CMS Region 7 Updates – 03/23/2018

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ACA/Marketplace Updates

Reminder: Failure to File and Reconcile—Helping Consumers Understand and Take Action

Consumers are not eligible for advance payments of the premium tax credit (APTC) if APTC was previously paid on behalf of the tax filer of the application, but the tax filer did not file a federal income tax return for the year during which APTC was paid and did not reconcile the associated APTC.

Households who received APTC in a past year but whose tax filer did not file a tax return and reconcile past APTC are flagged by the Internal Revenue Service (IRS) as "failure to file and reconcile"—or FTR—when the Federally-facilitated Marketplace ("Marketplace") requests updated tax data. Starting with Open Enrollment for 2016, the Marketplace began discontinuing APTC for consumers whose tax filers had APTC paid on their behalf but did not file a tax return for that year. In 2018, the Marketplace also began ending APTC for enrollees whose tax filers did file a tax return but did not reconcile APTC (non-reconcilers).

Application Attestation:

Due to lags in IRS data updates, the Marketplace application contains a tax filing-related question (Figure 1) that allows enrollees who received APTC in the past to attest, under penalty of perjury, to having filed a tax return and reconciled APTC for any year during which APTC was paid on their behalf. This attestation allows enrollees to maintain APTC even if IRS' data has not yet reflected that they filed and reconciled.

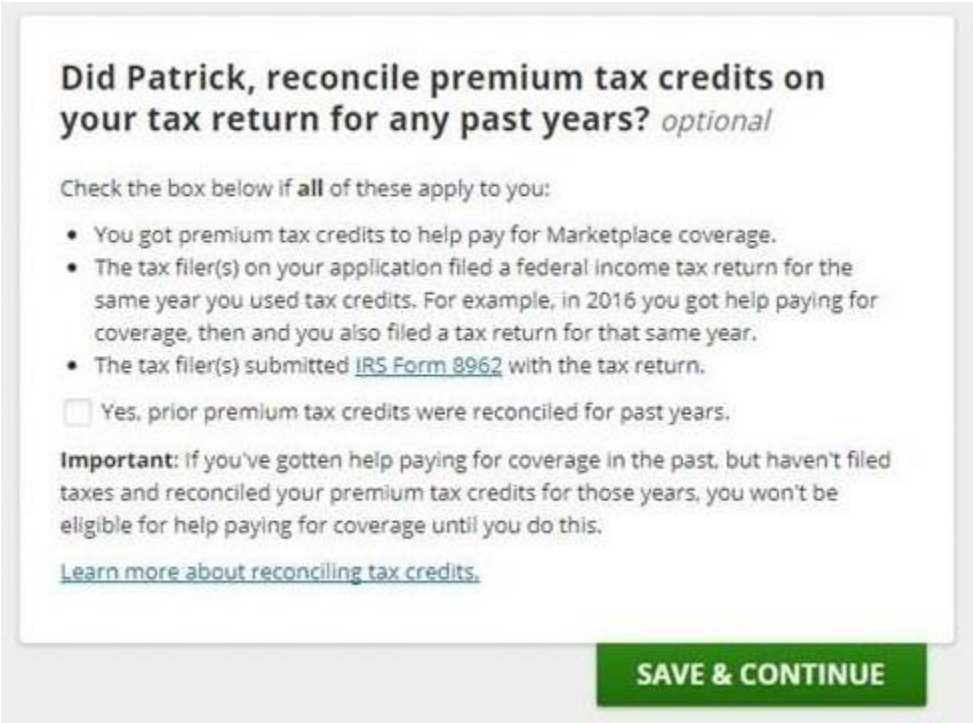

Figure 1: Attestation question on the Marketplace application.

FTR Recheck

Because the Marketplace gave consumers the option to attest to having filed and reconciled during the open enrollment period, it performs a recheck of IRS data to verify that those who attested actually filed and reconciled. In February 2018, the Marketplace checked the tax filing status of consumers:

1. Who are enrolled in a 2018 Marketplace plan with APTC; and
2. Who received APTC in 2016 but had not filed a 2016 tax return and/or reconciled 2016 APTC, according to IRS data.

Following this data recheck in February, the Marketplace sent two FTR warning notices that encouraged consumers to make sure their tax filer filed and reconciled for 2016, and if he or she did not, to file and reconcile immediately or their APTC will be removed. One notice was mailed to tax filers and one notice was addressed to the household contact for the application (which in most circumstances it the same as the tax filer).

What Assisters Can Do:

- Make sure enrollees know the process changed for 2018 coverage: enrollees are not eligible for APTC if their tax filer did not reconcile their past APTC using IRS Form 8962, even if they filed their 2016 taxes. These consumers must amend their 2016 tax returns and complete IRS Form 8962.
- Encourage enrollees who received APTC in 2016 to file (or amend) their 2016 federal income taxes and reconcile their APTC as soon as possible, even if they missed the filing deadline or they are within their filing extension period.
- Remind enrollees that even if they usually don't have to file an income tax return, if they received APTC, they must file a return for that year.
- Help enrollees who haven't filed their taxes understand what steps to take, including helping them access their Forms 1095-A and report any errors.

Answer to an Assister Question:

Assister Question: I assisted a consumer that showed me a letter from the Marketplace stating that he would lose his APTC unless the Marketplace received word from IRS that the he filed and reconciled his past taxes and APTC. He ended up losing his APTC and is paying full price for coverage. If he files and reconciles his past taxes and APTC now, would he be eligible for APTC instantly? Would he receive premium money back from his insurance company for the months that he was paying full price vs a lesser premium with the APTC applied?

Answer: It can take several weeks for a tax return to be processed by IRS and then for that filing status to be available to the Marketplace, so it's important to file as soon as possible upon receiving a warning notice, and to file and reconcile for all years APTC has been received. If an enrollee has already had his APTC discontinued, he can regain APTC prospectively after he files and reconciles, by updating his application and clicking "Yes" to the application question asking whether all past premium tax credits were reconciled. However, APTC will not be restored retroactively to the date it was discontinued, so no premium payments will be refunded from the issuer.

###

Coverage to Care Resources for Assisters and Consumers

What resources are available for consumers?

C2C consumer resources, many of which are available in different languages (English, Arabic, Chinese, Haitian Creole, Korean, Russian, Spanish, and Vietnamese) include:

- *A Roadmap to Better Care and a Healthier You*- The roadmap explains what health coverage is and how to use it to get primary care and preventive services you need.
- *5 Ways to Make the Most of Your Health Coverage* – A quick reference on how to make the most of your health coverage.
- *How to Maximize Your Health Coverage* – This short animated video is available in English and Spanish to demonstrate why using health coverage is important and where to begin. Watch, download, or share.
- *A Roadmap to Behavioral Health* is a companion guide to the Roadmap to Better Care and a Healthier You with vital information about mental health and substance use disorder services, finding a behavioral health provider, defining behavioral health terms, receiving services, and following up on care.

C2C Partner Resources include:

- *Manage Your Health Care Costs* is a guide for assisters to help consumers understand health insurance costs and terms, know their own specific health insurance costs, plan for health care costs, and know how to pay their premium.
- *Partner Toolkit* - This toolkit provides ideas on how to partner, including ready-to-use language and social media graphics, in both English and Spanish, to help you share C2C resources with people in your community.
- *A Roadmap to Better Care and a Healthier You — Customizable* This file allows you to create your own custom version of the Roadmap, and includes fillable fields where you can add information that could be helpful to your community, such as your own contact information or other local resources.

How can my organization use *From* C2C materials?

Please use the resources available on the C2C website go.cms.gov/c2c at community outreach events. Assisters can distribute the materials or use them to help create your own. Use the fillable PDF of the Roadmap to customize our Roadmap with your information so consumers can contact you directly if they have questions about accessing care. All resources can be downloaded from the website or printed copies can be ordered at no cost to your organization from the CMS Product Ordering Website (http://productordering.cms.hhs.gov/).

How can I become a C2C partner?

Assisters may easily become a partner by downloading the Partner Toolkit and begin sharing information. The Partner Toolkit contains a web badge you can use to link to our site, a drop-in newsletter article, a blog post, social media posts and graphics, and information about the program. Assisters can download it on the C2C website: go.cms.gov/c2c To receive updates on new products and other C2C information, Assisters may also sign up for updates directly from C2C by signing up for the C2C listserv.

###

Summary of Webinar presentation on "Marketplace Eligibility Appeals"

The Friday, February 16, 2018 assister webinar included a presentation on the Marketplace eligibility appeals process. Once consumers apply for coverage in the Marketplace, they will get an eligibility notice that explains what they qualify for. If consumers do not agree with a decision made by the Health Insurance Marketplace, they may be eligible to file an appeal.

Here are some highlights from the presentation:

WHEN can a consumer file a Marketplace appeal?

- Consumers have 90 days from the date of their eligibility notice to start an appeal of that eligibility determination.

WHAT kinds of Marketplace decisions can consumers appeal?

- Whether they're eligible to buy a Marketplace plan
- Whether they can enroll in a Marketplace plan outside the regular Open Enrollment Period
- Whether they're eligible for lower costs based on their income
- The amount of savings they're eligible for
- In certain states, whether they're eligible for Medicaid or the Children's Health Insurance Program (CHIP)
- Whether they are eligible for an exemption from the individual responsibility requirement

HOW can consumers file a Marketplace eligibility appeal? Here are the 2 ways consumers can request an appeal:

• Consumers may mail a letter or their state's appeal request form to:

Health Insurance Marketplace
Attn: Appeals

• Consumers may fax an appeal request to this secure fax line: 1-877-369-0129

*Note: Depending on the state and consumers' eligibility results, consumers' **may be able to appeal through the Marketplace or they may have to file an appeal with their state Medicaid or CHIP agency**. The consumers' eligibility notice will explain.

THEN what happens?

Once consumers submit their eligibility appeal, the Marketplace Appeals Center will review their request. They'll get a letter in the mail letting them know that the Marketplace Appeals Center received the appeal. The Marketplace Appeals Center will contact consumers to discuss the appeal and, if possible, will work with consumers to **resolve the appeal informally**. If consumers have questions about their eligibility appeal, they can call the Marketplace Appeals Center at 1-855-231-1751. TTY users should call 1-855-739-2231. If consumers are not satisfied with the outcome of the informal resolution of their eligibility appeal, they have **the right to a hearing**. A hearing is a more formal way for consumers to present their case and get a decision on their appeal. If consumers want a hearing, a federal hearing officer will conduct it, usually by phone. Generally, consumers will get a letter in the mail at least 15 days before their hearing with the date, time, and instructions on how to call into the hearing.
If consumers don't show up for their hearing, their appeal will be dismissed. If a consumer's appeal is dismissed, it's the same as if the appeal had never filed an appeal, and the consumer's last Marketplace eligibility determination will remain in effect.

IF AN APPEAL IS URGENT, consumers can request an expedited appeal.
Consumers can file a request for an expedited (faster) appeal if the time needed for the standard appeal process would jeopardize the consumer's life or ability to attain, maintain, or regain maximum function.
Consumers' requests to expedite their appeal should specifically explain how a standard appeal would jeopardize their life or their ability to attain, maintain, or regain maximum function.
Consumers' requests to expedite their appeals will be processed as quickly as possible. A final appeal decision will be made as quickly as possible.

THE MARKETPLACE CAN HELP. Consumers can visit Healthcare.gov here to get more information on how to get help filing an appeal. If consumers want to get help in a language other than English, they have the right to get help and information about appeals and other Marketplace issues in their language at no cost. To talk to an interpreter, consumers can call 1-800-318-2596.

SHOP MARKEPLACE DECISIONS CAN ALSO BE APPEALED. Consumers can visit Healthcare.gov here to get more information on how to appeal a SHOP Marketplace decision.

Additional Resources:

- **HealthCare.gov – "How to appeal a Marketplace decision"**
- **Fact sheet and instructions - Appeals: Eligibility & Health Plan Decisions in the Health Insurance Marketplace**
- **How to Appeal a Marketplace Decision versus a Health Plan Decision**
- **What to Do if your Marketplace Appeal is Invalid**

Q&A from the Marketplace Appeals Presentation

Q1: How can consumers request an expedited appeal?
A1: To resolve a case more quickly, consumers must tell the Marketplace Appeals Center on their appeal form why an appeal request needs to be expedited. Appeals can be expedited if the appellant has an immediate need for health services, and a delay could seriously jeopardize their life, health, or ability to attain, maintain, or retain maximum function. If an appellant's health status changes after he or she has filed their appeal (which did not include a request for an expedited appeal), they can call the Marketplace Appeals Center and ask for an expedited appeal, explaining why they need one.

Q2: How can consumers appeal decisions made by their insurance company?
A2: These types of appeals should be pursued through the consumer's insurance company, not through the Marketplace Appeals Center. Please refer to plan documents or contact the insurance company for further information about their appeal process.

Q3: Where can we find the form consumers can use to designate an authorized representative?
A3: The authorized representative form can be found in the middle of the page here: https://www.healthcare.gov/marketplace-appeals/getting-help/

Q4: Why does it take 90 days for the Marketplace Appeals Center to process appeal requests?
A4: Oftentimes, the appeals process takes that amount of time when the Marketplace Appeals Center needs additional documentation from the consumer. All appeals are processed as timely as possible.

###

Refresher: Reporting a Life Change

When consumers have life events, it is essential that they report them to the Marketplace. This is because certain life events could impact both consumers' eligibility for coverage as well as the level of financial assistance (APTC or CSRs) that they may qualify for. Certain life changes could also result in consumers' being determined or assessed as eligible for Medicaid or CHIP, which could lead to additional cost savings or covered benefits for them or their family. That is why reporting a life change is so important.

Consumers are required to report changes affecting eligibility information on their application within **30 days** of the change.

Certain life changes may also make consumers eligible for a Special Enrollment Period (SEP) that may allow them to make changes to their coverage. If consumers are eligible for an SEP they have **60 days** to make changes to their coverage.

For more SEP information, visit:

https://marketplace.cms.gov/technical-assistance-resources/sep-preenrollment-verification-overview.pdf

https://marketplace.cms.gov/outreach-and-education/special-enrollment-periods-available-to-consumers.pdf

Consumers can report life changes in one of two ways:

1. Online: Consumers can visit HealthCare.gov and log in to their Marketplace account (or create an account if they don't have one). Select their submitted application; then, select **"Report a life change"** from the menu on the left.
2. By phone: Contact the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325.

After a consumer reports a life change, he or she will receive a new eligibility notice that explains whether they qualify for an SEP. The eligibility notice will also explain both their coverage options and whether they are eligible for lower costs based on their reporting Life Change.

Steps to Report a Life Change

To report a life change, consumers should take the following steps to update their application online.

1. Log into their HealthCare.gov account.
2. Choose the application they want to update.
3. Click "**Report a life change**" on the left-hand menu.
4. Read through the list of changes and click "**Report a life change**" to get started.
5. Select the kind of change they want to report.
6. Navigate through their application and report any changes to their income, household members, address, new health coverage offers, and other information.

For more information about reporting life changes, visit Healthcare.gov:

- https://www.healthcare.gov/reporting-changes/when-you-move/
- https://www.healthcare.gov/reporting-changes/why-report-changes/
- https://www.healthcare.gov/reporting-changes/how-to-report-changes/
- https://www.healthcare.gov/reporting-changes/which-changes-to-report/

###

Notices Mailed to Consumers Who May Be Enrolled in Marketplace Coverage & Medicare

Key Takeaway: Recently, the Federally-facilitated Marketplace (FFM) mailed paper notices to the household contacts of consumers who may be enrolled in a Marketplace plan and Medicare that qualifies as minimum essential coverage (MEC). The notices include instructions on what to do next. Generally, consumers determined eligible for MEC Medicare should not be enrolled in Marketplace coverage and are not eligible for a Marketplace plan with APTC or CSRs. If consumers who receive this notice contact assisters with questions, assisters can help them understand the notice and complete the necessary next steps.*

*****Medicare Parts A and C are considered MEC. Medicare Parts B and D are not considered MEC.*

Overview

The FFM confirms MEC Medicare enrollment through a Medicare Periodic Data Matching (PDM) process. During this round of Medicare PDM, the Marketplace identified all consumers who are enrolled in MEC Medicare and Marketplace coverage (i.e. "dually enrolled" consumers). If the FFM confirms MEC it's possible that these consumers may be at risk for a tax liability if they are receiving APTC for their Marketplace coverage. Therefore, all consumers who are identified as enrolled in MEC Medicare should return to their application to end their Marketplace coverage.

Recently, as part of Medicare PDM, the FFM mailed paper notices to the household contact for all consumers found to be dually enrolled in MEC Medicare and Marketplace coverage with and without APTC. The notices included:

- Names of consumers who were found to be dually enrolled;
- A recommendation that individuals who are found to be enrolled in MEC Medicare should not be enrolled in Marketplace coverage and are not eligible for APTC/CSR through the Marketplace;
- Instructions on the correct action to take on Marketplace coverage (for consumers enrolled in MEC Medicare); and
- Contact information to confirm if they are enrolled in Medicare or if they have any questions.

Q&A: How to help consumers who receive the notice.

Q1: If a consumer is 65, but doesn't have enough quarters to qualify for premium-free Medicare Part A and can't afford premium Part A, do they have to enroll in Part B and can they stay on their Marketplace plan?

A1: For consumers who must pay a premium for Medicare Part A, we recommend that they compare their Marketplace benefits and premiums to Medicare to see what best fits their needs and budget. In this scenario, they would not have to take Part B.

Q2: Shouldn't consumers dually enrolled in MEC Medicare and Marketplace coverage end their Marketplace coverage right away? Won't they have to pay back any APTCs?

A2: Yes, they may be liable to pay back all or some of the APTC paid on their behalf during months of overlapping coverage. We strongly encourage that they end their Marketplace coverage only after they have confirmation of their Medicare Part B enrollment to avoid gaps in coverage.

Q3: What if a person is of Medicare age but does not qualify for premium-free Medicare Parts A or B? Can she still enroll through the Marketplace?

A3: Yes, as long as she is otherwise eligible (e.g. they are lawfully present, their eligibility has been verified through electronic data sources, etc.), she can still enroll in a Marketplace plan.

Q4: Are there special instructions for those who are dually enrolled and entitled to Medicare due to an end-stage renal disease (ESRD) diagnosis?

A4: Consumers with a diagnosis of ESRD can choose between enrolling in Medicare or Marketplace coverage at the time of their ESRD diagnosis. But if a consumer with ESRD does choose to enroll in Medicare Part A, we highly recommend that they enroll in Medicare Part B as well to ensure their medical costs associated with their ESRD diagnosis are covered.

###

Final Notices Sent To Consumers Who Were Found To Be Dually-Enrolled In Marketplace Coverage with Financial Help and MEC Medicaid or CHIP: Consumer Action Suggested

*Key Takeaway: In February 2018, the Marketplace**[1]** sent an initial warning notice to consumers who were found to be enrolled in Medicaid or the Children's Health Insurance Program (CHIP) that counts as qualifying coverage (also known as minimum essential coverage, or MEC)[2] and were also enrolled in Marketplace coverage with advance payments of the premium tax credit (APTC) and/or income-based cost-sharing reductions (CSRs). The initial warning notices requested that consumers take the appropriate action by a specific date. Consumers who did not do so are being sent a final notice this spring, informing them that: (a) the Marketplace has ended any APTC/CSRs being paid on their behalf, (b) their Marketplace coverage will continue without financial help, and (c) eligibility for APTC/CSRs for anyone else on the Marketplace application has been redetermined, if applicable. **Dually-enrolled consumers who do not want to pay full cost for their share of the Marketplace plan premium and covered services will need to end their Marketplace coverage immediately.** Assisters can help affected consumers understand the notice and complete the necessary next steps.*

Overview

Consumers who are determined eligible for or are enrolled in Medicaid or CHIP that counts as qualifying coverage are ineligible for APTC and CSRs to help pay for the cost of their Marketplace plan premium and covered services.[3], [4] Medicaid/CHIP PDM is the process the Marketplace uses to identify consumers who are enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP (i.e. "dually-enrolled" consumers). In February 2018, following the most recent data match with state Medicaid and CHIP agencies, the Marketplace sent an **initial warning notice** to the household contact for dually-enrolled consumers,[5] stating that if they did not take action by the date in the notice, the Marketplace would end any APTC/CSRs being paid on affected consumers' behalf, and their Marketplace coverage would continue without financial help.[6] The notice told consumers to do one of the following (and provided instructions) by a specified date: end their Marketplace coverage with APTC/CSRs if they were enrolled in Medicaid or CHIP; OR update their Marketplace application to tell the Marketplace that they're not enrolled in Medicaid/CHIP. The notice was mailed and/or posted to the household contact's Marketplace account, depending on what they selected as their communication preference.

This spring, a **final notice** is being sent to the household contact for consumers who did not respond by the date specified in the initial warning notice, letting them know that affected consumers are still enrolled in a Marketplace plan but will no longer receive financial help for their 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. 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, has been 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 is also sending an updated Eligibility Determination Notice (EDN). All notices are mailed and/or posted to the household contact's Marketplace account

Consumers who receive the Medicaid/CHIP PDM final notice may contact assisters for help understanding the notice and determining next steps. Here are some examples of the ways that assisters can help consumers who contact them:

- **Help consumers understand the notice**. Explain that the notice has been sent to them because the Marketplace has identified them as being enrolled in Marketplace coverage with APTC/CSRs *and* Medicaid or CHIP. This is important because consumers who are determined eligible for or are enrolled in Medicaid or CHIP are not eligible for APTC and CSRs to help pay for the cost of their Marketplace plan premium and covered services. Because the consumer did not respond by the date listed in the initial warning notice, they will remain enrolled in a Marketplace plan but will no longer receive financial help for their 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. 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, has been redetermined. ***Dually-enrolled consumers who do not want to pay full cost for their share of the Marketplace plan premium and covered services will need to 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 changes to financial assistance will become effective.

- **Encourage consumers who have been determined eligible for or are enrolled in Medicaid or CHIP to take immediate action** to end their Marketplace coverage if they do not want to pay full cost for their share of the Marketplace plan premium and covered services (see these instructions on HealthCare.gov: https://www.healthcare.gov/medicaid-chip/cancelling-marketplace-plan/). Explain the 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.

- **Inform consumers who don't think they're enrolled in Medicaid or CHIP, who aren't sure if their Medicaid or CHIP benefits count as qualifying coverage, or who aren't sure if they've been determined eligible for or if they're enrolled in Medicaid or CHIP,** that they may wish to contact their state Medicaid or CHIP agency to confirm their enrollment status (instructions are in the notice). If the state agency confirms that the consumer is not eligible for or enrolled in Medicaid or CHIP that counts as qualifying coverage, and/or if the consumer doesn't agree that their financial help should end, they can appeal the Marketplace's decision (more information is in the notice). However, if the state agency confirms that the consumer is eligible for or enrolled in Medicaid or CHIP that counts as qualifying coverage, the consumer will need to end their Marketplace coverage immediately if they don't want to remain enrolled in Marketplace coverage without financial assistance. 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.

- **Advise consumers who want more information about Medicaid or CHIP** to contact their state Medicaid or CHIP agency.

Q&A: How to help consumers who receive the Medicaid/CHIP PDM final notice

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 applications with one or more dually-enrolled consumers. This spring, the Marketplace is sending a final notice to the household contact for applications with dually-enrolled consumers who did not take action by the date in the initial warning notice. The Marketplace is also sending an updated EDN for all consumers in the household. All notices are mailed and/or posted to the household contact's Marketplace account, depending on what they selected as their communication preference.

Q2: How will consumers identify the Medicaid/CHIP PDM final notice, and what does the notice say?

A2: 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."* 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 end Marketplace coverage immediately 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 counts as qualifying coverage, OR who aren't sure whether they're enrolled in or eligible for Medicaid or CHIP;
- Tells them what financial help consumers on the policy who are not dually-enrolled will get, if applicable;
- Directs consumers to the final EDN for more information on how to submit an appeal to the Marketplace if a consumer believes their financial assistance was ended incorrectly.

Copies of the notice are available in English and Spanish, with instructions on how to get language assistance services for consumers who need help in another language.

Q3: Can affected consumers who didn't respond to the initial warning notice retroactively terminate their Marketplace plan to avoid having to pay full cost for their share of Marketplace plan premiums and covered services?

A3: The Marketplace generally will not provide retroactive terminations for Marketplace coverage for dually-enrolled consumers. We urge consumers who are determined eligible for or enrolled in Medicaid or CHIP who do not want to remain enrolled in Marketplace coverage without financial assistance to end their Marketplace coverage immediately.

Q4: When will Marketplace coverage without financial assistance become effective for affected consumers?

A4: The Medicaid/CHIP PDM Stop APTC final notice will include the date on which changes to financial assistance will become effective for the household.

Q5: What should I tell consumers who think their financial help was terminated incorrectly to do?

A5: Tell consumers who believe their financial assistance was ended incorrectly that they can appeal the decision. The information on how to submit an appeal to the Marketplace is on their final notice. Help them understand the following information.

- Generally, they have 90 days from the date of this notice to request an appeal with the Marketplace.
- They can represent themelves or appoint a representative to help them with their appeal. This person can be a friend, relative, lawyer, or someone else.
- They can ask to keep their eligibility during your appeal. If they were previously eligible for Marketplace coverage or financial assistance and your eligibility is changed, they can appeal this change. In this case, they may be able to keep your previous eligibility during your appeal.
- The outcome of an appeal could change the eligibility of other members of their household even if they don't ask for an appeal. To request an appeal, they can do one of these things:
- Visit HealthCare.gov/marketplace-appeals to get the Appeal Request form for your state; or
- Write a letter requesting an appeal. They need to include name, address, and the reason they're requesting the appeal. If they're requesting an appeal for someone else (like your child), also include their name. Then, they fax the appeal request to a secure fax line: 1-877-369-0130 or mail it to: Health Insurance Marketplace ATTN: Appeals465 Industrial Blvd. London, KY 40750-0061

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[1] References to the "Marketplace" throughout refer to the Federally-Facilitated Marketplaces (including State Partnership Marketplaces) and State-Based Marketplaces using the federal eligibility and enrollment platform.

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

[3] Generally, 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 did not receive notices in this round of Medicaid/CHIP PDM. Consumers in these states 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 Medicaid or CHIP that counts as qualifying coverage, they will have to pay full price for their 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.

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New Assister Resources

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 a Refresher on Data Matching Issues (DMIs), How to Resolve DMIs, and How to Upload Required Documents

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.

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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, 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

Merit-based Incentive Payment System (MIPS) Deadline – March 31, 2018

The **March 31, 2018** data submission deadline for the Merit-based Incentive Payment System (MIPS) is quickly approaching!

As you prepare to submit 2017 MIPS data for the Quality performance category, CMS encourages you to review its 2017 Quality resources. Below is a list of all of the Quality performance category resources in one place:

- Quality Performance Fact Sheet – Provides an overview of the 2017 Quality performance category requirements and information about what is needed to submit your 2017 Quality data.
- Quality Measure Specifications – Includes descriptions of, and requirements for, each of the Quality performance category measures.
- 2017 Quality Benchmarks – Details the benchmarks that each Quality performance category measure is assessed against to determine how many points the measure earns.
- Quality Measure Specifications Supporting Documents – Provides additional information for clinicians submitting quality measures via claims and registries.
- MIPS Quality Performance Category Claims Data Submission Fact Sheet – Discusses how to submit data through your claims for the Quality performance category, and offers data collection and submission tips for you and your billing staff.
- MIPS Eligible Measure Applicability (EMA) Resources – Includes an overview fact sheet and supporting documents that provide details about EMA analysis and how it affects your Quality performance calculation and score.
- Patient-Facing Encounter Codes Fact Sheet and List – Defines patient-facing encounters and details the categories included in the patient-facing encounter codes list, which is used to determine the non-patient facing status of MIPS eligible clinicians.
- 30-day All-cause Hospital Readmission Measure – Provides a detailed description of the 30-day All-Cause Hospital Readmission Measure, a risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized and experienced an unplanned readmission for any cause to a short-stay acute-care hospital within 30 days of discharge.
- Quality Continuing Medical Education (CME) Course – Offers an overview of the Quality performance category requirements in 2017. Register through the Medicare Learning Network® (MLN) Learning Management System (LMS) to receive CME credit.

Remember, **March 31, 2018** is the deadline for 2017 MIPS data submission. View this fact sheet to learn more.

For More Information

- **Visit qpp.cms.gov** to check your participation status, explore measures, and to review guidance on MIPS, APMs, what to report, and more.
- **Go to the Quality Payment Program Resource Library on CMS.gov** to review new and existing QPP resources.

Questions?

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

###

You Can Now Find the EHR Incentive Programs Frequently Asked Questions (FAQs) on the EHR Incentive Programs Website

You can now find the EHR Incentive Programs FAQs on the EHR Incentive Programs website. To find a specific FAQ, health care providers can search the FAQ page on the EHR Incentive Programs website by topic or within the comprehensive FAQ document by FAQ number.

###

On the Opioids White House Summit/Faith-based Funding Option

White House Opioid Summit
The White House hosted an Opioid Summit to discuss the Administration-wide efforts to combat the opioid crisis. The Summit included individuals who have been affected by the opioid crisis and addiction- and recovery-focused organizations. Members of President Trump's Administration, including **Alex M. Azar II,** Secretary Department of Health and Human Services; **Ben Carson Sr., M.D.**, Secretary Department of Housing and Urban Development; **Kellyanne Conway**, Counselor White House; **Kirstjen Nielsen**, Secretary Department of Homeland Security; **Jeff Sessions**, Attorney General Department of Justice; **David Shulkin**, **M.D**., Secretary Department of Veterans Affairs; and **John Sullivan**, Deputy Secretary Department of State detailed actions they have undertaken to confront the opioid crisis on all possible fronts.

We are delighted that so many of our faith and community partners were able to attend the White House Opioid Summit and represent the essential work happening in communities across the country that are responding to emergencies and meeting the long term demands of the opioid epidemic, as well as, taking a lead role in prevention efforts.

Funding Options for Faith-based Organizations
In his plenary remarks addressing the opioid epidemic to those attending the recent meeting of the National Governors Association, HHS Secretary Azar, recognized faith-based partners as one of the essential allies on the front line of this battle. "Americans of faith have taken a leading role in the compassionate approach we need to take to this crisis, and we're eager to support their work however we can."

To that end, Secretary Azar noted that the anticipated State Targeted Response (STR) grants year will emphasize that "states have a wide range of options for using [the funds]. This includes treatment vouchers, which allow the use of the funds for evidence-based services from faith-based providers." STR funds are distributed through the Single State Agencies (SSAs) for Substance Abuse Services. Refer to this directory for the SSA in your state.

SAMHSA's Treatment Improvement Protocol February 2018
Treatment Improvement Protocol (TIP) reviews the use of the three Food and Drug Administration (FDA)-approved medications used to treat opioid use disorder (OUD)—methadone, naltrexone, and buprenorphine—and the other strategies and services needed to support recovery for people with OUD. Free and available to download here.

###

All Payer Combo Option & Other Payer Advanced APMs

This FAQ answers regarding the All-Payer Combination and Other Payer Advanced APMs, and provides links to payer-specific fact sheets and guidance materials.

Helpful Weblinks:
FAQ Document: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/All-Payer-Combination-Option-and-Other-Payer-Advanced-APMs-FAQs.PDF
Glossary: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/All-Payer-Combination-Option-Glossary.PDF

###

Additional Advancing Care Information Identifier for Use with the 2018 CMS QRDA III Implementation Guide

The Centers for Medicare & Medicaid Services (CMS) has published an updated Programs. This is a republication of the 2018 CMS QRDA III IG for Eligible Clinicians and Eligible Professionals published on 11/27/2017. The updated version now includes an additional identifier (ACI_IACEHRT_1) for the Advancing Care Information Improvement Activities Bonus to be used when an eligible improvement activity using certified electronic health record technology (CEHRT) is submitted to the Quality Payment Program. The 2018 CMS QRDA III IG provides implementation guidance for the calendar year 2018 performance period.

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

When you're submitting QRDA III data to the Quality Payment Program for 2018 and you need to account for the ACI_IACEHRT_1, you can simply include this identifier as part of the Advancing Care Information section of your submission file.

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 Quality Payment Program/Merit-based Incentive Payment System data submissions, visit the Quality Payment Program website. You can also contact the Quality Payment Program Service Center by phone: 1-866-288-8292/TTY: 1-877-715-6222 or via email: QPP@cms.hhs.gov.

###

IRF/LTCH Provider Preview Reports- Now Available

Inpatient Rehabilitation Facility (IRF) and Long-term Care Hospital (LTCH) Provider Preview Reports are now available. Providers have the opportunity to review their performance data on quality measures based on Quarter 3 -2016 to Quarter 2 - 2017 data, prior to the June 2018 IRF Compare and LTCH Compare refresh, during which this data will be publicly displayed.

CMS identified an error with data calculation which has led to suppression of the measure, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (NQF #0680) on the LTCH preview report for March 2018.

Providers have until April 5, 2018 to review their performance data.

Corrections to the underlying data will not be permitted during this time. However, providers can request a CMS review during the preview period if they believe their data is inaccurate.

For more information:

- IRF Quality Public Reporting webpage, IRF Compare, and Preview Report Access Instructions LTCH Quality Public Reporting webpage, LTCH Compare and Preview Report Access Instructions

###

Methods for Assuring Access to Care: Exceptions for High Managed Care Penetration & Rate Reduction Threshold (CMS 2406-P)

The Centers for Medicare and Medicaid Services (CMS) issued a notice of proposed rulemaking (NPRM) that would provide exemptions from the regulatory access to care requirements within the Medicaid program. Specifically, the NPRM would exempt states with high rates of comprehensive Medicaid managed care from analyzing data and monitoring access in fee-for-service delivery systems. Additionally, the NPRM would provide similar exemptions to all states when they make nominal rate reductions to fee-for-service payment rates.

To view the Final Rule with comment, visit https://www.federalregister.gov/documents/2018/03/23/2018-05898/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services---exemptions-for-states

For more information on Access, visit https://www.medicaid.gov/medicaid/access-to-care/index.html

###

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Funding Opportunity: Measure Development for the Quality Payment Program

CMS is pleased to announce a new funding opportunity for the development, improvement, updating, and expansion of quality measures for use in the Quality Payment Program. CMS will be partnering directly with clinicians, patients, and other stakeholders to provide up to $30 million of funding and technical assistance in development of quality measures over three years.

Cooperative agreements provide a unique opportunity for CMS to partner with external entities, such as clinical specialty societies, clinical professional organizations, patient advocacy organizations, educational institutions, independent research organizations, and health systems, in developing, improving, updating, and expanding quality measures for the Quality Payment Program. By giving external entities needed resources to help guide their measure-development efforts though this funding opportunity, CMS can leverage the unique perspectives and expertise of these external entities, such as clinician and patient perspectives, to advance the Quality Payment Program measure portfolio. The cooperative agreements will allow CMS to collaborate with stakeholders to address essential topics such as: clinician engagement, burden minimization, consumer-informed decisions, critical measure gaps, quality measure alignment, consumer-informed decisions, clinician engagement, and efficient data collection that minimizes health care provider burden.

The priority measures developed, improved, updated or expanded under the cooperative agreements will be aligned with the CMS Quality Measure Development Plan. The CMS Quality Measure Development Plan provides a strategy for filling clinician and specialty area measure gaps and for recommendations to close these gaps in order to support the Quality Payment Program, and identifies the following initial priority areas for measure development: Clinical Care, Safety, Care Coordination, Patient and Caregiver Experience, Population Health and Prevention, and Affordable Care. The gap areas include, but not limited to: Orthopedic Surgery, Pathology, Radiology, Mental Health and substance use conditions, Oncology, Palliative Care, and Emergency Medicine.

More broadly than the CMS Quality Measure Development Plan, which is specific for the Quality Payment Program, CMS measures work is guided by the Meaningful Measurement framework which identifies the highest priorities for quality measurement and improvement. The Meaningful Measure Areas serve as the connectors between CMS goals under development and individual measures/initiatives that demonstrate how high quality outcomes for our Medicare, Medicaid, and CHIP beneficiaries are being achieved. They are concrete quality topics which reflect core issues that are most vital to high quality care and better patient outcomes.

Through these cooperative agreements, CMS aims to provide the necessary support to help external entities expand the Quality Payment Program quality measure portfolio with a focus on clinical and patient perspectives and minimizing burden for clinicians. Focusing on patient perspectives will ensure measures focus on what is important to patients and drive the improvement of patient outcomes. To accomplish this, the cooperative agreements prioritize the development of: outcome measures, including patient reported outcome and functional status measures; patient experience measures; care coordination measures; and measures of appropriate use of services, including measures of overuse.

For more information, search for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Funding Opportunity: Measure Development for the Quality Payment Program on Grants.gov or visit our website, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html.

###

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 (EP)/Eligible Clinician eCQMs for potential inclusion in the following programs:

- The Hospital Inpatient Quality Reporting Program;
- The Medicare and Medicaid Electronic Health Record Incentive Programs for eligible hospitals, critical access hospitals and EPs; and
- The Quality Payment Program: The Merit-based Incentive Payment System and Alternative Payment Models.

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.

To find out more about eCQMs and CQL, visit the eCQI Resource Center

###

Medicare and Medicaid Updates

CMS Proposes Regulation to Alleviate State Burden

Proposed rule furthers President Trump's commitment to "cutting the red tape" by relieving states of burdensome paperwork requirements

The Centers for Medicare & Medicaid Services (CMS) issued a notice of proposed rulemaking (NPRM) that would provide state flexibility from certain regulatory access to care requirements within the Medicaid program. Specifically, the NPRM would exempt states from requirements to analyze certain data and monitor access when the vast majority of their covered lives receive services through managed care plans. CMS regulations separately provide for access requirements in managed care programs. Additionally, the NPRM would provide similar flexibility to all states when they make nominal rate reductions to fee-for-service payment rates.

States have raised concerns over undue administrative burden associated with meeting the requirements of the final rule, Medicaid Program; Methods for Assuring Access to Covered Medicaid Services (published in November 2015). Specifically, states with few Medicaid members enrolled in their fee-for-service program or when members are only temporarily enrolled, and states making small reductions to fee-for-service payment rates, have urged CMS to consider whether analyzing data and monitoring access in that program is a beneficial use of state resources. To respond to these concerns, the NPRM proposes the following changes:

- States with an overall Medicaid managed care penetration rate of 85% or greater (currently, 17 States) would be exempt from most access monitoring requirements.
- Reductions to provider payments of less than 4% percent in overall service category spending during a State fiscal year (and 6% over two consecutive years) would not be subject to the specific access analysis..
- When states reduce Medicaid payment rates, they would rely on baseline information regarding access under current payment rates, rather than be required to predict the effects of rate reductions on access to care, which states have found very difficult to do.

This notice furthers President Trump's commitment to "cut the red tape" and is part of a series of initiatives aimed at helping states focus more resources and time on patient outcomes in their Medicaid programs. In a speech to the National Association of Medicaid Directors last year, CMS Administrator Seema Verma emphasized CMS's commitment to "turn the page in the Medicaid program" by giving states more freedom to design innovative programs that achieve positive results for the people they serve. In total, the proposed changes are estimated to reduce state administrative burden by 561 hours with a total savings of over $1.6 million.

These proposed regulatory changes do not change the underlying statutory responsibilities for states to ensure that Medicaid recipients have appropriate access to services. These efforts are instead designed to support CMS efforts to move away from micromanaging state programs and instead focus on measuring program outcomes and holding states accountable for achieving results.

"Today's proposed rule builds on our commitment to strengthening the Medicaid program and assist those it serves through state partnerships that improve quality, enhance accessibility and achieve outcomes in the most cost effective manner," said CMS Administrator Seema Verma. "These new policies do not mean that we aren't interested in beneficiary access, but are intended to relieve unnecessary regulatory burden on states, avoid increasing administrative costs for taxpayers, and refocus time and resources on improving the health outcomes of Medicaid beneficiaries."

In a March 14, 2017 letter to Governors, the Department of Health and Human Services and CMS announced a new commitment "to empower all states to advance the next wave of innovative solutions to Medicaid's challenges – solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner."

For more information regarding CMS 2406-P: Methods for Assuring Access to Covered Medicaid Services – Exemptions for States with High Managed Care Penetration Rates and Rate Reduction Threshold, and to make a comment regarding the proposed rule, please visit (https://www.medicaid.gov/medicaid/access-to-care/index.html)

###

Trump Administration Announces MyHealthEData Initiative to Put Patients at the Center of the US Healthcare System

CMS launches "Blue Button 2.0" tool, calls on all health insurers to make data available to patients

The Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma announced a new Trump Administration initiative – MyHealthEData – to empower patients by giving them control of their healthcare data, and allowing it to follow them through their healthcare journey.

Last year President Trump issued an Executive Order to Promote Healthcare Choice and Competition Across the United States. In response the Administration is moving towards a system in which patients have control of their data and can take it with them from doctor to doctor, or to their other healthcare providers.

The government-wide MyHealthEData initiative is led by the White House Office of American Innovation with participation from the Department of Health and Human Services (HHS) – and its Centers for Medicare & Medicaid Services (CMS), Office of the National Coordinator for Health Information Technology (ONC), and National Institutes of Health (NIH) – as well as the Department of Veterans Affairs (VA). The initiative is designed to empower patients around a common aim - giving every American control of their medical data. MyHealthEData will help to break down the barriers that prevent patients from having electronic access and true control of their own health records from the device or application of their choice. Patients will be able to choose the provider that best meets their needs and then give that provider secure access to their data, leading to greater competition and reducing costs.

The MyHealthEData initiative will work to make clear that patients deserve to not only electronically receive a copy of their entire health record, but also be able to share their data with whomever they want, making the patient the center of the healthcare system. Patients can use their information to actively seek out providers and services that meet their unique healthcare needs, have a better understanding of their overall health, prevent disease, and make more informed decisions about their care.

In an address at the Healthcare Information and Management Systems Society (HIMSS) Annual Conference in Las Vegas, Administrator Verma also announced the launch of Medicare's Blue Button 2.0 – a new and secure way for Medicare beneficiaries to access and share their personal health data in a universal digital format. This enables patients who participate in the traditional Medicare program to connect their claims data to the secure applications, providers, services, and research programs they trust.

For example, Medicare's Blue Button 2.0 will allow a patient to access and share their healthcare information, previous prescriptions, treatments, and procedures with a new doctor which can lead to less duplication in testing and provide continuity of care. Medicare's Blue Button 2.0 is expected to foster increased competition among technology innovators to serve Medicare patients and their caregivers, finding better ways to use claims data to serve patients' health needs.

More than 100 organizations, including some of the most notable names in technological innovation, have signed on to use Medicare's Blue Button 2.0 to develop applications that will provide innovative new tools to help these patients manage their health.

In her remarks, Administrator Verma specifically called on all healthcare insurers to follow CMS's lead and give patients access to their claims data in a digital format.

"CMS serves more than 130 million beneficiaries through our programs, which means we are uniquely positioned to transform how important healthcare data is shared between patients and their doctors," said Administrator Verma. "Today, we are calling on private health plans to join us in sharing their data with patients because enabling patients to control their Medicare data so that they can quickly obtain and share it is critical to creating more patient empowerment."

Additionally, CMS intends to overhaul its Electronic Health Record (EHR) Incentive Programs to refocus the programs on interoperability and to reduce the time and cost required of providers to comply with the programs' requirements. CMS will continue to collaborate with ONC to improve the clinician experience with their EHRs.

Administrator Verma said CMS has implemented laws regarding information blocking – a practice in which providers prevent patients from getting their data. Under some CMS programs, hospitals and clinicians must show they have not engaged in information blocking activities.

The Administrator also highlighted other CMS plans to empower patients with data:

- CMS is requiring providers to update their systems to ensure data sharing.
- CMS intends to require that a patient's data follow them after they are discharged from the hospital.
- CMS is working to streamline documentation and billing requirements for providers to allow doctors to spend more time with their patients.
- CMS is working to reduce the incidence of unnecessary and duplicative testing which occurs as a result of providers not sharing data.

To view a fact sheet with more information, visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-03-06.html

To read a copy of the Administrator's speech, visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-03-06-2.html

###

CMS finalizes coverage of Next Generation Sequencing tests, ensuring enhanced access for cancer patients

A new opportunity for cancer patients as advanced diagnostic laboratory tests now have expanded Medicare coverage

The Centers for Medicare & Medicaid Services (CMS) took action to advance innovative personalized medicine for Medicare patients with cancer. CMS finalized a National Coverage Determination that covers diagnostic laboratory tests using Next Generation Sequencing (NGS) for patients with advanced cancer (i.e., recurrent, metastatic, relapsed, refractory, or stages III or IV cancer). CMS believes when these tests are used as a companion diagnostic to identify patients with certain genetic mutations that may benefit from U.S. Food and Drug Administration (FDA)-approved treatments, these tests can assist patients and their oncologists in making more informed treatment decisions. Additionally, when a known cancer mutation cannot be matched to a treatment then results from the diagnostic lab test using NGS can help determine a patient's candidacy for cancer clinical trials.

This decision was made following the parallel review with the FDA, which granted its approval of the FoundationOne CDx (F1CDx™) test on Nov. 30, 2017. At the same time, CMS issued a proposed NCD for NGS cancer diagnostics. F1CDx™ is the first breakthrough-designated, NGS-based in vitro diagnostic test that is a companion diagnostic for 15 targeted therapies as well as can detect genetic mutations in 324 genes and two genomic signatures in any solid tumor.

"We want cancer patients to have enhanced access and expanded coverage when it comes to innovative diagnostics that can help them in new and better ways," said Seema Verma, CMS Administrator. "That is why we are establishing clear pathways to coverage, while at the same time supporting laboratories that currently furnish tests to the people we serve."

In addition to covering the FDA-approved F1CDx™, CMS is covering FDA-approved or cleared companion in vitro diagnostics when the test has an FDA-approved or cleared indication for use in that patient's cancer and results are provided to the treating physician for management of the patient using a report template to specify treatment options.

"These tests can help doctors consult with patients about more targeted care or enrollment in a clinical trial," said Kate Goodrich, M.D., CMS chief medical officer and director of the Center for Clinical Standards and Quality (CCSQ). "The expanded coverage in this final NCD now includes additional tests for relapsed, refractory, and earlier stage III cancers to aid in the treatment of these cancer patients."

This NCD recognizes the importance of analytical and clinical validation of the diagnostic laboratory test that is part of FDA approval or clearance and provides national coverage after demonstration that use of the diagnostic laboratory test guides the management and treatment of the patient improves health outcomes. Tests that gain FDA approval or clearance as an in vitro companion diagnostic will automatically receive full coverage under this final NCD, provided other coverage criteria are also met. Coverage determinations for other diagnostic laboratory tests using NGS for Medicare patients with advanced cancer will be made by local Medicare Administrative Contractors. In addition, after considering all public comments, this final decision expanded coverage to patients with relapsed, refractory or stage III cancers. The final decision also extends coverage to repeat testing when the patient has a new primary diagnosis of cancer.

After reviewing all the public comments for this specific determination, we have removed coverage with evidence development in this final NCD. Many commenters reported that they are already developing or have developed the evidence to demonstrate these diagnostic laboratory tests using NGS to improve health outcomes for Medicare

beneficiaries with cancer – or are equipped to conduct their own studies to generate evidence that use of the test guides management and treatment, and improves health outcomes for the Medicare population. We strongly encourage continuing and publishing the results of these important studies, especially on the endpoints of overall survival, progression free survival, objective response, and patient reported outcomes relevant to the quality of life for Medicare beneficiaries. This is not only important to ensuring that patients, caregivers and their providers can make informed decisions, but also to continue to develop and publish results to develop new technologies in the healthcare system.

For more information:

CMS: Medicare Coverage Center

CMS: National Coverage Analyses (NCAs) Alphabetical Index

CMS: Public Comments

CMS: Coverage with Evidence Development

The CMS, an agency within the U.S. Department of Health and Human Services, directs the planning, coordination, and implementation of the programs under the Social Security Act and related statutes, to administer Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. The agency also directs the development of effective relationships between these programs and private and federally supported health-related programs.

###

Summary: Nursing Home Compare Health Inspection Star Rating Freeze

On February 28, 2018, the Centers for Medicare & Medicaid Services (CMS) placed a "freeze" on the health inspection rating component of the Nursing Home Five Star Quality Rating System. CMS announced a new survey process for Long Term Care facilities on November 27, 2017 that ensures consistency among all nursing home surveys. In order to ensure public data on Nursing Home Compare is accurate, CMS is instituting a freeze on the health inspection star rating score until all nursing homes are surveyed at least once under the new survey process for Long Term Care facilities. CMS anticipates the freeze to last about a year. Facilities will continue to receive an overall Five Star rating and summaries of survey findings will continue to be available to the public on Nursing Home Compare.

Helpful Weblinks:
Nursing Home Compare: https://www.medicare.gov/nursinghomecompare/search.html

###

Announcement of Medicaid Drug Rebate Program National Rebate Agreement CMS 2397-FN

The Centers for Medicare & Medicaid Services (CMS) has released a final notice in the Federal Register updating the Medicaid National Drug Rebate Agreement (NDRA) for use by the Secretary of the Department of Health and Human Services (HHS) and manufacturers under the Medicaid Drug Rebate Program (MDRP).

For more information, click here: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-05947.pdf

###

New Medicare Cards Coming in April

CMS will begin mailing new Medicare cards to people with Medicare beginning in April. Click on the New Medicare Card Newsletter February 2018 to find the latest updates on our implementation activities and information that you need to know to get ready.

###

New Medicare Card Webinars for Consumers, Medicare Beneficiaries & Caregivers

The Centers for Medicare & Medicaid Services (CMS) Kansas City Regional Office is hosting 4 New Medicare Card Webinars for Consumers, Medicare Beneficiaries & Caregivers.

In the past several months, you received invitations from us and/or attended a **FREE** webinar on the **New Medicare Card.** We are now asking for your help by hosting educational sessions which includes promoting these webinars and gathering consumers, Medicare beneficiaries, and caregivers in one location to watch and listen to one of our next series of webinars. If you are unable to host an event, we ask that you share the information about these webinars with Medicare Beneficiaries and Caregivers you serve.

As a reminder, 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, scenarios, and what Medicare beneficiaries should do to ensure they receive their new card. As well, these webinars will provide timely information such as the 2018 Medicare cost-sharing amounts, explain the myMedicare.gov portal where a beneficiary can access their own personal Medicare claims, and information, and explain the Medicare Outpatient Observation Notice (MOON) which determines when someone is in outpatient vs. inpatient care.

The schedule of the webinars and registration links are below. We hope you are able to host an educational learning session for the beneficiaries and caregivers you serve. We would be interested in hearing directly from you if you will be doing so. We can also provide you with materials and resources to share with attendees at your webinar viewing. Please contact Lorelei Schieferdecker at Lorelei.Schieferdecker@cms.hhs.gov or Julie Brookhart at Julie.Brookhart@cms.hhs.gov.

If several people are joining to view a webinar at one location, we ask that you only register once for that webinar. ***NOTE: Please double check your email address when registering to make sure you receive the confirmation email with details on how to access the webinar.***

Tuesday, 4/17/2018 2:00 pm to 3:00 pm Central time
https://newmedicarecardwebinar04-17-2018.eventbrite.com

Friday, 4/20/2018 10:00 am to 11:00 am Central time
https://newmedicarecardwebinar4-20-18.eventbrite.com

Thursday, 4/26/2018 9:30am to 10:30am Central time
https://newmedicarecardwebinar4-26-18.eventbrite.com

Monday, 4/30/2018 1:30 pm to 2:30 pm Central time
https://newmedicarecardwebinar4-30-18.eventbrite.com

###

10 Things to Know About Your New Medicare Card

10 things to know about your new Medicare card

Medicare is mailing new Medicare cards starting in April 2018. Here are 10 things to know about your new Medicare card:

1. **Mailing takes time:** Your card may arrive at a different time than your friend's or neighbor's.
2. **Destroy your old Medicare card:** Once you get your new Medicare card, destroy your old Medicare card and start using your new card right away.
3. **Guard your card:** Only give your new Medicare Number to doctors, pharmacists, other health care providers, your insurers, or people you trust to work with Medicare on your behalf.
4. **Your Medicare Number is unique:** Your card has a new number instead of your Social Security Number. This new number is unique to you.
5. **Your new card is paper:** Paper cards are easier for many providers to use and copy, and they save taxpayers a lot of money. Plus, you can print your own replacement card if you need one!
6. **Keep your new card with you:** Carry your new card and show it to your health care providers when you need care.
7. **Your doctor knows it's coming:** Doctors, other health care facilities and providers will ask for your new Medicare card when you need care.
8. **You can find your number:** If you forget your new card, you, your doctor or other health care provider may be able to look up your Medicare Number online.
9. **Keep your Medicare Advantage Card:** If you're in a Medicare Advantage Plan (like an HMO or PPO), your Medicare Advantage Plan ID card is your main card for Medicare – you should still keep and use it whenever you need care. However, you also may be asked to show your new Medicare card, so you should carry this card too.
10. **Help is available:** If you don't get your new Medicare card by **April 2019**, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit CMS.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

CMS Product No. 12018
January 2018

###

KEPRO's Free Patient Navigation Program

For Medicare beneficiaries, understanding their doctor and making their way through difficult medical systems and treatments can be very overwhelming. KEPRO's free Patient Navigation program can help people with Medicare be a partner in and take control of their own health. KEPRO's Patient Navigators can work 1-on-1 with Medicare beneficiaries to:

- Help coordinate care
- Offer tips on how to manage medications
- Help better understand a diagnosis or treatment plan
- Provide resources and information to help patients understand, treat, and prevent diseases
- Help improve quality of life

The following is an example of how the Patient Navigation program works. In this example, a Medicare beneficiary was discharged from a rehabilitation facility under the care of his wife after a brain bleed. His wife requested that he join the Patient Navigation program after his appeal was denied. He was able to walk with a front-wheeled walker, although he was independent before his hospitalization. His discharge plan was for home health, and he had no medical equipment at home. He had an upcoming visit with his primary care physician, and his wife was unsure how she would transport him. KEPRO's Patient Navigator was able to assist the wife with setting up transportation for the doctor's appointment. The Patient Navigator also followed up with the home health agency, as the wife needed additional medical equipment, such as a shower chair. The Patient Navigator followed and assisted this beneficiary for 32 days to make sure there were no further needs and that he was progressing well with the home health agency.

KEPRO's Patient Navigation program is available for Fee-for-Service (FFS) Medicare beneficiaries. This program is part of their benefits from Medicare and is offered at no cost to them.

Please encourage your FFS Medicare beneficiaries to contact KEPRO for their healthcare navigation needs. For more information about KEPRO's Patient Navigation program, please visit www.keproqio.com/pfe/PatientNavigation.aspx.

###

Upcoming Webinars and Events and Other Updates

HRSA Calling for Abstracts for 2018 National Ryan White Conference on HIV Care & Treatment

March 21, 2018 – HIV.gov

The call for abstracts is now open for the Health Resources and Services Administration's HIV/AIDS Bureau's 2018 National Ryan White Conference on HIV Care and Treatment. The conference will take place December 11-14, 2018, at the Gaylord National Hotel and Convention Center at the National Harbor in Oxon Hill, MD. **[READ MORE]**

###

HIMSS Recap: View CMS Educational Session Slides

CMS' HIMSS18 Presentations Are Now Available on the CMS Website

The Centers for Medicare & Medicaid Services (CMS) recently participated in the 2018 Healthcare Information and Management Systems Society (HIMSS) Annual Conference & Exhibition in Las Vegas from March 5-9, 2018.

CMS has posted the presentations from HIMSS18. Use the link below to access the presentations on each topic.

HIMSS18 Presentations (available at the bottom of the page):

- Meaningful Measures Initiative
- Quality Payment Program Year 2
- Quality Payment Program: Advancing Care Information
- Advanced Alternative Payment Models
- Quality Payment Program Developer Tools & EHRs Town Hall

###

CMS Special Open Door Forum: The IMPACT Act and Improving Care Coordination

Wednesday, March 28, 2018 2:00-3:00 pm Eastern Time Conference Call Only

This Special Open Door Forum (SODF) will provide information and solicit feedback pertaining to development and testing of Standardized Patient Assessment Data Elements as mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act). This SODF will provide an update on the national field test, ongoing stakeholder engagement activities, and will highlight ways for stakeholders to remain engaged and informed during the upcoming year.

We invite questions, comments, and ideas from providers, patients, consumers, researchers, and advocates in advance or during the Forum.

Please submit questions, comments, and ideas to: PACQualityInitiative@cms.hhs.gov.

The presentation is posted on the IMPACT Act Downloads and Videos webpage.

Special Open Door Participation Instructions:
Participant Dial-In Number: 1-800-837-1935

Conference ID #: 4098015

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

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website at https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html for downloading under downloads section as well as the IMPACT Act Downloads and Videos webpage.

###

New Medicare Card Webinars for Consumers, Medicare Beneficiaries & Caregivers

The Centers for Medicare & Medicaid Services (CMS) Kansas City Regional Office is hosting 4 New Medicare Card Webinars for Consumers, Medicare Beneficiaries & Caregivers.

In the past several months, you received invitations from us and/or attended a **FREE** webinar on the **New Medicare Card.** We are now asking for your help by hosting educational sessions which includes promoting these webinars and gathering consumers, Medicare beneficiaries, and caregivers in one location to watch and listen to one of our next series of webinars. If you are unable to host an event, we ask that you share the information about these webinars with Medicare Beneficiaries and Caregivers you serve.

As a reminder, 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, scenarios, and what Medicare beneficiaries should do to ensure they receive their new card. As well, these webinars will provide timely information such as the 2018 Medicare cost-sharing amounts, explain the myMedicare.gov portal where a beneficiary can access their own personal Medicare claims, and information, and explain the Medicare Outpatient Observation Notice (MOON) which determines when someone is in outpatient vs. inpatient care.

The schedule of the webinars and registration links are below. We hope you are able to host an educational learning session for the beneficiaries and caregivers you serve. We would be interested in hearing directly from you if you will be doing so. We can also provide you with materials and resources to share with attendees at your webinar viewing. Please contact Lorelei Schieferdecker at Lorelei.Schieferdecker@cms.hhs.gov or Julie Brookhart at Julie.Brookhart@cms.hhs.gov.

If several people are joining to view a webinar at one location, we ask that you only register once for that webinar. ***NOTE: Please double check your email address when registering to make sure you receive the confirmation email with details on how to access the webinar.***

Tuesday, 4/17/2018 2:00 pm to 3:00 pm Central time
https://newmedicarecardwebinar04-17-2018.eventbrite.com

Friday, 4/20/2018 10:00 am to 11:00 am Central time
https://newmedicarecardwebinar4-20-18.eventbrite.com

Thursday, 4/26/2018 9:30am to 10:30am Central time
https://newmedicarecardwebinar4-26-18.eventbrite.com

Monday, 4/30/2018 1:30 pm to 2:30 pm Central time
https://newmedicarecardwebinar4-30-18.eventbrite.com

###

Get Answers to Frequently Asked Medicare Hospital Attestation Questions

The Medicare eligible hospital and critical access hospital (CAH) attestation deadline has been changed from Wednesday, February 28, 2018, to Friday, March 16, 2018, at 11:59 p.m. Pacific Time. This extension is being granted to provide hospitals additional time to submit attestation data and eCQM data.

To help you with the attestation process, CMS has answered a series of frequently asked questions from recent Medicare hospital attestation webinars:

- December 5 webinar Q&A
- December 20 webinar Q&A
- January 18 webinar Q&A

Slide decks, recordings, and transcripts from these webinars are also available on the Eligible Hospital Information page.

QNet Help Desk

Don't forget that eligible hospitals and CAHs attesting to CMS for the EHR Incentive Program must submit data through the QualityNet Secure Portal (QNet). 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

###

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.

###

Medicare Learning Network

News & Announcements

- Coverage of Next Generation Sequencing Tests Ensures Enhanced Access for Cancer Patients
- IMPACT Act Transfer of Health Measures: Public Comment Period Ends May 3
- Hospice Quality Reporting Program: HART v1.4.0
- Hospital VBP Program FY 2020 Baseline Measures Report
- MyHealthEData Initiative Puts Patients at the Center of the US Health Care System
- New Medicare Card Transition Begins In Less Than a Month
- MACRA Funding Opportunity: Measure Development for the Quality Payment Program
- IRF and LTCH Compare Refresh
- Quality Payment Program: Submit 2017 Participation Data through March 31
- EHR Incentive Program: Hospitals Submit Proposals for New Measures until June 29
- PEPPER for Short-term Acute Care Hospitals
- DME Supplier Feedback on Telephone Discussion and Reopening Process Demonstration
- EHR Incentive Programs FAQs
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Help Your Patients Go Further With Food

Provider Compliance

- Billing for Stem Cell Transplants — Reminder
- Bill Correctly for Device Replacement Procedures — Reminder

Claims, Pricers & Codes

- April 2018 Average Sales Price Files

Upcoming Events

- IMPACT Act and Improving Care Coordination Special Open Door Forum — March 28
- Spinal Orthoses Referring Providers Comparative Billing Report Webinar — April 11
- CMS National Provider Enrollment Conference — April 24 and 25

Medicare Learning Network® Publications & Multimedia

- April 2018 Update: ASC Payment System MLN Matters Article — New
- Internet Only Manual Update to Correct Errors and Omissions: SNF 2018 MLN Matters Article — New
- SSI/Medicare Beneficiary Data for FY 2016: IPPS Hospitals, IRFs, LTCHs MLN Matters Article — New
- Billing Requirements for OPPS Providers with Multiple Service Locations MLN Matters Article — New
- Reinstating the QMB Indicator in the Medicare FFS Claims Processing System MLN Matters Article — Revised
- Quarterly Update for CLFS and Laboratory Services Subject to Reasonable Charge Payment MLN Matters Article — Revised
- Home Health Prospective Payment System Booklet — Revised
- Federally Qualified Health Center Booklet — Revised
- Medicare Parts A and B Appeals Process Booklet — Reminder
- The Medicare Secondary Payer Provisions Web-Based Training Course — Reminder
- CLIA Program and Medicare Laboratory Services — Reminder
- Provider Compliance Tips for Glucose Monitors Fact Sheet — New
- Provider Compliance Tips for Manual Wheelchairs Fact Sheet — New
- Provider Compliance Tips for Ordering Lower Limb Prostheses Fact Sheet — New
- Provider Compliance Tips for Laboratory Tests – Bacterial Cultures Fact Sheet — New
- Provider Compliance Tips for Wheelchair Options/Accessories Fact Sheet — New
- Provider Compliance Tips for Ostomy Supplies Fact Sheet — New
- Provider Compliance Tips for Ordering Oxygen Supplies and Equipment Fact Sheet — New
- Provider Compliance Tips for Negative Pressure Wound Therapy Fact Sheet — New
- Provider Compliance Tips for Surgical Dressings Fact Sheet — New
- Provider Compliance Tips for Urological Supplies Fact Sheet — New
- Low Volume Appeals Settlement Call: Video Presentation — New
- ESRD QIP Call: Audio Recording and Transcript — New
- Rural Health Clinic Fact Sheet — Revised

###

Newly Posted Training Materials

- 2018 Medicare Amounts (in other languages)
- New Medicare Card (Front) job aid
- Frequently Used Medicare Acronyms job aid
- Module 1: Understanding Medicare
- Module 9: Medicare Prescription Drug Coverage

Webinar Recordings

- November Learning Series Webinar: Medicare Supplement Insurance (Medigap) policies
- December Learning Series Webinar: Medicare and the Health Insurance Marketplace
- January Learning Series Webinar: Medicare Enrollment Periods
- February Learning Series Webinar: 2018 Medicare Costs

- Marketplace 101 Webinar

###

New / Updated CMS Publications

- Closing the Coverage Gap: Medicare Prescription Drugs are Becoming More Affordable
- Getting Medical Care and Prescription Drugs in a Disaster or Emergency Area

###

Did You Know?

March is also National Kidney Month. Learn about Medicare for People with End-Stage Renal Disease (ESRD) with these PowerPoint slides, available in both English and Spanish.

New Medicare Cards are being mailed starting in April, 2018. Visit the CMS partners and employers web page, "What do the new cards mean for partners & employers" for the latest information and tools.

Reminder: A New Website Coming Soon! The CMS National Training Program is upgrading our website to a Learning Management System. Soon, you'll be able to take self-paced, online courses that will help you and those you work with, make well-informed choices about their coverage! We will announce it when the new site is available.

###

CMS National Training Program Monthly Partner Update Webinar

April 3, 2018 2:30 – 3:30 pm ET

This webinar will cover:

- Blue Button 2.0 – A developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to the applications, services and research programs they trust.
- Periodic Data Matching – An overview of the 4th round of Medicare periodic data matching.
- Oncology Care Model – Enhanced services such as care coordination, navigation, and national treatment guidelines for care.
- Consumer Assessment of Healthcare Providers & Systems Report – Includes measures on hospice care and hospital survey results.

Registration is required to attend!

Go to https://meetings-cms.webex.com/meetings-cms/onstage/g.php?MTID=e30576470d829ae720334e3400d1a77f4 and register.

Upon registration, you will receive an email from "messenger@webex.com" with the webinar link and dial in information. Follow the instructions in the email to attend.

###

2nd Annual Adolescent Health Conference: Positive Approaches to Improving Adolescent Health

June 7-8, 2018 Kansas City Airport Hilton

Register: http://artstech-kc.org/regional_adolescent_health_conference

###

Unsubscribe

If you wish to unsubscribe from future CMS Region 7 emailings, please send an email to Lorelei Schieferdecker at Lorelei.Schieferdecker@cms.hhs.gov with the word "Unsubscribe" in the subject line.