for this evaluation.

See the report here: https://innovation.cms.gov/Files/reports/rsnat-firstintevalrpt.pdf
Appendices: https://innovation.cms.gov/Files/reports/rsnat-firstintevalrpt-app.pdf

###

Final Essential Community Providers (ECP) List

For the 2019 plan year, the Centers for Medicare & Medicaid Services (CMS) is releasing a final list of Essential Community Providers (ECPs) to assist issuers with identifying providers that qualify for inclusion in a qualified health plan issuer's plan network toward satisfaction of the ECP standard under 45 CFR 156.235. Under that regulation, ECPs are defined as providers who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service (PHS) Act and entities described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA).

For additional information, click here:
Final ECP list and description webpage: https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy
ECP petition submission website https://data.healthcare.gov/cciio/ecp_petition

###

CMS Office of the Actuary releases 2017-2026 Projections of National Health Expenditures

National health expenditure growth is expected to average 5.5 percent annually over 2017-2026, according to a report published today as a 'Web First' by Health Affairs and authored by the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS).

Growth in national health spending is projected to be faster than projected growth in Gross Domestic Product (GDP) by 1.0 percentage point over 2017-2026. As a result, the report projects the health share of GDP to rise from 17.9 percent in 2016 to 19.7 percent by 2026.

The outlook for national health spending and enrollment over the next decade is expected to be driven primarily by fundamental economic and demographic factors: trends in disposable personal income, increases in prices for medical goods and services, and shifts in enrollment from private health insurance to Medicare that result from the continued aging of the baby-boom generation into Medicare eligibility.

"Personal healthcare spending" measures spending for medical goods and services provided directly to patients. Over the projection period, growth in personal healthcare prices and growth in the use and intensity of care provided collectively explain about three quarters of the growth in personal healthcare spending.

The report also found that by 2026, federal, state and local governments are projected to finance 47 percent of national health spending, up from 45 percent in 2016.

"Today's report from the independent CMS Office of the Actuary shows that healthcare spending is expected to continue growing more quickly than the rest of the economy," said CMS Administrator Seema Verma. "This is yet another call to action for CMS to increase market competition and consumer choice within our programs to help control costs and ensure that our programs are available for future generations."

These projections are constructed using a current-law framework and include major health provisions from the Tax Cut and Jobs Act and funding throughout the projection period for the Children's Health Insurance Program. These projections do not reflect other health provisions from the Bipartisan Budget Act of 2018.

Additional findings from the report:

- **Total national health spending growth:** Growth is projected to have been 4.6 percent in 2017, up slightly from 4.3 percent growth in 2016, as a result of i) accelerating growth in Medicare spending, ii) slightly faster growth in prices for healthcare goods and services, and iii) increases in premiums for insurance purchased through the Marketplaces. In 2018, total health spending is projected to grow by 5.3 percent, driven partly by growth in personal healthcare prices. Growth in personal healthcare prices is projected to rise to 2.2 percent in 2018 from 1.4 percent in 2017, reflecting, in part, faster projected prescription drug price growth as the dollar value of drugs losing patents in 2018 is smaller than in prior years. National health expenditure growth is projected to average 5.5 percent for 2019-2020 largely due to expected faster average growth in Medicare partially offset by slower average growth in private health insurance spending. For 2021-2026, average national health spending growth is projected to increase by an average of 5.7 percent, or 0.2 percentage point faster compared to average growth in 2019-2020. During this timeframe, Medicare spending growth is projected to continue to outpace growth in private health insurance spending, mostly due to enrollment growth (as baby boomers continue to age out of private insurance and into the Medicare program).

- **Medicare:** Among the major payers for healthcare over the 2017-2026 period, Medicare is projected to experience the most rapid annual growth at 7.4 percent, largely driven by enrollment growth and faster growth in utilization from recent near-historically low rates.

- **Private health insurance:** Private health insurance spending is projected to average 4.7 percent over 2017-2026, the slowest of the major payers, reflecting low enrollment growth and downward pressure on utilization growth influenced by: i) lagged impact of slowing growth in income in 2016 and 2017, ii) increasing prevalence of high-deductible health plans, and iii) to a lesser extent, repeal of the penalty associated with individual mandate.

- **Medicaid:** Medicaid is projected to average 5.8 percent annual growth over 2017-2026, which is slower than the average observed for 2014-2016 of 8.3 percent, when the major impacts from the Affordable Care Act's expansion took place.

- **Personal healthcare spending:** Over 2017-2026, growth in personal healthcare spending is projected to average 5.5 percent. Among the factors, personal healthcare price growth is anticipated to be the largest factor at 2.5

percentage points, growth in the use and intensity of goods and services is expected to contribute 1.7 percentage points of total growth, and population growth (0.9 percentage point) and changing demographics (0.5 percentage point) account for the remaining growth.

- **Prescription drug spending:** Among the major sectors of healthcare, spending growth is projected to be fastest for prescription drugs, averaging 6.3 percent for 2017-2026. This is due in part to faster projected drug price growth, particularly by the end of the period, influenced by trends in relatively costlier specialty drugs.

- **Insured share of the population:** The proportion of the population with health insurance is projected to decrease from 91.1 percent in 2016 to 89.3 percent in 2026, due in part to the elimination of the penalty payments associated with the individual mandate and also to a continuation of a downward trend in the offering and take-up of employer-sponsored health insurance.

The Office of the Actuary's report will appear at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

An article about the study is also being published by Health Affairs and is available here: http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1655

###

Visit the CQM Issue Tracker to Review eCQM Draft Measure Packages for 2019 Reporting

The Centers for Medicare & Medicaid Services (CMS) invites vendors and stakeholders to review and provide feedback on draft electronic clinical quality measure (eCQM)packages that include logic and header changes for eCQMs under consideration for CMS quality reporting and payment programs.

This opportunity will allow CMS to learn from EHR vendors who have the technical capabilities to review the draft measures in the new Clinical Quality Language (CQL) standard for logic expression and test the Health Quality Measures Format (HQMF) code by directly consuming machine readable XML files for eCQMs. Testing will help CMS to identify instances in which the XML code produces errors so that issues can be resolved prior to posting the fully specified measures this spring. The draft measures in HTML, XML, and JSON formats will be available **February 28, 2018** through **March 20, 2018**, on the CQM Issue Tracker. CMS will send a formal posting announcement on February 28, 2018, with direct links to the measures on the CQM Issue Tracker.

Please report questions and comments regarding the draft measure packages to the CQM Issue Tracker tickets listed above.

###

Updating eCQMs for 2019 Reporting

CMS is updating Eligible Hospital and Eligible Professional/Eligible Clinician eCQMs for potential inclusion in the following programs:

- The Hospital Inpatient Quality Reporting Program (IQR)
- The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for eligible hospitals, critical access hospitals and eligible professionals; and
- The Quality Payment Program (QPP): The Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

The updated eCQMs will be available on the eCQI Resource Center in Spring 2018. The measures will be expressed using CQL logic and will continue to use the Quality Data Model (QDM) as the conceptual model to express clinical concepts contained within quality measures. Refer to the QDM v5.3 Annotated version and current version of the CQL standard to better understand how they work together to provide eCQMs that are human readable, yet structured for electronic processing. Measures will not be eligible for 2019 reporting unless and until they are proposed and finalized through notice-and-comment rulemaking for each applicable program.

For More Information

To find out more about electronic clinical quality measures and CQL, visit the eCQI Resource Center.

###

Apply to Participate in the 2018 Center for Medicare & Medicaid Services (CMS) Study on Burdens Associated with Reporting Quality Measures to Receive Improvement Activity Credit for 2018

The Centers for Medicare & Medicaid Services (CMS) is conducting the 2018 Burdens Associated with Reporting Quality Measures Study, as outlined in the Quality Payment Program Year 2 final rule (CMS 5522- FC).

CMS is conducting this study to:

- Examine clinical workflows and data collection methods using different submission systems;
- Understand the challenges clinicians face when collecting and reporting quality data; and
- Make future recommendations for changes that will attempt to eliminate clinician burden, improve quality data collection and reporting, and enhance clinical care.

Clinicians and groups who are eligible for the Merit-based Incentive Payment System (MIPS) that participate successfully in the study will receive full credit for the 2018 MIPS Improvement Activities performance category. Applications for this study will be accepted through **March 23, 2018** and will be notified in spring of 2018 if selected.

Who Should Apply

MIPS-eligible clinicians participating in MIPS as an individuals or as part of a group. Clinicians do not need any outside knowledge of MIPS to participate in the study; rather the study team is interested in learning more about clinicians' experience participating in MIPS.

A limited number of clinicians who are not eligible for MIPS in 2018 will also be included in the study. To check you participation status please see the QPP Website.

Study Requirements

The study runs from April 2018 to March 2019. Study participants will have to meet the following requirements in order to complete the study and receive full Improvement Activity credit. For participants reporting as a group, their entire group will receive credit. For participants reporting as individuals, only the participating clinician will receive credit.

- Complete a 2017 MIPS participation survey in April/May 2018.
- Complete a 2018 MIPS planning survey September/October 2018.
- The Study team will invite selected participants to join a virtual 90-minute focus group between November 2018 and February 2019.
- Meet minimum requirements for the MIPS Quality performance category by submitting data for at least three measures in the MIPS Quality performance category, as required for 2018 MIPS participation. The data submitted must:
- Include one outcome measure;
- Be submitted to CMS by the final MIPS reporting deadline (March 31, 2019);
- Be submitted through any method accepted under MIPS for year 2 of the Quality Payment Program (2018).

To Apply

Click here to begin your application.

Applicants will be notified by email of their status in spring of 2018.

For more information about the study, please visit the CMS website or email MIPS_Study@abtassoc.com.

###

Upcoming Webinars and Events and Other Updates

New Medicare Card Webinar

The Centers for Medicare & Medicaid Services (CMS) Kansas City Regional Office invites you to attend the **New Medicare Card Webinar**. 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. The webinar 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 the **free** webinar is to educate those who serve people with Medicare and their caregivers so they can be a valuable resource on this initiative.

CMS will host separate webinars and informational sessions for people with Medicare and their caregivers.

Register:

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.

###

MACRA Patient Relationship Categories and Codes Educational Webinar

The Centers for Medicare & Medicaid Services (CMS) is hosting an educational webinar on **Wednesday, February 21st from 2:00 – 3:30 p.m. ET** on the MACRA Patient Relationship Categories and Codes. CMS will provide guidance for clinicians and stakeholders in classifying patient relationships, for which CMS has implemented an initial **voluntary reporting period** that began on January 1, 2018. Presenters will also address questions from participants.

Webinar Details
Title: MACRA Patient Relationship Categories and Codes
Date: Wednesday, February 21st, 2018
Time: 2:00-3:30 p.m. ET
Registration Link: https://engage.vevent.com/index.jsp?eid=3523&seid=131

The audio portion of this webinar will be broadcast through the web. You can listen to the presentation through your computer speakers. CMS will open the phone line for the Q&A portion. If you cannot hear audio through your computer speakers, please contact: CMSQualityTeam@ketchum.com.

If you have any questions about the webinar or MACRA Patient Relationship Categories and Codes, please contact macra-episode-based-cost-measures-info@acumenllc.com.

###

2018 Disability-Competent Care Series

Resources for Integrated Care is excited to announce the 2018 Disability-Competent Care Webinar Series. This series is intended to aid providers and health care professionals in improving the delivery of care to persons with disabilities. Individuals with disabilities enrolled in both Medicare and Medicaid are at higher risk for poor health outcomes when compared to individuals without disabilities.[1] This seven-part series will explore key concepts of the Disability-Competent Care (DCC) model and how organizations can best implement these concepts to empower providers and participants with

disabilities to best meet their care needs. Continuing Education Units (CEU) and Continuing Medical Education (CME) credit from CMS' Learning Management System will be available at no cost to webinar attendees.

2018 Disability-Competent Care Webinar Series
Dates: Wednesdays, February 21 - April 4, 2018
Time: 2:00 pm - 3:00 pm ET

The webinar series debuts on February 21, 2018 and will continue every Wednesday through April 4, 2018. This series is supported by the CMS Medicare-Medicaid Coordination Office.

[1] Office of the Assistant Secretary for Planning and Evaluation. (2016). Report to Congress: Social Risk Factors and Performance under Medicare's Value Based Purchasing Programs. Pages 177 –221

The full schedule for the webinar series is included below. Please scroll down for additional information on the first three webinars and details on how to register for the series.

Webinar 1: Improving Accessibility of Provider Settings
This webinar will focus on medical office accessibility, including physical and communication barriers that may impede participants with disabilities from receiving care. Representatives from the Colorado Department of Health Care Policy and Financing and CMS Office of Minority Health will discuss issues related to the ADA and provider accessibility, and the experience of developing and implementing a primary care clinic site survey. Finally, Inland Empire Health Plan will present their approach to supporting provider accessibility, tracking provider setting accessibility, and making the information available to participants and care managers.

Webinar 2: Serving Adults with Disabilities on the Autism Spectrum
This webinar will provide a basic understanding of the autism spectrum and will examine the unique care management needs of adults with disabilities who are on the autism spectrum. The discussion will highlight the experience of being autistic and the disparities and barriers these participants experience in obtaining care. LA Care health plan will highlight successful strategies they have developed to improve customer experience, including training and supporting their staff working with this population and their families and care providers.

Webinar 3: Palliative and Hospice Care for Adults with Disabilities
This webinar will discuss palliative and hospice care services and the delivery of these services to participants with disabilities. Our discussion will address advanced care planning and strategies for empowering participants and their providers to initiate these discussions. Care Oregon will present their palliative and hospice care programs, including staff and provider training that highlights how to support participants during this stage of their lives.
Intended Audience:

This series is intended for providers and health care professionals, front-line staff with health plans and provider practices, and other stakeholders interested in improving their ability to meet the needs of adults with functional limitations.

Continuing Education Credit Information:
The Centers for Medicare & Medicaid Services (CMS) is accredited to provide continuing education credit by the International Association for Continuing Education and Training (IACET) for Continuing Education Units (CEU) and by the Accreditation Council for Continuing Medical Education (ACCME) for Continuing Medical Education (CME, AMA PRA Category 1 credit for physicians and non-physicians); click here to read CMS' Accreditation Statements. CEUs or CMEs will be awarded to participants who meet all criteria for successful completion of this educational activity.

PLEASE NOTE:
- Webinar participants seeking CEU or CME credit should only claim credit commensurate with the extent of their participation in the activity.
- Estimated time to participate in the webinar: 1 hour including introductory information and interactive Q&A.
- Participants will be lead through the following requirements to obtain a CEU or CME certificate:
- Read the learning objectives and faculty disclosures
- Participate in the webinar
- Complete the post-test and program evaluation form
- A score of at least 80% on the post-test must be achieved in order to obtain CEU or CME credit.

Registration Information:
After clicking the registration link hosted on https://resourcesforintegratedcare.com/ and completing the registration form, you will receive an email from do_not_reply@on24event.com containing event log-on information. The email also contains an attachment that, when opened, will save the event log-on information to an Outlook calendar.

On the day of the live event, please use the web link to join the webinar. You can access the platform using a computer, smart phone, or tablet. The audio portion of the presentation will automatically stream through your computer/device speakers. Please make sure that the volume on your speakers is turned up. Phone dial-in information will also be available during the live event if you are unable to listen to the audio through the computer/device speakers.

For individuals that will be away from a computer, smart phone, or tablet on the day of the live webinar event, please email us at RIC@lewin.com to request dial-in information.

The Disability-Competent Care model was developed by providers and four health plans that serve Medicare-Medicaid enrollees. It was created to specifically address the unique needs of adults with disabilities. The Lewin Group, under contract with the CMS Medicare-Medicaid Coordination Office, partnered with Christopher Duff and other disability practice experts to create The 2018 Disability-Competent Care Webinar Series. Recordings of the 2018 webinar series as well as previous webinar series will be available for online streaming or download at https://www.resourcesforintegratedcare.com. The Resources for Integrated Care website also features additional resources and tools for providers and health plans.

Please contact RIC@lewin.com with any questions.

###

Register for Upcoming 2017 MIPS Submission Question and Answer Sessions

CMS Will Answer Questions about MIPS Submission Feature During Three "Office Hours" Sessions

Deadlines are fast approaching to submit data for the 2017 Merit-based Incentive Payment System (MIPS) performance period. The 2017 submission period runs **through March 31, 2018 with two exceptions**:

1. Groups using the CMS Web Interface have until **March 16, 2018** at 8pm ET to submit data.

2. Individual Eligible Clinicians submitting quality data via claims, must submit claims by **March 1, 2018**.

To help individual eligible clinicians and groups prepare for submission, CMS will be hosting three "Office Hours" sessions over the next several weeks. CMS subject matter experts will answer commonly asked questions about the submission feature on qpp.cms.gov, as well as answer attendees' questions live. Registrants will also have the opportunity to email their questions prior to the sessions.

Review the Office Hour topics and register below. Please note that Qualified Registries, Qualified Clinical Data Registries and Web Interface Reporters should utilize their support calls for data submission support.

Date: February 14, 3:30-4:30pm ET

Title: Quality Payment Program Data Submission Office Hours: Individual Eligible Clinician and Group Submission

Register:
https://meetingconnect.webex.com/meetingconnect/onstage/g.php?MTID=e403e3464cec883a31314bc1f45f11d0e

Date: February 28, 3-4pm ET

Title: Quality Payment Program Data Submission Office Hours: MIPS Quality Data Submission

Register:
https://meetingconnect.webex.com/meetingconnect/onstage/g.php?MTID=e48f0bf615c2b96b0d46afa2990f71cf5

Date: March 14, 3-4pm ET

Title: Quality Payment Program Data Submission Office Hours: MIPS Attestation for Advancing Care Information and Improvement Activities

Register:
https://meetingconnect.webex.com/meetingconnect/onstage/g.php?MTID=e91c195e7ad08aa6bf083477491616247

Please note: Space for these sessions is limited. Register now to secure your spot. The audio portion of the sessions will be broadcast through the web. You can listen to the presentation through your computer speakers.

For More Information

For step-by-step instructions on how to submit MIPS data, check out this video and fact sheet. Questions about your participation status or MIPS data submission? Contact the Quality Payment Program Service Center by:

- Email: qpp@cms.hhs.gov
- Phone: 1-866-288-8292 (TTY: 1-877-715-6222)

###

New Additions to the CMS New Medicare card Partners & Employers page:

- The New Medicare Card slides from January 31, 2018 National Medicare Education Program webinar are available, labeled as the January 2018 partner update slides.

- The "10 Things to Know About Your New Medicare Card" fact sheet is now available in additional languages (Korean, Chinese, Japanese, Vietnamese, Arabic).

- A downloadable (captioned) version of the informational video is available. This version can be used in patient waiting rooms or other venues where patients congregate.

###

Assister Webinar

Friday, February 2 webinar with a presentation on Changes in Circumstances is available at: https://goto.webcasts.com/starthere.jsp?ei=1173220&tp_key=d6cb7315a3.

###

Medicare Learning Network

News & Announcements

- Patients over Paperwork: January Newsletter
- Open Payments Registration
- MIPS: Call for Advancing Care Information Measures and Improvement Activities
- Quality Payment Program: Advanced APM Table
- Hospice Quality Reporting Program Resources
- LTCH Quality Reporting Program: Materials from December Training
- SNF QRP Quality Measure and Review and Correct Report: Calculation Error
- Home Health Review and Correct Report: Correction
- Influenza Activity Continues: Are Your Patients Protected?
- MIPS Reporting Deadlines Fast Approaching: 10 Things to Do and Know
- Quality Payment Program: Performance Scores for 2017 Claims Data
- Diabetic Self-Management Training Accreditation Program: New Webpage and Helpdesk
- Measures of Hospital Harm: Comment by February 16
- EHR Incentive Program: Accepting Proposals for New Measures by June 29
- New Option for Submission of Medicare Cost Reports

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors — Reminder
- Home Health Care: Proper Certification Required — Reminder

Claims, Pricers & Codes

- January 2018 OPPS Pricer File

Upcoming Events

- What's New with Physician Compare Webinar — February 21 or 22
- Comparative Billing Report on Opioid Prescribers Webinar — February 21 or March 7
- Improving Accessibility of Provider Settings Webinar — February 21
- ESRD QIP: Final Rule for CY 2018 Call — February 22
- 2018 QCDR Measures Workgroup Webinar — February 27
- Serving Adults with Disabilities on the Autism Spectrum Webinar — February 28
- MIPS Quality Data Submission Webinar — February 28
- Palliative and Hospice Care for Adults with Disabilities Webinar — March 7
- Low Volume Appeals Settlement Option Update Call — March 13
- Open Payments: The Program and Your Role Call — March 14
- MIPS Attestation for Advancing Care Information and Improvement Activities Webinar — March 14

Medicare Learning Network Publications & Multimedia

- E/M Service Documentation Provided by Students MLN Matters Article — New
- Medicare Enrollment Resources Educational Tool — Revised
- Medicare Part B Immunization Billing Educational Tool — Reminder
- PECOS FAQs Booklet — Revised
- PECOS for DMEPOS Suppliers Booklet — Revised
- Safeguard Your Identity and Privacy Using PECOS Booklet —Revised
- PECOS for Provider and Supplier Organizations Booklet — Revised
- PECOS Technical Assistance Contact Information Fact Sheet — Revised
- Health Professional Shortage Area Physician Bonus Program Fact Sheet — Revised
- Medicare Secondary Payer Booklet – Reminder
- Beneficiaries in Custody under a Penal Authority Fact Sheet — Reminder

###

New Medicare Card Project

Wednesday, February 28, 2018

From April 2018 to April 2019, older adults will receive new Medicare cards from CMS. To help protect elders from identity theft, these new cards will replace social security numbers with Medicare numbers that are unique to each beneficiary.

Follow the CMS Medicare messaging guidelines (PDF, 106 KB, 3 pp) to share these changes with elders in your community. To help prevent identity theft, remind elders to guard their cards.

This webinar focuses on the implementation of the new Medicare card and its impact throughout Indian Country.

Objectives:

- Why CMS is undertaking this project
- What the Medicare Beneficiary Identifier (MBI) is
- How CMS will transition from the old number (HICN) to the MBI
- What providers should do to get ready for the new MBI
- How this project impacts Native Americans
- How CMS outreach efforts increase awareness

Have questions for our presenter? Let us know before the webinar by emailing Itssinfo@kauffmaninc.com, or during the webinar.

###

Register

More information

Please note your location's call-in time:

9 a.m. Hawaii
10 a.m. Alaska
11 a.m. Pacific
12 p.m. Mountain
1 p.m. Central
2 p.m. Eastern

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