CMS Region 7 Updates – 5/04/2018

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ACA/Marketplace Updates

Enroll in SHOP Coverage

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Questions about SHOP? Contact the SHOP Call Center at 1-800-706-7893 (TTY: 711) weekdays from 9 a.m. to 5 p.m. Eastern Time.

Thank you,
The SHOP Team

###

MACRA/Quality Payment Program (QPP) Updates

2018 Measure Development Plan (MDP) Annual Report

The Centers for Medicare & Medicaid Services (CMS) today posted the 2018 Quality Measure Development Plan (MDP) Annual Report, which describes progress in developing clinician quality measures to support the Quality Payment Program. The *CMS Quality Measure Development Plan* (MDP) is a focused framework to help develop and improve these measures, point out the known measurement and performance gaps, and recommend prioritized approaches to close those gaps. The 2018 MDP Annual Report supplements the MDP with additional information to support measure development and records progress since the first annual report in 2017. The 2018 MDP Annual Report describes efforts including identifying and developing meaningful outcome measures, partnering with patients in the measure development process, partnering with clinicians and professional societies, and funding new measure development.

The strategic approach to measure development outlined in the MDP and additional findings in the Measure Development Plan annual reports provide information and support to key stakeholders who develop clinician quality measures for consideration for the Quality Payment Program.
For more information about the 2018 MDP Annual Report, go to the Quality Payment Program measure development page

###

Join CMS for a Webinar on Participation Criteria for Year 2 of the Quality Payment Program

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Attendees will learn about:

- How CMS determines a clinician's participation status in MIPS at the individual and group level
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- Advanced APMs All-Payer Combination Option
- APM Scoring Standard benefits for participation in a MIPS APM
- Checking your participation status for the 2018 Performance Year

CMS will address questions from participants at the end of the webinar, as time allows.

Webinar Details

Title: Participation Criteria for Year 2 of the Quality Payment Program

Date: Wednesday, May 9, 2018

Time: 1:00-2:15 p.m. ET

Registration Link: https://engage.vevent.com/rt/cms/index.jsp?seid=1091

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###

CMS Changes Name of the EHR Incentive Programs and Advancing Care Information to "Promoting Interoperability"

To continue our commitment to promoting and prioritizing interoperability of health care data, the Centers for Medicare & Medicaid Services (CMS) is overhauling and streamlining the Electronic Health Record (EHR) Incentive Programs for hospitals as well as for the Advancing Care Information performance category of the Merit-based Incentive Payment System (MIPS), which is one track of the Quality Payment Program. This change will move the programs beyond the existing requirements of meaningful use to a new phase of EHR measurement with an increased focus on interoperability and improving patient access to health information.

To better reflect this focus, effective immediately CMS is renaming:

- The EHR Incentive Programs to the **Promoting Interoperability (PI) Programs** for eligible hospitals, critical access hospitals, and Medicaid providers
- The MIPS Advancing Care Information performance category to **the Promoting Interoperability performance category** for MIPS eligible clinicians

Please note that this rebranding does not merge or combine the EHR Incentive Programs and MIPS. In the coming weeks, CMS will be updating its websites and educational resources to reflect this change.

###

Independence at Home Demonstration Corrected Performance Year 2 Results

Updated May 1, 2018

Home-based primary care allows health care providers to spend more time with their patients, perform assessments in a patient's home environment, and assume greater accountability for all aspects of the patient's care. This focus on timely and appropriate care is designed to improve the overall quality of care and quality of life for patients served, while lowering health care costs by forestalling the need for care in institutional settings.

The Independence at Home Demonstration provides chronically ill patients with a complete range of primary care services in the home setting. Medical practices led by physicians or nurse practitioners provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations. The Demonstration also tests whether home-based care can reduce the need for hospitalization, improve patient and caregiver satisfaction, and lead to better health for beneficiaries and lower costs to Medicare.

The Independence at Home Demonstration is authorized by Section 3024 of the Affordable Care Act. The demonstration began in 2012 and was originally authorized for three years. It was subsequently extended for two additional years through September 30, 2017 by the Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015. The Bipartisan Budget Act of 2018, enacted February 9, 2018, extended the demonstration for an additional two years through September 30, 2019.

Summary of Results from Performance Year 2

In the second performance year of the demonstration, 10,484 beneficiaries were enrolled in the 15 participating practices. For the second performance year, all 15 of the Independence at Home practices improved performance from the first performance year in at least two of the six quality measures for the demonstration. Four practices met the performance thresholds for all six quality measures.

In the original release of Performance Year 2 results in August 2016, CMS stated that the 15 participating practices saved $10,612,506 in aggregate, and that seven participating practices earned incentive payments of $5,719,526 (See Table 1 below).

Table 1. Performance Year 2 Results for Participating Practices (Released in August 2016)

Independence at Home Practice Name	Year 2 Spending Target*	Year 2 Expenditures*	Practice Incentive Payment
Boston Medical Center	$4,148	$4,236	
Christiana Care Health System	$3,911	$4,450	
Cleveland Clinic Home Care Services	$3,619	$3,565	
Doctors Making Housecalls	$3,107	$2,788	$1,441,634
Doctors on Call	$4,820	$4,538	
House Call Doctors Inc.	$4,156	$4,727	
Housecall Providers, Inc.	$3,223	$2,393	$1,107,295
MD2U-KY, MD2U-IN	$4,067	$3,980	
Mid-Atlantic Consortium	$4,067	$3,576	$866,865
Northwell Health Care	$3,276	$2,708	$874,151
VPA Dallas	$4,270	$3,942	$454,009
VPA Flint	$4,106	$3,955	
VPA Jacksonville	$3,714	$3,722	
VPA Lansing	$4,163	$3,817	$360,301
VPA Milwaukee	$3,449	$3,091	$615,271

* The Year 2 Spending Target and Year 2 Expenditures are on a per beneficiary per month (PBPM) basis.

After these results were released, CMS discovered two errors in its work that affected (1) the calculation of Performance Year 2 savings for the revised regression-based methodology and (2) the application of the policy related to overlapping beneficiaries in shared savings models within CMS for the original and revised regression-based methodologies. The revised Performance Year 2 results, reflecting the correction of these errors, are presented in Table 2 below. The corrected analysis found that in Performance Year 2, Independence at Home practices saved, in aggregate, a net of $7,821,374, an average of $89 per beneficiary. Seven participating practices earned incentive payments in the amount of $5,322,343.

Table 2. Corrected Performance Year 2 Results for Participating Practices

Independence at Home Practice Name	Year 2 Spending Target*	Year 2 Expenditures*	Practice Incentive Payment
Boston Medical Center	$3,862	$3,862	
Christiana Care Health System	$3,912	$4,454	
Cleveland Clinic Home Care Services	$3,558	$3,574	
Doctors Making Housecalls	$3,094	$2,787	$1,341,649
Doctors on Call	$4,747	$4,610	
House Call Doctors Inc.	$4,128	$4,698	
Housecall Providers, Inc.	$3,018	$2,298	$942,156
MD2U-KY, MD2U-IN	$3,986	$3,930	
Mid-Atlantic Consortium	$4,066	$3,580	$851,948
Northwell Health Care	$3,276	$2,708	$874,151
VPA Dallas	$4,266	$3,940	$446,872
VPA Flint	$4,204	$4,119	
VPA Jacksonville	$3,647	$3,645	
VPA Lansing	$4,094	$3,757	$345,795
VPA Milwaukee	$3,305	$2,983	$519,772

* The Year 2 Spending Target and Year 2 Expenditures are on a per beneficiary per month (PBPM) basis.

Quality Measures

Under the Independence at Home Demonstration, participating practices must meet the performance thresholds for at least three of the six quality measures in order to qualify for the incentive payment. The six measures are:

- Follow up contact within 48 hours of a hospital admission, hospital discharge, and emergency department visit;
- Medication Reconciliation in the home within 48 hours of a hospital discharge and emergency department visit;
- Annual documentation of patient preferences;
- All-cause hospital readmissions within 30 days;
- Hospital admissions for Ambulatory Care Sensitive Conditions; and
- Emergency department visits for Ambulatory Care Sensitive Conditions.

Shared Savings Methodology Modifications

For the first performance year of the Independence at Home Demonstration, a regression-based methodology was predominantly used to determine demonstration savings. Under the regression-based methodology, CMS derived the savings estimates by making comparisons between the treatment group, or demonstration beneficiaries, and a matched comparison group of beneficiaries identified in CMS' administrative data who meet the demonstration eligibility criteria and do not receive home-based primary care. For the second performance year of the demonstration, CMS identified potential issues under the regression-based methodology with the comparability between the treatment group and the matched comparison group used in the analysis of the demonstration savings. CMS conducted many analyses concerning the comparability issues.

To construct the comparison group, beneficiaries who met the demonstration eligibility criteria and were statistically similar to the demonstration beneficiaries in their health conditions, activities of daily living (ADL) limitations, and demographic characteristics, such as age and sex, were matched to demonstration beneficiaries. For the second performance year, revisions were made to the detailed health characteristics and other variables used for matching. CMS also revised the approach to measuring characteristics of beneficiaries who continued in the demonstration from its first year into its second year without meeting all of the eligibility criteria again. Finally, changes were made to the selection of beneficiaries in the treatment group used for analysis. Collectively, these changes helped to improve comparability between Independence at Home beneficiaries and their matched comparison group beneficiaries. Participants using the regression methodology in

the first performance year had the choice between the original regression methodology and this revised regression methodology for the second performance year.

###

Join CMS for an Overview of eCQM Reporting and Promoting Interoperability Program Proposals for the FY 2019 IPPS Proposed Rule

This Outreach and Education webinar for participants in the Hospital Inpatient Quality Reporting (IQR) Program and the Medicare and Medicaid Promoting Interoperability Programs (previously known as the Medicare and Medicaid Electronic Health Record [EHR] Incentive Programs) is scheduled for **Wednesday, May 16, 2018, at 2:00 p.m. ET**.

This presentation will provide participants with an overview of the proposals in the recently released Fiscal Year (FY) 2019 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Proposed Rule related to electronic clinical quality measure (eCQM) reporting requirements for the Hospital IQR Program and the PI Programs. The overview will also provide instructions on how to submit public comments as a matter of record and receive response in the final rule.

Webinar Details

Title: FY 2019 IPPS Proposed Rule: Overview of eCQM Reporting and Promoting Interoperability Program Proposals

Date: Wednesday, May 16, 2018

Time: 2:00-3:00 p.m. ET

Registration link: https://cc.readytalk.com/r/b01bm00palh2&eom

Speakers:

- Shanna Hartman, MS, RN, Nurse Consultant, CMS
- Grace H. Snyder, JD, MPH, Program Lead, CMS
- Kathleen Johnson, RN, Health Insurance Specialist, CMS
- Steven E. Johnson, MS, Health Insurance Specialist, CMS

The webinar slides will be available for download from www.QualityReportingCenter.com *under Upcoming Events the day before the presentation.*

For More Information

For further assistance regarding the information contained in this message, please contact the Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Team at https://cms-ip.custhelp.com or (844) 472-4477.

###

Updated eCQM Specifications and New eCQM Reading Guide Now Available

The Centers for Medicare & Medicaid Services (CMS) has posted the eCQM annual update for the 2019 reporting period for Eligible Hospitals and Critical Access Hospitals (CAHs), and the 2019 performance period for Eligible Professionals and Eligible Clinicians. CMS updates the specifications annually to align with current clinical guidelines and code systems so they remain relevant and actionable within the clinical care setting. These updated eCQMs are fully specified and are to be used to electronically report 2019 clinical quality measure data for CMS quality reporting programs. 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.

CMS has updated eCQMs for potential inclusion in the following programs:

- The Hospital Inpatient Quality Reporting (IQR) Program
- The Medicare Promoting Interoperability Program (formerly known as the Medicare Electronic Health Record (EHR) Incentive Program)
- The Medicaid Promoting Interoperability Program (formerly known as the Medicaid EHR Incentive Program)
- Quality Payment Program: The Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs)
- Comprehensive Primary Care Plus (CPC+)

What's New for 2019 Reporting/Performance?

Use of Clinical Quality Language (CQL) - eCQMs for 2019 reporting will be expressed using the new CQL standard for logic expression and will continue to use the Quality Data Model (QDM) as the conceptual model to express clinical concepts. 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 and structured for electronic processing.

Guide to Reading eCQMs - This updated resource assists stakeholders in interpreting and understanding eCQMs. The guide provides information on eCQMs such as file naming conventions, understanding an eCQM human-readable rendition, QDM data criteria, value sets, and more.

Where to Find the Updated Measure Specifications

The updated measure specifications are available on the eCQI Resource Center for Eligible Hospitals and Critical Access Hospitals and Eligible Professionals and Eligible Clinicians under the 2019 Reporting/Performance Year.

Where to find the 2019 eCQM Value Sets

The 2019 Reporting/Performance Period eCQM value sets are available through the National Library of Medicine's Value Set Authority Center (VSAC). The value sets are available as a complete set, as well as value sets per measure.

Provide Feedback on the Updated Measures

To report questions and comments regarding the updated measures, visit the eCQM Issue Tracker. Note that an ONC Issue Tracking System account is required to ask a question or comment.

For More Information

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

Medicare and Medicaid Updates

CMS Encourages Eligible Suppliers to Participate in Expanded Medicare Diabetes Prevention Program Model

Nationally expanded performance-based payment model now enrolling service suppliers

The Centers for Medicare & Medicaid Services (CMS) in April expanded the Medicare Diabetes Prevention Program (MDPP), a national performance-based payment model offering a new approach to type 2 diabetes prevention in eligible Medicare beneficiaries with an indication of pre-diabetes. For the first time, both traditional healthcare providers and community-based organizations can enroll as Medicare suppliers of health behavior change services. This innovative model promotes patient-centered care and continues to test market-driven reforms to drive quality of care and improve outcomes for America's seniors, more than a quarter of whom have type 2 diabetes.

CMS recognizes that prevention is a critical part of creating an affordable healthcare system that puts patients first, and we encourage eligible suppliers to partner with us on this shared goal by participating in the national expansion of the MDPP.

As the CMS Innovation Center's first preventive services model test to expand nationally, the MDPP is a key example of how we're putting innovation to work. The model launched in 2012 as a small, voluntary model test at 17 sites across the country in partnership with the YMCA-USA, Centers for Disease Control and Prevention (CDC), and other public and private partners. Now, CMS is expanding this set of services nationwide based on promising results. In the initial model test, 45 percent of beneficiaries met the 5 percent weight loss target, which translates to a clinically meaningful reduction in the risk of developing type 2 diabetes.

Through the MDPP, trained community health workers and other health professionals empower beneficiaries at high risk of developing type 2 diabetes to take ownership of their health through curriculum-driven coaching and proven behavior change strategies for weight control. As a new preventive service for qualifying Medicare beneficiaries, MDPP services are available without a referral or co-payment.

The MDPP is not only a good value for our beneficiaries. Investing in prevention through performance-based payments and market-based incentives, this promising model will save the Medicare program more than $180 million by keeping beneficiaries healthy and averting new cases of diabetes[i].

One of the critical innovations in the MDPP is its approach to care delivery: For the first time, community-based organizations can enroll in Medicare to provide evidence-based diabetes prevention services after achieving preliminary or full recognition through the CDC. These organizations can enroll in Medicare to become an MDPP Supplier today, and CMS will continue to accept supplier applications on a rolling basis. Eligible organizations can begin the screening and enrollment process to become an MDPP Supplier by using the Provider Enrollment Chain and Ownership System (PECOS) or submitting the paper CMS-20134 Form. For information on the steps to enrollment, please refer to the MDPP Enrollment Fact Sheet.

Diabetes exerts an unacceptable toll on our beneficiaries, their families, and the Medicare program, which spends more than $104 billion every year treating patients with this preventable disease. The Medicare Diabetes Prevention Program is leveraging innovation to bring valuable preventive services to our beneficiaries, and I urge eligible organizations across the country to enroll today in this exciting performance-based payment opportunity.

###

CMS Proposes Changes to Empower Patients and Reduce Administrative Burden

Changes in Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System would advance price transparency and interoperability

The Centers for Medicare & Medicaid Services (CMS) proposed changes to empower patients through better access to hospital price information, improve patients' access to their electronic health records, and make it easier for providers to spend time with their patients. The proposed rule issued today proposes updates to Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS).

"We seek to ensure the healthcare system puts patients first," said Administrator Seema Verma. "Today's proposed rule demonstrates our commitment to patient access to high quality care while removing outdated and redundant regulations on providers. We envision a system that rewards value over volume and where patients reap the benefits through more choices and better health outcomes. Secretary Azar has made such a value-based transformation in our healthcare system a top priority for HHS, and CMS is taking important, concrete steps toward achieving it."

The policies in the IPPS and LTCH PPS proposed rule would further advance the agency's priority of creating a patient-driven healthcare system by achieving greater price transparency and interoperability – essential components of value-based care – while also significantly reducing the burden for hospitals so they can operate with better flexibility and patients have the information they need to become active healthcare consumers.

While hospitals are already required under guidelines developed by CMS to either make publicly available a list of their standard charges, or their policies for allowing the public to view a list of those charges upon request, CMS is updating its guidelines to specifically require that hospitals post this information. The agency is also seeking comment on what price transparency information stakeholders would find most useful and how best to help hospitals create patient-friendly interfaces to make it easier for consumers to access relevant health care data so they can more readily compare providers.

The proposed policies released today begin implementing core pieces of the government-wide MyHealthEData initiative through several steps to strengthen interoperability or the sharing of healthcare data between providers. Specifically, CMS is proposing to overhaul the Medicare and Medicaid Electronic Health Record Incentive Programs (also known as the "Meaningful Use" program) to:

- make the program more flexible and less burdensome,
- emphasize measures that require the exchange of health information between providers and patients, and
- incentivize providers to make it easier for patients to obtain their medical records electronically.

To better reflect this new focus, we are re-naming the Meaningful Use program "Promoting Interoperability." In addition, the proposed rule reiterates the requirement for providers to use the 2015 Edition of certified electronic health record technology in 2019 as part of demonstrating meaningful use to qualify for incentive payments and avoid reductions to Medicare payments. This updated technology includes the use of application programming interfaces (APIs), which have the potential to improve the flow of information between providers and patients. Patients could collect their health information from multiple providers and potentially incorporate all of their health information into a single portal, application, program, or other software. This can support a patient's ability to share their information with another member of their care team or with a new doctor, which can reduce duplication and provide continuity of care. In the proposed rule, CMS is requesting stakeholder feedback through a Request for Information on the possibility of revising Conditions of Participation to revive interoperability as a way to increase electronic sharing of data by hospitals.

As part of its commitment to burden reduction, CMS is proposing in the FY 2019 IPPS/LTCH PPS proposed rule to remove unnecessary, redundant, and process-driven quality measures from a number of quality reporting and pay-for-performance programs. The proposed rule would eliminate a significant number of measures acute care hospitals are currently required to report and remove duplicative measures across the 5 hospital quality and value-based purchasing programs. This would result in the removal of a total of 19 measures from the programs and would de-duplicate another 21 measures while still maintaining meaningful measures of hospital quality and patient safety. Additionally, CMS is proposing a variety of other changes to reduce the number of hours providers spend on paperwork. CMS is proposing this new flexibility so that hospitals can spend more time providing care to their patients thereby improving the quality of care their patients receive.

In sum this results in the elimination of 25 total measures across the 5 programs with well over 2 million burden hours reduced for hospital providers impacted by the IPPS proposed rule, saving them $75 million.

For a fact sheet on the proposed rule (CMS-1694-P), please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-24.html

To view the proposed rule (CMS-1694-P), please visit: https://www.federalregister.gov/public-inspection/

###

Upcoming Webinars and Events and Other Updates

New Medicare Card Webinar for Consumers, Medicare Beneficiaries & Caregivers

New Medicare Card Webinar for Consumers, Medicare Beneficiaries & Caregivers
Tuesday, June 5, 2018
1:30-2:30 PM Central Time

The Centers for Medicare & Medicaid Regional Office in Kansas City is hosting a **FREE** webinar on the **New Medicare Card** and is asking for your help in reaching the citizens you serve in your community. We would appreciate it if you would be willing to help us by promoting these webinars and gathering consumers, Medicare beneficiaries, and caregivers in one location to watch and listen to one of our upcoming series of webinars.

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. This webinar 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, this webinar 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.

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.

Registration Link: https://newmedicarecardwebinar5.eventbrite.com

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 will receive the confirmation email with details on how to access the webinar.*

Below are links to materials and resources to share with attendees at your webinar viewing.

New Medicare Card Resources

The Outreach & education page: https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/Outreach-and-education.html

For overall info/materials for providers/partners/stakeholders: https://www.cms.gov/medicare/new-medicare-card/nmc-home.html

The beneficiary blog: https://blog.medicare.gov/2018/05/02/look-out-for-your-new-medicare-card/

The provider drop-in article: https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/NMC-Provider-Drop-in-.pdf

The Products Page: https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/Products-to-share-with-beneficiaries.html

The beneficiary announcement in English: https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/NMC-Beneficiary-Announcement.pdf

The beneficiary announcement in Spanish: https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/NMC-Spanish-Beneficiary-Announcement-.pdf

The beneficiary drop-in bulletin in English: https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/NMC-Drop-in-Bulletin.pdf

The beneficiary drop-in Spanish: https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/NMC-Drop-in-Bulletin-in-Spanish.pdf

Destroy your card video: https://www.youtube.com/watch?v=Rf9q0dVinF8

Mailing map: https://www.medicare.gov/newcard/

The updated social media kit: https://www.cms.gov/Medicare/New-Medicare-Card/Partners-and-Employers/NMC-Guide-to-Sharable-New-Medicare-Card-.pdf

The Partners and Employers Widgets:

- In English for partners: https://www.cms.gov/Medicare/New-Medicare-Card/Partners-and-Employers/English-provider-and-partner-widget-landing-page.html
- In Spanish for partners: https://www.cms.gov/Medicare/New-Medicare-Card/Partners-and-Employers/Spanish-provider-and-partner-widget-landing-page.html
- In English for beneficiaries: https://www.cms.gov/Medicare/New-Medicare-Card/Partners-and-Employers/English-beneficiary-widget-landing-page.html
- In Spanish for beneficiaries: https://www.cms.gov/Medicare/New-Medicare-Card/Partners-and-Employers/Spanish-beneficiary-widget-landing-page.html

If you have questions, please contact Lorelei Schieferdecker at Lorelei.Schieferdecker@cms.hhs.gov or Julie Brookhart at Julie.Brookhart@cms.hhs.gov.

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- Advanced APMs All-Payer Combination Option
- APM Scoring Standard benefits for participation in a MIPS APM
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###

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.

###

CMS National Training Program Learning Series Webinar

May 10, 2018 1:00 – 2:30 PM ET

We'll provide an overview of CMS' program-related resources. To register for the webinar, visit https://meetings-cms.webex.com/meetings-cms/onstage/g.php?MTID=e8a806fd6f55325b84f3c742ae18e7749.

###

Now Accepting Comments: HRSA Burden Reduction RFI (Request for Information)

As part of ongoing work to reduce public and stakeholder burden, HRSA released a Request for Information (RFI) on May 1. HRSA seeks public input on changes that it could make to create a more streamlined, flexible, and less burdensome compliance and reporting structure. This Request for Information (RFI) seeks input from entities significantly affected by HRSA regulations and policy, including State, local, and Tribal governments, health care providers, small businesses, consumers, non-governmental organizations, and trade associations.

The RFI seeks feedback on specific areas of select HRSA programs including: Health Centers, the Hill-Burton program, the Ryan White HIV/AIDS program, National Health Service Corps and NURSE Corps, health professions training programs, the National Practitioner Data Bank, and overall HRSA grants management. All comments must be submitted **by July 2, 2018** in order to be considered. See the HRSA website for submission instructions.

###

Join CMS for an Overview of eCQM Reporting and Promoting Interoperability Program Proposals for the FY 2019 IPPS Proposed Rule

This Outreach and Education webinar for participants in the Hospital Inpatient Quality Reporting (IQR) Program and the Medicare and Medicaid Promoting Interoperability Programs (previously known as the Medicare and Medicaid Electronic Health Record [EHR] Incentive Programs) is scheduled for **Wednesday, May 16, 2018, at 2:00 p.m. ET**.

This presentation will provide participants with an overview of the proposals in the recently released Fiscal Year (FY) 2019 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Proposed Rule related to electronic clinical quality measure (eCQM) reporting requirements for the Hospital IQR Program and the PI Programs. The overview will also provide instructions on how to submit public comments as a matter of record and receive response in the final rule.

Webinar Details

Title: FY 2019 IPPS Proposed Rule: Overview of eCQM Reporting and Promoting Interoperability Program Proposals

Date: Wednesday, May 16, 2018

Time: 2:00-3:00 p.m. ET

Registration link: https://cc.readytalk.com/r/b01bm00palh2&eom

Speakers:

- Shanna Hartman, MS, RN, Nurse Consultant, CMS
- Grace H. Snyder, JD, MPH, Program Lead, CMS
- Kathleen Johnson, RN, Health Insurance Specialist, CMS
- Steven E. Johnson, MS, Health Insurance Specialist, CMS

The webinar slides will be available for download from www.QualityReportingCenter.com *under Upcoming Events the day before the presentation.*

For More Information

For further assistance regarding the information contained in this message, please contact the Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Team at https://cms-ip.custhelp.com or (844) 472-4477.

###

Enrollment for the All of Us Research Program Begins on May 6, 2018

On Sunday, May 6, the National Institutes of Health's *All of Us* Research Program will begin national enrollment, inviting people ages 18 and older, regardless of health status, to join this momentous effort to advance individualized prevention, treatment, and care for people of all backgrounds. Part of the Precision Medicine Initiative, All of Us is expected to be the largest and most diverse longitudinal health research program ever developed.

ONC supports the Precision Medicine Initiative through Sync for Science a pilot program, allowing participants to share their electronic health record data with a research study of their choice, like All of Us.

To join the All of Us Research Program, visit www.JoinAllofUs.org. Enrollment is open to all eligible adults who live in the United States.

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Mental Health Awareness Training Grants (MHAT)/Substance Abuse and Mental Health Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) is accepting applications for grants to expand the delivery of Mental Health First Aid (MHFA), Youth Mental Health First Aid (YMHFA) and other mental health awareness curriculum. It is expected that these programs will prepare and train others on how to appropriately and safely respond to individuals with mental health disorders, particularly individuals with SMI and/or SED.

Who Should Apply? Among others, eligibility includes community and faith-based organizations, as well as those serving youth, veterans, armed services personnel, and their families.

Don't Miss This Grant Informational Webinars

- Thurs., May 10, 2018 from 3:00 p.m.-4:30 p.m. EDT

Dial-In Number: 800-593-0773
Participant Passcode: 6355346
Participants can **join the event directly.**

###

Medicare Learning Network

News & Announcements

- New Medicare Card: Help Your Patients
- CMS Changes Name of the EHR Incentive Programs and Advancing Care Information to "Promoting Interoperability"
- Protect Medicare and Medicaid: Report Fraud, Waste, and Abuse
- Hospital Inpatient Quality Reporting Program: Submission Deadline May 15
- IRF, LTCH, and SNF Quality Reporting Programs: Submission Deadline May 15

- Open Payments Review and Dispute Data by May 15
- MACRA Funding Opportunity: Deadline Extended to May 30
- STD Awareness Month: Talk, Test, Treat
- New Medicare Cards: You Can Use MBIs Right Away
- New Strategy to Fuel Data-driven Patient Care, Transparency
- CMS Encourages Eligible Suppliers to Participate in Expanded Medicare Diabetes Prevention Program Model
- Patients Over Paperwork April Newsletter
- Hospital Quality Reporting Center Spring 2018 Newsletter
- Administrative Simplification: Transactions
- Can't Find An Answer To Your Question?
- Hand Hygiene Day is May 5

Provider Compliance

- Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims — Reminder
- Provider Compliance Tips for Ordering Lower Limb Orthoses

Upcoming Events

- 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
- Quality Payment Program: Participation Criteria for Year 2 Webinar — May 9
- eCQI Resource Center Demonstration and Annual Update Webinar — May 10
- Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
- Settlement Conference Facilitation Expansion Call — May 22
- Comparative Billing Report on Critical Care Services Webinar — June 6
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Medicare Learning Network® Publications & Multimedia

- Quarterly HCPCS Drug/Biological Code Changes: July 2018 Update MLN Matters Article — New
- New Physician Specialty Code for Medical Genetics and Genomics MLN Matters® Article — New
- Processing Instructions to Update the Identification Code Qualifier Being Used in the NM108 Data Element MLN Matters Article — New
- Revisions to the Telehealth Billing Requirements for Distant Site Services MLN Matters Article — New
- Enhancements to Processing of Hospice Routine Home Care Payments MLN Matters Article — New
- Comprehensive ESRD Care Model Telehealth - Implementation MLN Matters Article — New
- Removal of KH Modifier from Capped Rental Items MLN Matters Article — New
- Acute Care Hospital IPPS Booklet — Revised

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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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Older Americans Month

Each May, we celebrate Older Americans Month to honor and recognize older Americans for the contributions they make to our families, communities, and society. From sharing their well-earned wisdom and life experiences to mentoring students to volunteering their time, older Americans can (and do!) play a significant role in the mental and physical wellness of younger generations.

Show your support when you visit the Older Americans Month website and download the necessary materials, activity ideas, and resources to promote and celebrate this year's theme, "**Engage at Every Age."**

Mental Health Awareness

The issue of mental health is now part of the national dialogue, as we are trying to understand its various conditions. To encourage healthy dialogue, SAMHSA, and all of HHS, is promoting the following events:

- **May 10**: National Children's Mental Health Awareness Day
- **May 16-19**: National Prevent Week (*"Action Today. Healthier Tomorrow"*)

[May 14: Promotion of Mental Wellness Day; **May 15**: Underage Drinking & Alcohol Misuse Prevention; **May 16**: Prescription & Opioid Drug Misuse Prevention; **May 17**: Illicit Drug Use & Youth Marijuana Prevention; **May 18**: Suicide Prevention; **May 19**: Youth Tobacco Use Prevention]

- **May 18**: National Older Adults Mental Health Awareness Day (Live webcast)

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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.