CMS Region 7 Updates – 04/20/2018

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ACA/Marketplace Updates

CMS Issues Final 2019 Payment Notice Rule to Increase Access to Affordable Health Plans for Americans Suffering from High Obamacare Premiums

Final rule will improve program integrity, increase state flexibility, and reduce regulatory burdens

The Centers for Medicare & Medicaid Services (CMS) issued the HHS Notice of Benefit and Payment Parameters for 2019. The final rule will mitigate the harmful impacts of Obamacare and empower states to regulate their insurance market. The rule will do this by advancing the Administration's goals to increase state flexibility, improve affordability, strengthen program integrity, empower consumers, promote stability, and reduce unnecessary regulatory burdens imposed by the Patient Protection and Affordable Care Act.

"Too many Americans are facing skyrocketing premiums that they can't afford and every year consumers are faced with the threat of fewer choices. This rule gives states new tools to stabilize their health insurance markets and empower citizens to find coverage that fits their families' needs and budgets," said CMS Administrator Seema Verma.

The Patient Protection and Affordable Care Act has led to higher premiums and fewer choices. Between 2013 and 2017, the average premiums more than doubled in the states using the Federal Health Insurance Exchange platform and half of the counties in America had only one issuer to choose from this year. The final rule provides states with the tools needed to help lower health premiums or, stabilize premium growth. The final rule will also enhance consumer choice by removing provisions that discourage issuers from offering plans that address the specific needs of Americans.

The final rule builds on the significant steps already taken by the Administration to promote health care choice and competition and decrease costs. Earlier this year, the Departments of Health and Human Services, Labor, and the Treasury published a proposed rule to expand the availability of short-term, limited-duration health insurance to provide consumers with more affordable options. CMS also issued the Market Stabilization Rule last year, which was implemented to lower premiums and increase consumer choice. All of this work is especially important at a time when the impact of the Patient Protection and Affordable Care Act has priced many consumers out of the insurance market.

The final rule includes the following key provisions:

Increasing Flexibility

- **Essential Health Benefits (EHB):** To allow insurers to offer more affordable health plans, CMS is providing states with additional flexibility in how they select their EHB-benchmark plan. The final rule provides states with substantially more options in what they can select as an EHB-benchmark plan. Instead of being limited to 10 options, states will now be able to choose from the 50 EHB-benchmark plans used for the 2017 plan year in other states or select specific EHB categories, such as drug coverage or hospitalization, from among the categories used for the 2017 plan year in other states.

States will also now be able to build their own set of benefits that could potentially become their EHB-benchmark plan, subject to certain scope of benefits requirements.

- **Qualified Health Plan (QHP) Certification Standards:** The final rule returns important oversight authority to states regarding state review of network adequacy, and eases burden on issuers related to essential community providers. The rule also eliminates the meaningful difference requirement for QHPs to give insurers more flexibility in designing plans.

Improving Affordability

- **Exemptions**: Exchanges will be able to make a determination of lack of affordable coverage based on projected income using the lowest cost Exchange metal level plan offered through the Exchange when there is no bronze level plan available in the service area.

Strengthening Program Integrity

- **Risk Adjustment:** The final rule amends the HHS-operated risk adjustment data validation program to reduce burdens on issuers. In addition, the HHS-operated risk adjustment program is recalibrated for the 2019 benefit year to incorporate new data that reflects the actual experience of individual and small group market enrollees, which should more closely reflect the risk within markets. In States where HHS operates the risk adjustment program, CMS will also provide states with the flexibility to request a reduction to the otherwise applicable risk adjustment transfers in the individual, small group or merged market by up to 50 percent beginning with the 2020 benefit year, which may be helpful in attracting and retaining insurers and more precisely accounting for relative risk differences in the state market. States requesting such a reduction must provide evidence and analysis that show the state-specific rules or market dynamics warrant the adjustment to more precisely account for the relative risk differences in the State's market and justifies the reduction amount requested.

- **Advanced Premium Tax Credit (APTC) Program Integrity:** The final rule improves program integrity by requiring Exchanges to implement stronger checks to verify applicants actually earn the income they claim to qualify for APTCs. The rule also requires Exchanges to discontinue APTCs for enrollees who fail to file taxes and reconcile past APTCs, even if the Exchange does not first send notice directly to the tax filer.

Empowering Consumers

- **Special Enrollment Periods (SEPs):** CMS is aligning the enrollment options for all dependents who are newly enrolling in Exchange coverage through an SEP and are being added to an application with current enrollees, regardless of the SEP the dependent qualifies under. For consumers newly gaining or becoming a dependent and enrolling through the birth, adoption, foster care placement, or court order SEPs, CMS amended and standardized the alternate coverage start date options available under all of these SEPs. CMS will also allow pregnant women who are receiving health care services through Children's Health Insurance Program (CHIP) coverage for their unborn child to qualify for a loss of coverage SEP upon losing access to this coverage. Finally, CMS exempts consumers from the prior coverage requirement that applies to certain special enrollment periods if they lived in a service area without qualified health plans available through an Exchange.

Promoting Stability

- **Medical Loss Ratio (MLR):** The final rule amends MLR requirements to reduce regulatory burden in order to stabilize insurance markets, increase insurer participation and expand consumer choice. Specifically, the rule reduces quality improvement activity reporting burdens on insurers and allows states to request reasonable adjustments to the MLR standard for the individual market if the state shows a lower MLR standard could help stabilize its individual insurance market.

Reducing Unnecessary Regulatory Burden

- **Small Business Health Options Program (SHOP):** The final rule removes several regulatory requirements on SHOPs and outlines a new enrollment process in the SHOP Exchanges using the Federal platform. This change allows SHOPs to eliminate the online enrollment process and allows employers to enroll directly with an Exchange-registered agent, broker, or issuer and, the FF-SHOPs and SBE-FP for SHOPs will exercise the flexibilities outlined in the notice for plan years beginning on or after January 1, 2018. By January 1, 2017 only 7,600 employer groups, covering 39,000 lives, were in enrolled in the federal SHOP Exchange, far short of the 4 million people the Congressional Budget Office once projected would be enrolled by 2017. Turning over enrollment to qualified agents and brokers will help small business more easily enroll in coverage and lower costs.

- **Rate Review:** The final rule increases the primary role of state regulators in the rate review process, while reducing the regulatory burden for states and issuers. The rule exempts student health insurance coverage from Federal rate review requirements, and raises the default threshold for review of reasonableness from 10 percent to 15 percent.

The Final Annual Issuer Letter was also released. This Letter provides operational and technical guidance to issuers that want to offer Qualified Health Plans (QHPs) in the Federally-facilitated Exchanges (FFEs) for plan years beginning in 2019.

CMS also issued new guidance expanding hardship exemptions. Under this hardship exemption guidance, individuals who live in counties with no issuers or only one issuer, will now qualify for a hardship exemption from paying the Affordable Care Act's penalty for not having coverage. The guidance also allows CMS to consider a broad range of circumstances that result in consumers needing hardship exemptions.

In addition, CMS issued a bulletin to extend the transitional policy for one additional year. This policy allows for the transition to fully Affordable Care Act compliant coverage in the individual and small group health insurance markets until 2019. CMS is releasing this bulletin to provide states additional flexibility and control over their health insurance markets.

To view the Final Annual Issuer Letter, please visit: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#Health Insurance Marketplaces

To view the Hardship Exemption guidance, please visit: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2018-Hardship-Exemption-Guidance.pdf

To view the Extended Transitional Policy guidance, please visit: https://www.cms.gov/cciio/resources/regulations-and-guidance/#Health Insurance Market Reforms

To view the Payment Notice Fact Sheet associated with this rule, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-09.html

To view the Final Notice on the Federal Register, please visit: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf

###

Additional Special Enrollment Period Available for Individuals Affected by 2017 Hurricanes and Hurricane-Related Weather Events

On September 28, 2017, CMS released guidance about a Special Enrollment Period (SEP) and other flexibilities that were available for consumers affected by Hurricanes and hurricane-related weather events that occurred in 2017. The guidance included information about an Exceptional Circumstance SEP that allowed affected consumers to select a 2018 Marketplace plan or make changes to their existing 2018 plan from December 16 to December 31, 2017.

CMS has identified consumers who were erroneously denied access to this Exceptional Circumstances SEP and is notifying these consumers of eligibility for another SEP due to the error or misrepresentation of the Marketplace. These consumers will be able to select a 2018 Marketplace plan or make changes to their existing 2018 plan **by May 24, 2018**. Coverage accessed under this SEP will begin June 1st or July 1st, depending on the date the consumer selects their plan. Consumers wishing to access coverage prior to June 1st must file an appeal within 90 days of the date of SEP Eligibility Notice.

Who is eligible?

Individuals who attested to residing in an area affected by a 2017 hurricane or hurricane related event who submitted an application within the last two weeks of December, but were not determined eligible for an SEP at that time, will be eligible for this new SEP. Per the September 28, 2017 guidance, an area is considered affected if it is a county meeting the level of "individual assistance" or "public assistance" by the Federal Emergency Management Agency (FEMA).

What documentation is needed?

CMS has identified the population eligible for this SEP within Marketplace systems so that they can be easily identified by the Marketplace Call Center representatives and other CMS officials. Anyone eligible for this SEP will receive a hard copy notice of this SEP in the mail. CMS will not require the submission of any documentation to prove eligibility for this SEP.

Steps to helping a consumer access this SEP:

Eligible consumers can access this SEP directly through HealthCare.gov or through the Marketplace Call Center.

To pick a plan through HealthCare.gov, consumers should:

1. Log into their Marketplace account.
2. Select "Start a new application or update an existing one."
3. Click on their name in the top right of the screen and choose "My applications & coverage."

4. Select your current application. You'll see steps to continue to enrollment for anyone who was eligible to buy a 2018 Marketplace plan.

Note: Consumers will not be able to access this SEP through HealthCare.gov if they make changes to their online application. If a consumer has had changes to their application since they last applied, like changes to household income or family size, they should call the Marketplace Call Center at 1-800-318-2596 to update their information and enroll.

###

MACRA/Quality Payment Program (QPP) Updates

Visit the JIRA Website to Submit Official Comments by May 9, 2018

The Centers for Medicare & Medicaid Services (CMS) clinical quality language (CQL)-based measure specifications for eCQMs under development for possible future consideration are now available for public comment. CMS encourages all comments regarding the draft measure specifications for two measures currently under development, but is particularly interested in feedback on the technical CQL-based specifications. Specific questions to stakeholders about the PC-02 (Cesarean Birth) measure are included in the measure-specific framing document. To read the measure specifications and framing documents, please visit: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/PC-Currently-Accepting-Comments.html.

How to Submit Comments

- Log in to your JIRA account**:** https://oncprojectracking.healthit.gov/
- **A JIRA account is required to submit a comment**. If you are new to JIRA and do not have an account, sign up here: https://oncprojectracking.healthit.gov/support/login.jsp
- Comments will be accepted until **11:59 p.m. ET** on **May 9, 2018**

Once logged in, enter your comments by following these instructions:

1. Select "Projects" on the home screen, then select "View all Projects".

2. Under Quality-Measures, select "Comments on eCQMs under development".

3. To enter comments, select "Create issue", then select the type of issue from the "Issue type" menu.

4. Fill out the fields labeled "Summary," "Contact name," "Contact email," and "Contact phone."

5. In the "Summary" field, type in the following title:

- **"Comment—Opioids"** for the Safe Use of Opioids – Concurrent Prescribing measure
- **"Comment—PC-02"** for the PC-02 Cesarean Birth measure

6. Enter your comments in the "Description" field, then select the measure you are commenting on from the "Draft measures" menu:

- For the Safe Use of Opioids – Concurrent Prescribing measure, select **"Opioids"**
- For the PC-02 Cesarean Birth measure, select **"PC-02"**

7. Select "Create" to submit your comments. If you would like to enter additional comments, select "Create another" and then "Create".

For More Information

If you have any questions, please contact hospital-mdm@mathematica-mpr.com. For more information on using JIRA, please see the JIRA User Guide.

###

CMS Extends the MACRA Funding Opportunity

On April 12, 2018, the Centers for Medicare & Medicaid Services (CMS) updated and republished the "Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Funding Opportunity: Measure Development for the Quality Payment Program" on Grants.gov to reflect an application due date of May 30, 2018 at 3:00 PM ET. The deadline was extended as a result of stakeholder inquires about the application process.

You can find the "Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Funding Opportunity: Measure Development for the Quality Payment Program" by searching the title or Catalog of Federal Domestic Assistance (CFDA) number, 93.986 on Grants.gov.

Please visit our webpage on the CMS website for a list of frequently asked questions and transcripts of our pre-application conference calls held in March.

For programmatic questions about this Funding Opportunity please email: MACRA- measure-funding@cms.hhs.gov. For administrative questions about this Funding Opportunity please email: grants@cms.hhs.gov.

###

Apply to Participate in the 2018 CMS Study on Burdens Associated with Reporting Quality Measures to Receive Improvement Activity Credit for 2018

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

CMS is conducting this study to:

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

Clinicians and groups who are eligible for the Merit-based Incentive Payment System (MIPS) that participate successfully in the study will receive full credit for the 2018 MIPS Improvement Activities performance category. Applications for this study will be accepted through **April 30, 2018** and will be notified in spring of 2018 if selected.

Who Should Apply

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

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

Study Requirements

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

- Complete a 2017 MIPS participation survey in April/May 2018.
- Complete a 2018 MIPS planning survey September/October 2018.
- The Study team will invite selected participants to join a virtual 90-minute focus group between November 2018 and February 2019.
- Meet minimum requirements for the MIPS Quality performance category by submitting data for at least three measures in the MIPS Quality performance category, as required for 2018 MIPS participation.

The data submitted must:

- Include one outcome measure.
- Be submitted to CMS by the final MIPS reporting deadline (March 31, 2019); and

- Be submitted through any method accepted under MIPS for year 2 of the Quality Payment Program (2018).

To Apply

Click here to begin your application.

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

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

###

Medicare and Medicaid Updates

Market Saturation and Utilization Data Tool

The Centers for Medicare & Medicaid Services (CMS) has developed a Market Saturation and Utilization Data Tool that includes interactive maps and a dataset that shows national-, state-, and county-level provider services and utilization data for selected health service areas. Market saturation, in the present context, refers to the density of providers of a particular service within a defined geographic area relative to the number of the beneficiaries receiving that service in the area.

The seventh release of the data tool includes a quarterly update of the data to the fourteen health services areas from release 6, and also includes Federally Qualified Health Centers and Ophthalmology data. Release 7 will therefore include seven, twelve-month reference periods and the following health service areas: Home Health, Ambulance (Emergency, Non-Emergency, Emergency & Non-Emergency), Independent Diagnostic Testing Facilities (Part A and Part B), Skilled Nursing Facilities, Hospice, Physical and Occupational Therapy, Clinical Laboratory (Billing Independently), Long-Term Care Hospitals, Chiropractic Services, Cardiac Rehabilitation Programs, Psychotherapy, Federally Qualified Health Centers, and Ophthalmology. Also new to Release 7 is a trend analysis graphing tool that allows users to graph the percentage change and trend over time at the national level for the available metrics and health services areas.

The Market Saturation and Utilization Data Tool is one of many tools used by CMS to monitor and manage market saturation as a means to help prevent potential fraud, waste, and abuse. The data can also be used to reveal the degree to which use of a service is related to the number of providers servicing a geographic region. Provider services and utilization data by geographic regions are easily compared using an interactive map. There are a number of secondary research uses for these data, but one objective of making these data public is to assist health care providers in making informed decisions about their service locations and the beneficiary population they serve. The tool is available through the CMS website at: https://data.cms.gov/market-saturation. Future releases may include comparable information on additional health service areas.

Methodology

The analysis is based on paid Medicare Fee-for-Service (FFS) claims data from the CMS Integrated Data Repository (IDR). The IDR contains Medicare FFS claims, beneficiary data, provider data, and plan data. FFS claims data are analyzed for a 12-month reference period, and results are updated quarterly to reflect a more recent 12-month reference period.

The Market Saturation and Utilization methodology is different from other public use data with respect to determining the geographic location of a provider. In this analysis, claims are used to define the geographic area(s) served by a provider rather than the provider's practice address. Further, a provider is defined as "serving a county" if, during the 12-month reference period, the provider had paid claims for more than ten beneficiaries located in a county. A provider is defined as "serving a state" if that provider serves any county in the state.

The Market Saturation and Utilization methodology is also different from other public use data with respect to determining the number of Medicare beneficiaries who are enrolled in a fee-for-service (FFS) program. In this analysis, a FFS beneficiary is defined as being enrolled in Part A and/or Part B with a coverage type code equal to "9" (FFS coverage) for at least one month of the 12-month reference period. There must not be a death date for that month or a missing zip code for the beneficiary so that the beneficiary can be assigned to a county. Other public use data may define a FFS beneficiary using different criteria, such as requiring the beneficiary to be enrolled in the FFS program every month during the reference period.

Starting with Release 7 (April 2018), the interactive data set for all reference periods includes state- and county-level data for the following United States territories, commonwealths, and freely associated states: American Samoa (AS); Micronesia (FM); Guam (GU); Northern Mariana Islands (MP); Puerto Rico (PR); and the U.S. Virgin Islands (VI). The national-level data in the interactive data set for all previous reference periods reflects the U.S. plus the aforementioned territories.

The Market Saturation and Utilization Tool does not include information on market saturation and utilization for Medicaid or private insurance. However, the Medicare information included in the Tool may be a useful proxy for researchers or providers in these markets.

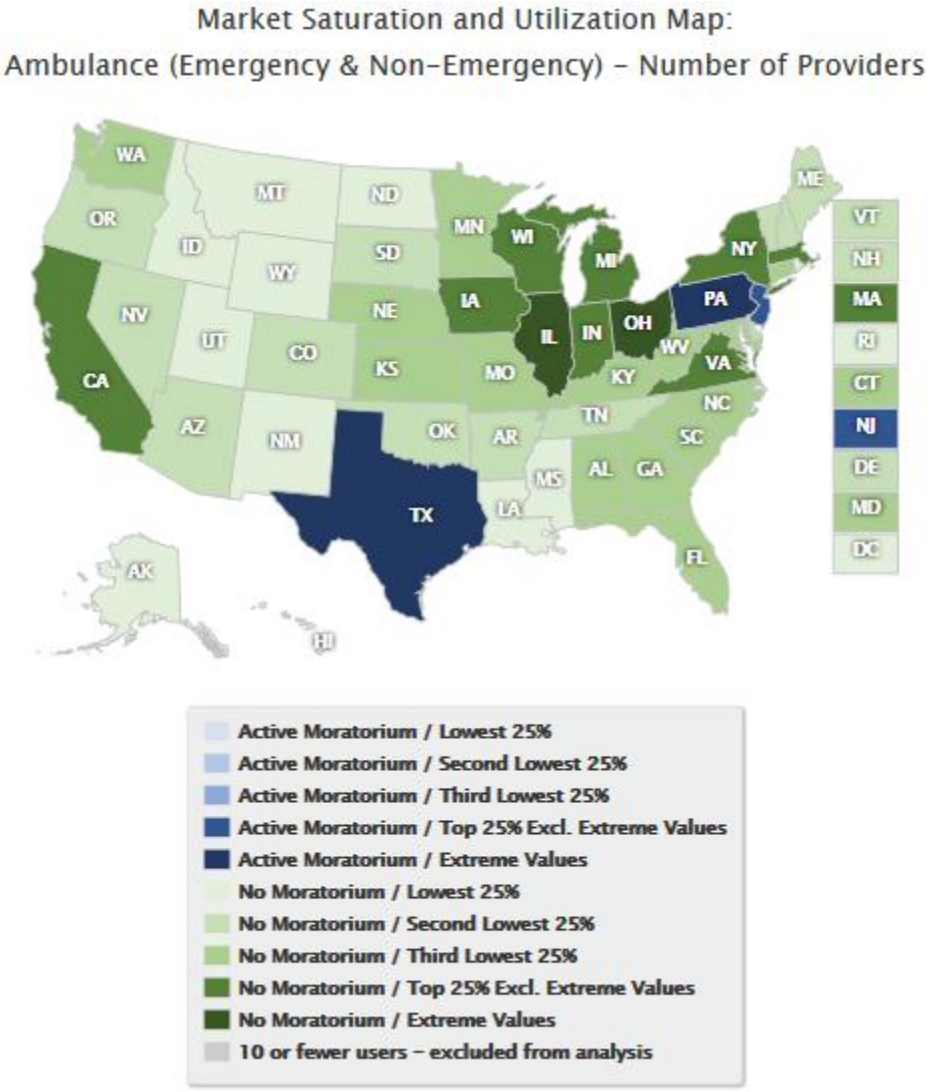
The Market Saturation and Utilization Data Tool includes an interactive map that is color-coded based on an analysis that separates the distribution into the following categories of states/counties for the selected metric: lowest 25 percent, second lowest 25 percent, third lowest 25 percent, top 25 percent excluding extreme values, and extreme values. An extreme value is one that greatly differs from other values in its field (e.g., Number of Providers). Counties that are excluded from the analysis are colored gray in the interactive map.

For those interested in states and counties affected by CMS' temporary provider enrollment moratoria during the reference periods for which data are available, the interactive map permits a visualization that identifies those states and counties. In this visualization, Ambulance and Home Health service areas for moratoria versus non-moratoria states/counties are identified based on color scheme.

The examples below utilize the Ambulance (Emergency & Non-Emergency) service area data (selected for illustration purposes only). Similar maps can be created through the Data Tool for all of the health service areas included in the seventh release and for the seven, twelve-month reference periods: 2014-10-01 to 2015-09-30, 2015-01-01 to 2015-12-31, 2015-04-01 to 2016-03-31, 2015-07-01 to 2016-06-30, 2015-10-01 to 2016-09-30, 2016-01-01 to 2016-12-31, and 2016-04-01 to 2017-03-31.

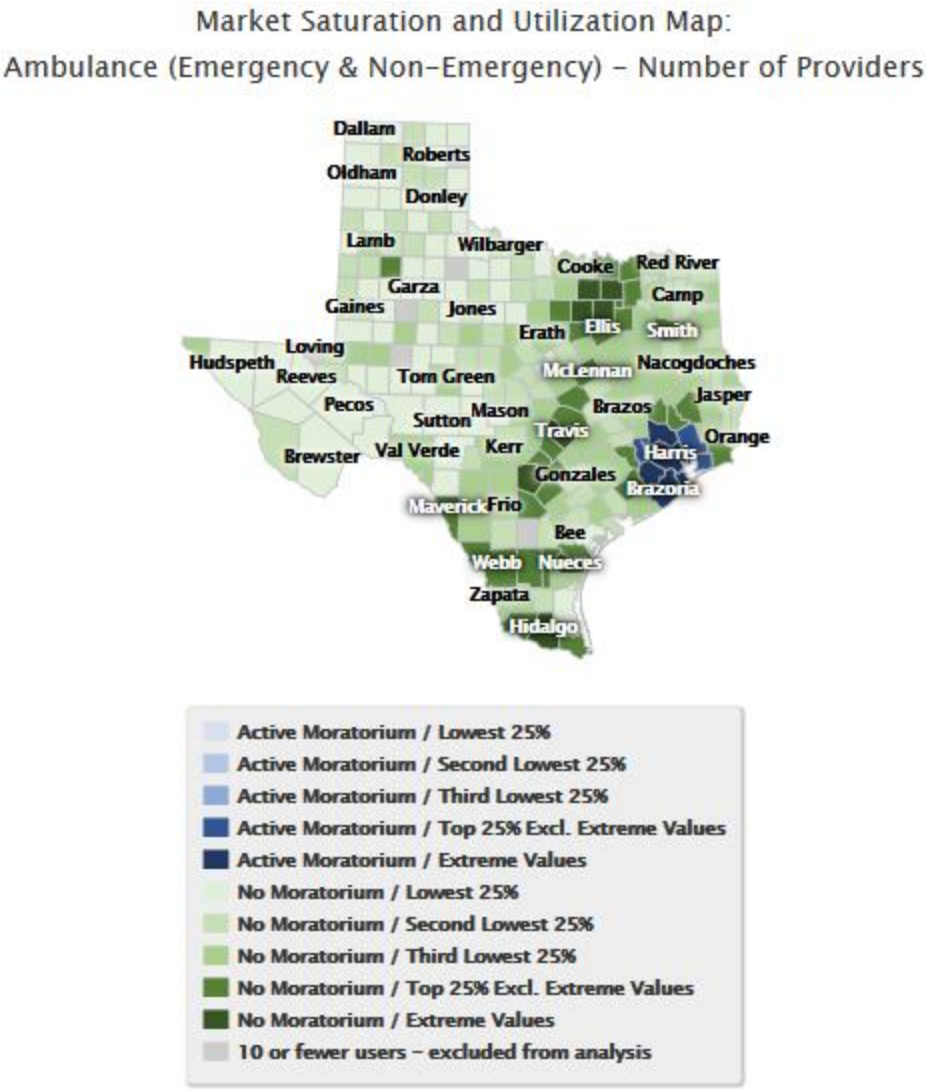
Map 1 displays the distribution of providers by state for the October 1, 2014 through September 30, 2015 reference period. The dual color scale distinguishes between moratoria (blue) and non-moratoria states (green).

Map 1. Ambulance (Emergency & Non-Emergency):
National Distribution of Number of Providers
October 1, 2014 – September 30, 2015
Color by Moratoria Status



Map 2 drills down to the county level and displays the distribution of providers by county within the State of Texas for the October 1, 2014 through September 30, 2015 reference period. The dual color scale distinguishes between moratoria (blue) and non-moratoria counties (green).

Map 2. Ambulance (Emergency & Non-Emergency):
County Distribution of Number of Providers
October 1, 2014 – September 30, 2015
Color by Moratoria Status



Similar maps can be created at the national- and state-level for the other metrics included in the Data Tool: Number of FFS Beneficiaries, Average Number of Users per Provider, Percentage of Users out of FFS Beneficiaries, Number of Users, Average Number of Providers per County and Total Payments.

Get CMS news at cms.gov/newsroom, sign up for CMS news via email and follow CMS on Twitter CMS Administrator @SeemaCMS, @CMSgov, and @CMSgovPress

Materials attached:
Fact Sheet: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-13.html

###

Advanced Diagnostic Laboratory Test Application and Related Guidance

The Centers for Medicare & Medicaid Services published its application for requesting Advanced Diagnostic Laboratory (ADLT) status for laboratory tests. The ADLT application and related guidance implements section 216 of the Protecting Access (PAMA) to Medicare Act of 2014 which established a new subcategory of clinical diagnostic laboratory tests known as "ADLTs" with separate reporting and payment requirements. Once the ADLT application is released, CMS will begin to review and approve requests for ADLT status.

For more information on the Application and Related Guidance click here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html

###

Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage - Office of Minority Health

In recognition of National Minority Health Month, the Centers for Medicare & Medicaid Services, Office of Minority Health (CMS OMH) released a report detailing disparities in the quality of care received by people enrolled in Medicare Advantage (MA). *Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage* describes racial, ethnic, and gender differences in health care experiences and clinical care received nationally in 2015-2016. This report highlights racial and ethnic differences in health care experiences and clinical care, compares quality of care for women and men, and looks at racial and ethnic differences in quality of care among women and men separately.

Key Findings include:

- On over 40% of the measures of clinical care examined, Asian and Pacific Islander (API) beneficiaries received better care than White beneficiaries.
- Gaps between Black and White MA beneficiaries were larger for men than for women in getting needed prescription drugs, rates of colorectal cancer screening, quality of diabetes care, and management of rheumatoid arthritis.
- Of the 35 measures of patient experience and clinical care examined, there were sizable differences favoring Whites over Hispanics on 15 of them.

Healthcare professionals, organizations, researchers, and hospital leaders can utilize this report along with other CMS tools and resources to help raise awareness of health disparities, develop interventions for racially and ethnically diverse Medicare beneficiaries, and implement quality improvement efforts that improve health equity.

This report is based on an analysis of two sources of information: the Healthcare Effectiveness Data and Information Set (HEDIS) and the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. HEDIS collects information from medical records and administrative data on the technical quality of care that Medicare beneficiaries receive for a variety of medical issues, including diabetes, cardiovascular disease, and chronic lung disease. The Medicare CAHPS survey is conducted annually by CMS and focuses on the health care experiences of Medicare beneficiaries across the nation.

The CMS OMH welcomes your participation in promoting health observances such as National Minority Health Month throughout the year to raise awareness about health issues affecting people across our nation. Feel free to share this report and our resources on prevention and health equity initiatives.

###

Feedback on New Direction Request for Information (RFI) Released, CMS Innovation Center's Market-Driven Reforms to Focus on Patient-Centered Care

Request for Information on Provider Contracting Issued

Today, the Centers for Medicare & Medicaid Services (CMS) announced that it has released the comments submitted by patients, clinicians, innovators, and others in response to the CMS Innovation Center's New Direction Request for Information (RFI). Last fall, CMS released the RFI to collect ideas on a new direction for the agency's Innovation Center to promote patient-centered care and test market driven reforms that: empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. The Innovation Center is a central focus of the Administration's efforts to accelerate the move from a healthcare system that pays for volume to one that pays for value and encourages provider innovation.

CMS received over 1,000 responses to the RFI from a wide variety of individuals and organizations located across the country, including medical societies and associations, health systems, physician groups, and private businesses. Since the RFI comment period closed last November, CMS has been reviewing the responses, which provided valuable insight on the potential to improve existing models as well as ideas for transformative new models that aim to empower patients with more choices and better health outcomes.

"HHS has made shifting our healthcare system to one that pays for value one of our top four department priorities," said HHS Secretary Alex Azar. "Using bold, innovative models in Medicare and Medicaid is a key piece of this effort. We value stakeholder input on the new direction for the Innovation Center, and look forward to engaging on especially promising, groundbreaking ideas such as direct provider contracting."

"We recognize that the best ideas don't come from Washington, so it's important that we hear from the front lines of our healthcare system about how we can improve care" said CMS Administrator Seema Verma. "The responses from this RFI will help inform and drive our initiatives to transform the health care delivery system with the goal of improving quality of care while reducing unnecessary cost."

The responses focused on a number of areas that are critical to enhancing quality of care for beneficiaries and decreasing unnecessary cost, such as increased physician accountability for patient outcomes, improved patient choice and transparency, realigned incentives for the benefit of the patient, and a focus on chronically ill patients. In addition to the themes that emerged around the RFI's guiding principles and eight model focus areas, the comments received in response to the RFI also reflected broad support for reducing burdensome requirements and unnecessary regulations.

CMS is sharing the feedback received to promote transparency and facilitate further discussion of how to move the Innovation Center in a new direction. The RFI was a critical step in the model design process to ensure public input was available to help shape new models. Over the coming year, CMS will use the feedback as it works to develop new models, focusing on the eight focus areas outlined in the RFI.

Today, CMS is also taking a next step to develop a potential model in the area of direct provider contracting, informed in part by the RFI. A direct provider contract model would allow providers to take further accountability for the cost and quality of a designated population in order to drive better beneficiary outcomes. Such a model would have the potential to enhance the doctor-patient relationship by eliminating administrative burden for clinicians and providing increased flexibility to provide the high-quality care that is most appropriate for their patients, thus improving quality while reducing expenditures.

As part of its process to gain further insight from the public in this area and ask more focused questions, CMS is issuing a follow up RFI. The information being requested is detailed in nature and is intended to provide CMS the data needed to potentially design and release a model in this area. CMS is excited to continue to evaluate the concept of direct provider contracting and is also focusing its attention on other areas guided by input and feedback from the New Direction RFI as well as the public.

The public comments that were received by the CMS Innovation Center in response to the New Direction RFI are available at: https://innovation.cms.gov/initiatives/direction.

The Direct Provider Contracting RFI is available at: https://innovation.cms.gov/initiatives/direct-provider-contracting/. Comments are due by 11:59 EDT on May 25, 2018.

###

Upcoming Webinars and Events and Other Updates

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.*

REGISTRATION:

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

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CMS Hospital/Quality Initiative Open Door Forum

Date: Wednesday, April 25, 2018

Start Time: 2:00pm-3:00pm Eastern Time (ET)

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

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

I. Opening Remarks

Chair – Tiffany Swygert (Center for Medicare)

Moderator – Jill Darling (Office of Communications)

II. Announcements & Updates

- FY 2019 Inpatient Prospective Payment System/Long Term Care Hospitals (IPPS/LTCH) Notice of Proposed Rulemaking: Update and other payment policy provisions
- Training Announcement for May in-person trainings for the IRF QRP and LTCH QRP. Links for additional details are available at the following links

- IRF: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html
- LTCH: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html

- NEW Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Podcast Now Available – Improving Response Rates of HCAHPS Hospitals

- http://www.hcahpsonline.org/en/podcasts/

III. Open Q&A

DATE IS SUBJECT TO CHANGE

Next CMS Hospital/Quality Initiative Open Door Forum: TBD

ODF EMAIL MAILBOX: Hospital_ODF@cms.hhs.gov

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

Open Door Participation Instructions:

This call will be Conference Call Only.

To participate by phone:

Dial: 1-800-837-1935 & Reference Conference ID: 32622211

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

Encore: 1-855-859-2056; Conference ID: 32622211

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

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

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

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

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IRF and LTCH Provider Training- Registration Now Open

LTCH QRP Provider In-Person Training Event, May 8-9, 2018

The Centers for Medicare & Medicaid Services (CMS) will be hosting a 2-day Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) in-person 'Train the Trainer' event for providers on May 8 and 9, 2018, in Baltimore, MD. See the LTCH Quality Reporting Training webpage for details.

IRF QRP Provider In-Person Training Event, May 9-10, 2018

The Centers for Medicare & Medicaid Services (CMS) will be hosting a 2-day Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) in-person 'Train the Trainer' event for providers on May 9 and 10, 2018, in Baltimore, MD. See the IRF Quality Reporting Training webpage for details.

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HHS Community Health News

Opioid Announcements from the National Rx Summit

NIH Launches HEAL Initiative, Doubles Funding to Accelerate Scientific Solutions to Stem National Opioid Epidemic
At the 2018 National Rx Drug Abuse and Heroin Summit, National Institutes of Health (NIH) Director Francis S. Collins, announced the launch of the HEAL (Helping to End Addiction Long-term) Initiative, an aggressive, trans-agency effort to speed scientific solutions to stem the national opioid public health crisis. Toward this effort, NIH is nearly doubling funding for research on opioid misuse/addiction and pain from approximately $600 million in fiscal year 2016 to $1.1 billion in fiscal year 2018, made possible from a funding boost by Congress. Read more here.

Surgeon General Released Public Health Advisory on Naloxone, an Opioid Overdose Reversing Drug
U.S. Surgeon General Jerome M. Adams, M.D., M.P.H., has released a **public health advisory** to urge more Americans to carry a potentially lifesaving medication that can reverse the effects of an opioid overdose. The medication, naloxone, is already carried by many first responders, such as EMTs and police officers. The Surgeon General is now recommending that more individuals, including family, friends, and those who are personally at risk for an opioid overdose, also keep the drug on hand. Read more here. Stay engaged through @Surgeon_General

National Drug Take Back Day-- April 28, 2018

National Prescription Drug Take Back Days can be an easy, collaborative activity to join. Many Americans are not aware that medicines that linger in home cabinets are highly susceptible to diversion, misuse, and abuse—with more than 50% of people who misuse prescription pain killers gained access to them through a friend or relative. By partnering with the local pharmacies, law enforcement or even a long-term care facility, you can address one of the more pressing challenges of the epidemic. Last year, the National Prescription Drug Take Back Day collected a total weight of pounds: 900,386 lbs. (450 Tons). Locate a collection site near you and help make your community a safer place.

Free Resources to Reduce Opioid Risk- National Security Council
The National Security Council has created warn-me labels and prescription drug disposal envelopes to limit the risk from opioids. To find out more, please visit www.stopeverydaykillers.org.
The Stericycle Seal&Send Envelope are DEA-compliant 8"x12" envelopes designed to hold up to 8 oz. of medication, of which 4 oz. may be liquid in a sealed container. Stericycle will destroy the medication using a process that is secure and safe for the environment. Envelopes are U.S. postage-paid, pre-addressed and include complete instructions.

In the News

5 Ways to Find the Best Treatment for Opioid Addiction
In a recent interview, Dr. Elinore McCance-Katz, Assistant Secretary, Substance Abuse and Mental Health Services Administration (SAMHSA), shared the key questions that should be asked of any treatment program in order to ensure your community member and loved one receives effective, long-term care for their substance use disorder.

Operation Prevention: Resources for Teens, Parents, Schools and Communities

The DEA has joined forces with Discovery Education to create Operation Prevention, a comprehensive, NO-COST program to combat opioid misuse. It's available today for every school, home, and state in the nation to help fight prescription opioid misuse and heroin use through free to access and easy-to-use educational resources tailored for elementary, middle and high schoolers. With Virtual Field Trips, Parent Resources, English & Spanish language standards aligned K-12 tools, and a national peer-to-peer video challenge, your community can kick-start life-saving actions today.

National Health Observances!

Alcohol Awareness Month
Drinking too much alcohol increases people's risk of injuries, violence, drowning, liver disease, and some types of cancer. The good news? We can all do our part to prevent alcohol misuse or abuse.
Spread the word about strategies for preventing alcohol misuse or abuse and encourage communities, families, and individuals to get involved. Here's a toolkit full of ideas to help you take action today!

May is Older Americans Month!
Older Americans Month is celebrated each May to honor and recognize older Americans for the contributions they make to our families, communities, and society. Get ready by visiting the Older Americans Month website for materials, activity ideas, and resources to help you promote and celebrate this year's theme, **Engage at Every Age.**

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Medicare Learning Network

News & Announcements

- New Medicare Card: New Numbers Are Confidential
- Market Saturation and Utilization Data Tool
- MIPS Study on Burdens Associated with Reporting Quality Measures: Apply by April 30
- IMPACT Act Transfer of Health Measures: Public Comment Period Ends May 3
- PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs
- National Minority Health Month: Partnering for Health Equity

Provider Compliance

- Ophthalmology Services: Questionable Billing and Improper Payments

Claims, Pricers & Codes

- April 2018 OPPS Pricer File

Upcoming Events

- Medicare Cost Report e-Filing System Webcast — May 1
- Comparative Billing Report on Spinal Orthoses Suppliers Webinar — May 2
- LTCH Quality Reporting Program In-Person Training Event — May 8 and 9
- IRF Quality Reporting Program In-Person Training Event — May 9 and 10
- Managing Older Adults with Substance Use Disorders Webinar — May 16

Medicare Learning Network® Publications & Multimedia

- Quarterly Update to the NCCI PTP Edits, Version 24.2 MLN Matters Article — New
- Change in Type of Service for CPT Code 77067 MLN Matters Article — New
- Ambulance Transportation for SNF Resident in Stay Not Covered by Part A MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Guidelines for Teaching Physicians, Interns, and Residents Booklet — Revised
- Billing Information for Rural Providers and Suppliers Booklet — Revised
- ICD-10-CM/PCS: The Next Generation of Coding Booklet — Reminder
- General Equivalence Mappings FAQs Booklet — Reminder

- Critical Access Hospital Booklet — Reminder
- Learn About Medicare Policy

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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

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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.