CMS Region 7 Updates – 5/18/2018

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ACA/Marketplace Updates

CAC Program Application Temporarily Suspended to Implement Application Updates

The Centers for Medicare & Medicaid is refreshing the Certified Application Counselor (CAC) program to promote better engagement with our CAC Designated Organizations (CDOs) and provide the assister community with an improved user experience. In order to make these changes, we have temporarily suspended the online CAC program application while we work on updates. A link to the new application will be posted summer 2018.

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05/11/18 Assister Webinar Presentation

Medicare and the Marketplace, Summary of Benefits and Coverage (SBC) – presentation is available online.

###

MACRA/Quality Payment Program (QPP) Updates

CMS is Accepting Proposals for New Measures for the Medicare Promoting Interoperability Program until June 29

The Centers for Medicare & Medicaid Services (CMS) is encouraging you to submit a measure proposal for the Annual Call for Measures for eligible hospitals and critical access hospitals participating in the Medicare Promoting Interoperability (PI) Program (formally named the Medicare EHR Incentive Program). Measure proposals will be accepted until **June 29, 2018** and will be considered for inclusion in rulemaking in calendar year (CY) 2019.

CMS is interested in adding measures that:

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

To propose a measure, send the completed application to CMSCallforMeasuresEHR@Ketchum.com. Applications can be found on the Promoting Interoperability Programs website.

New measure proposals will be reviewed at CMS for completeness. Incomplete applications will be disqualified. CMS will review and select measures for consideration based on the areas of interest and criteria listed above, and will notify participants if their measures have been selected.

Additional information related to the 2018 Call for Measures can be found on the CMS website.

###

CMS Unveils Enhanced "Drug Dashboards" to Increase Transparency on Drug Prices

An important part of the American Patients First initiative, the Dashboards provide new information on changes in spending per drug over time

The Centers for Medicare & Medicaid Services (CMS) released a redesigned version of the Drug Spending Dashboards. For the first time, the dashboards include year-over-year information on drug pricing and highlight which manufactures have been increasing their prices.

"Under President Trump's bold leadership, CMS is committed to putting patients first and increasing transparency," said CMS Administrator Seema Verma. "Publishing how much individual drugs cost from one year to the next will provide much-needed clarity and will empower patients and doctors with the information they need. As Secretary Azar has repeatedly pointed out, for years Medicare incentives have actually encouraged higher list prices for drugs, and this updated and enhanced dashboard is an important step to bringing transparency and accountability to what has been a largely hidden process."

The dashboards are interactive online tools that allow patients, clinicians, researchers, and the public to understand trends in drug spending. Data is reported for both Medicare and Medicaid. The new version of the dashboard reports the percentage change in spending on drugs per dosage unit and includes an expanded list of drugs.

Some of the most commonly used drugs across Medicare Part B, Medicare Part D, and Medicaid saw double-digit annual increases over the last few years. A few examples are highlighted in the tables below. Taking the 15 drugs with the highest total spending in each program, the drugs listed in the tables saw significant annual increases in spending per dosage unit from 2012 to 2016. Drugs were included if they experienced annual increases of at least 5 percent in Part B and at least 10 percent in Part D and Medicaid.

In 2012, Medicare spent 17 percent of its total budget, or $109 billion, on prescription drugs. Four years later in 2016, spending had increased to 23 percent, or $174 billion. In 2016, the drugs listed below accounted for $39 billion in total spending by Medicare and Medicaid.

Medicare Part B					
	Brand Name	**Generic Name**	**Annual Growth Rate (2012-2016)**	**Average Monthly Spending Per Beneficiary in 2016**	**Manufacturers**
1	Orencia*	Abatacept*	17.2% ($22 to $41)	$2,136	BMS Primarycare
2	Neulasta	Pegfilgrastim	8.5% ($2,788 to $3,869)	$1,195	Amgen
3	Xolair	Omalizumab	8.0% ($22 to $30)	$1,821	Genentech, Inc.
4	Vaccine Influenza Injection Muscle (Fluzone High-Dose)**		6.9% ($30 to $39)	N/A	
5	Sandostatin Lar*	Octreotide Acetate, mi-Spheres*	6.8% ($123 to $160)	$3,202	Novartis
6	Prevnar 13	Pneumococcal 13-Valent Vaccine	6.1% ($132 to $167)	N/A	Wyeth Pharm
7	Remicade	Infliximab	6.0% ($63 to $80)	$1,910	Janssen Biotech
8	Rituxan	Rituximab	5.6% ($615 to $765)	$1,985	Genentech, Inc.

*Indicates multiple brand and/or generic names for a specific HCPCS code. **Indicates brand/generic names unavailable. Name reflects the HCPCS short description.

Medicare Part D					
	Brand Name	**Generic Name**	**Annual Growth Rate (2012-2016)**	**Average Monthly Spending Per Beneficiary in 2016**	**Manufacturers**
1	Renvela	Sevelamer Carbonate	21.6% ($3 to $6)	$630	Genzyme
2	Lantus	Insulin Glargine, Hum.Rec.Anlog	18.6% ($13 to $25)	$209	Sanofi-Aventis
3	Zetia	Ezetimibe	18.3% ($5 to $9)	$181	Merck Sharp & D
4	Enbrel	Etanercept	18.2% ($498 to $972)	$2,741	Amgen
5	Humira Pen	Adalimumab	18.0% ($1,019 to $1,976)	$2,835	Abbvie US LLC

6	Lyrica	Pregabalin	17.4% ($3 to $6)	$205	Pfizer US Pharm
7	Lantus Solostar	Insulin Glargine, Hum.Rec.Anlog	14.2% ($14 to $25)	$196	Sanofi-Aventis
8	Crestor	Rosuvastatin Calcium	13.2% ($5 to $8)	$124	Astrazeneca
9	Januvia	Sitagliptin Phosphate	12.7% ($7 to $12)	$235	Merck Sharp & D
10	Xarelto	Rivaroxaban	10.6% ($8 to $12)	$202	Janssen Pharm.
11	Eliquis	Apixaban	10.4% ($4 to $6)	$194	BMS Primarycare

Medicaid				
	Brand Name	**Generic Name**	**Annual Growth Rate (2012-2016)**	**Manufacturers**
1	Lantus	Insulin Glargine, Hum.Rec.Anlog	18.7% ($13 to $25)	Sanofi-Aventis
2	Latuda	Lurasidone HCl	18.6% ($17 to $33)	Sunovion Pharma
3	Lyrica	Pregabalin	17.9% ($3 to $6)	Pfizer US Pharm
4	Enbrel	Etanercept	17.6% ($487 to $933)	Amgen
5	Humira Pen	Adalimumab	17.5% ($1,007 to $1,919)	Abbvie US LLC
6	Lantus Solostar	Insulin Glargine, Hum.Rec.Anlog	14.3% ($15 to $25)	Sanofi-Aventis
7	Abilify	Aripiprazole	11.4% ($21 to $32)	Otsuka America
8	Vyvanse	Lisdexamfetamine Dimesylate	11.0% ($5 to $8)	Shire US Inc.

Also, as part of CMS's commitment to transparency and data release, CMS today is updating the Part D Prescriber Public Use File (PUF) with data for 2016. This file includes summarized information on the more than one million distinct health care providers who prescribed drugs under the Part D program in 2016. This information enables a range of analyses to be performed on prescribing trends in Part D. The Part D Prescriber PUF is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Part-D-Prescriber.html.

In all of CMS's efforts, CMS protects the privacy and security of healthcare data. None of today's releases include any patient-identifiable data. The dashboards and a downloadable, machine-readable version of the data presented in the dashboards can be accessed at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs/index.html.

For more information, please visit the fact sheet here: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-05-15.html

###

The 2019 CMS QRDA I Implementation Guide for Hospital Quality Reporting, Schematron, and Sample Files Are Now Available

The Centers for Medicare & Medicaid Services (CMS) has published the 2019 CMS Quality Reporting Document Architecture (QRDA) Category I Hospital Quality Reporting (HQR) Implementation Guide (IG), Schematron, and sample files.

The 2019 CMS QRDA I HQR IG provides technical instructions for QRDA Category I reporting for eligible hospitals and critical access hospitals (CAHs) reporting electronic clinical quality measures for the calendar year 2019 reporting period for the following programs:

- Hospital Inpatient Quality Reporting (IQR) Program
- Medicare and Medicaid Promoting Interoperability (PI) Programs (formerly known as the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs) for eligible hospitals and CAHs

The 2019 CMS QRDA I IG contains the following high-level changes as compared with the reporting specifications for eligible hospitals and CAHs in the 2018 CMS QRDA I HQR IG:

- The 2019 CMS QRDA I HQR IG is based on the Health Level Seven (HL7) IG for CDA Release 2: QRDA Category I, Release 1, Standard for Trial Use (STU) Release 5
- The HL7 IG includes template updates to support the Quality Data Model version 5.3 Annotated
- Updated CMS program name codes from the former EHR Incentive Programs to the newly named PI Programs

Additional QRDA-Related Resources:

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

###

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.

Additional resources:

- Press Release: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-04-23.html
- https://innovation.cms.gov/initiatives/direct-provider-contracting/

###

Learn More about eCQMs for the 2019 Reporting/Performance Period

The Centers for Medicare & Medicaid Services (CMS) recently posted the electronic clinical quality measure (eCQM) annual update for the 2019 reporting period for eligible hospitals and critical access hospitals (CAHs), and the 2019 performance period for eligible professionals (EPs) and eligible clinicians. 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.

These updated eCQMs are to be used to electronically report 2019 CQM data for the following CMS quality reporting programs:

- The Hospital Inpatient Quality Reporting Program
- The Medicare and Medicaid Promoting Interoperability Programs (formerly known as the EHR Incentive Programs)
- Quality Payment Program: The Merit-based Incentive Payment System and Advanced Alternative Payment Models
- Comprehensive Primary Care Plus

New updates for the 2019 reporting/performance period include:

- The use of clinical quality language logic;
- eCQM Reading Guide; and
- Updated eCQM Value Sets and Specifications.

Provide Feedback

CMS encourages you to submit questions and comments regarding the updated measures via the eCQM Issue Tracker.

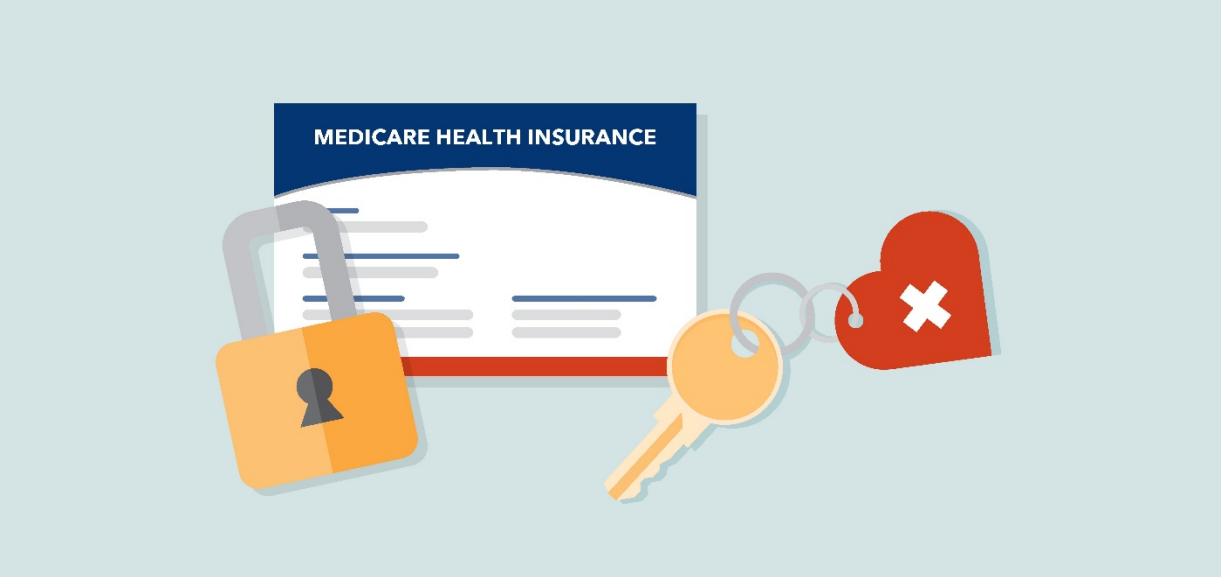
For More Information

To learn more about 2019 eCQM annual update, click here. To learn more about eCQMs, visit the eCQI Resource Center.

###

Guard your new Medicare ID card to avoid fraud

By Erin Scheithe – MAY 08, 2018



Medicare ID fraud happens when someone uses your Medicare card to get your personal information, like your Social Security or Medicare ID number. A fraudster could steal your identity to open new credit cards or bank accounts using your name and credit. They also could use your Medicare ID card information to file fake claims for healthcare you did not receive—like billing for a motorized scooter that you don't need. Medicare fraud wastes a lot of money each year and results in higher health care costs for everyone.

Follow these tips to guard your Medicare ID card:

- Keep your Medicare and Social Security cards secure.
- Don't share your numbers with anyone other than your health care team.
- If someone calls and asks for your Medicare information, hang up. Medicare will only call you if you've called and left a message or if a representative said that someone will call you back.
- Check your statements carefully and log into MyMedicare.gov to spot possible fraud and billing mistakes.
- Report suspicious activities by calling 1-800-MEDICARE (1-800-633-4227).

New Medicare cards

If you are a Medicare recipient, you might have heard that new Medicare cards are on their way to your mailbox. The new cards will have a unique Medicare ID number instead of your Social Security number. The new Medicare ID cards are good news for everyone, except fraudsters who use Social Security numbers to steal people's identity and commit Medicare fraud. You will receive your new Medicare ID card by April 2019.

Free placemat on Medicare ID fraud

Download the new placemat
Order in bulk

To celebrate Older Americans month this May, we created a new Medicare-themed placemat. The Medicare ID fraud placemat includes information to help older adults spot and avoid fraud.

The placemat is part of a series of consumer education placemats that meal service providers deliver to homebound seniors and senior meal sites. The placemats are free to download or order in bulk. This placemat also shares valuable information on the rollout of the new Medicare cards.

Spot Medicare ID fraud and report it

- Order our Medicare ID fraud prevention and awareness placemats and share with people in your community. You can use the placemats year-round to help educate older adults and others about how to protect themselves against fraudsters.
- Report any suspected fraud to your law enforcement's non-emergency number. If you suspect that someone is a victim of elder abuse or financial exploitation, also report it to Adult Protective Services (APS). Find your local APS at eldercare.acl.gov . If you think the person's safety may be at risk, call 911.
- Report Medicare fraud by calling 1-800-MEDICARE or report online through the Office of the Inspector General for the Department of Health and Human Services.

###

New Medicare Card, Same Old Scammers – Drop In Articles for Partner Newsletters

Medicare is mailing new, more secure Medicare cards with a Medicare Number that's unique to every person with Medicare. Medicare is getting rid of the old card because the old Medicare Number was based on a person's Social Security Number. Scammers sometimes use Social Security Numbers to try to steal someone's identity, open new credit cards or even take out loans in someone else's name.

Your benefits won't change with the New Medicare card, and it'll be mailed to you for free—you don't need to take any action to get it.

Scammers are hoping that you won't be informed about the change in Medicare cards and they may try to use the opportunity to get your personal information. Fight back by following these tips:

- **Don't pay for your new Medicare card.** It's free. If anyone calls and says you need to pay for it, that's a scam. Never give your Social Security Number, bank account number or send cash to anyone who says they need it for you to get your new Medicare card.
- **Don't give your Medicare Number to people you don't know or haven't contacted first.** Some scammers call pretending to be from Medicare, but Medicare—or someone representing Medicare—will never ask for your personal information for you to get your new Medicare card. Only share your Medicare Number with doctors or trusted people in the community who work with Medicare, like your State Health Insurance Assistance Program (SHIP). Say "no thank you" to anybody you don't know who offers to help you complete applications or forms that require you to fill out personal information like your Social Security Number.
- **Don't give your bank account information to people you don't know.** If someone offers to deposit a rebate or bonus into your bank account because you got a new Medicare card, that's a scam.

- **Don't let anyone trick you into believing your Medicare benefits will be canceled unless you give them your Medicare Number.** If someone threatens to cancel your health benefits if you don't share your Medicare Number, hang up! If you get a suspicious call, contact 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) or visit the Senior Medicare Patrol at smpresource.org.
- **Destroy your old Medicare card**. Once you get your new Medicare card, destroy your old Medicare card and start using your new one right away. Don't just throw the old card away—shred it or cut it into small pieces. Visit the CMSHHSgov channel on YouTube to watch our "Destroy your old Medicare card" video.

Mailing new Medicare cards to millions of Americans takes time. Your card may arrive at a different time than your friend's or neighbor's. Find out when new cards start mailing to your area by visiting Medicare.gov/NewCard, and signing up for email alerts from Medicare.

To learn more on how you can help fight Medicare fraud, visit Medicare.gov/fraud.

Spanish Version

Una nueva tarjeta de Medicare, los mismos estafadores de siempre

Medicare está enviando tarjetas de Medicare nuevas y más seguras con un número de Medicare único para todos los beneficiarios de Medicare. Medicare está eliminando la tarjeta antigua porque el número de Medicare antiguo se basaba en el número de Seguro Social del asegurado. Estafadores suelen utilizar números de Seguro Social para intentar robar identidades, obtener tarjetas de crédito nuevas y hasta conseguir préstamos en nombre de otra persona.

Sus beneficios no cambiarán con la nueva tarjeta de Medicare, y será enviada gratuitamente—no tendrá que tomar acción alguna para obtenerla.

Los estafadores desearían que usted no se entere del cambio a las tarjetas de Medicare y podrían intentar aprovechar para conseguir sus datos personales. Siga los siguientes consejos para defenderse:

- **No pague por la tarjeta de Medicare nueva.** Es gratis. Si alguien le llama y dice que tendrá que pagarla, es una estafa. Nunca debe ofrecer su número de Seguro Social o su número de cuenta bancaria ni enviar dinero en efectivo a alguien que se lo pide para poder entregarle la tarjeta de Medicare nueva.
- **No ofrezca su número de Medicare a personas desconocidas ni a personas que iniciaron el contacto.** Algunos estafadores llaman y pretenden ser de Medicare, pero Medicare—o alguien que representa Medicare—jamás le pedirá datos personales para enviarle su nueva tarjeta de Medicare. Solamente debería compartir su número de Medicare con médicos o personas de confianza de la comunidad que trabajan con Medicare, tal como su Programa Estatal de Asistencia con el Seguro Médico (SHIP, por sus siglas en inglés). Diga "no gracias" a cualquier persona desconocida que ofrece ayudarle a llenar solicitudes o formularios que exigen datos personales como su número de Seguro Social.
- **No brinde información sobre su cuenta bancaria a personas desconocidas.** Si alguien ofrece depositar un reembolso o bono en su cuenta bancaria porque usted haya recibido la nueva tarjeta de Medicare, es una estafa.
- **No se deje engañar por alguien que le dice que se cancelarán sus beneficios de Medicare si no le brinda su nuevo número de Medicare.** Si alguien amenaza con cancelar sus beneficios de salud si no le da su número de Medicare, ¡cuelgue! Si recibe una llamada sospechosa, llame al 1-800-MEDICARE (1-800-633-4227; TTY; 1-877-486-2048) o visite la Patrulla de Medicare para las Personas Mayores en smpresource.org.
- **Destruya su tarjeta de Medicare antigua.** Una vez que reciba la nueva tarjeta de Medicare, destruya la tarjeta de Medicare anterior y empiece a usar la nueva inmediatamente. No debería simplemente botar la tarjeta antigua—córtela en tiras o pedazos pequeños. Visite el canal de CMSHHSgov en YouTube para ver nuestro video titulado "Destroy your old Medicare card" (en inglés).

Toma tiempo enviar nuevas tarjetas de Medicare a millones de estadounidenses. Las tarjetas de usted, sus amigos o vecinos podrán llegar en momentos distintos. Para saber cuándo se comenzarán a enviar las tarjetas nuevas en su área, visite la página de es.Medicare.gov/NewCard, e inscríbase para recibir alertas de Medicare por correo electrónico.

Para aprender más sobre cómo puede combatir el fraude contra Medicare, visite es.Medicare.gov/fraud.

###

New Medicare Card: MBI Look-up Tool Clarification and RRB Mailing

The Medicare Administrative Contractor (MAC) portal MBI look-up tool will only return an MBI if the new Medicare card has been mailed; this avoids potential confusion if the MBI is used before the beneficiary receives their new Medicare card/MBI:

- Medicare is mailing new cards in phases by geographic location.
- Ask your patients for their new cards when they come for care.
- Use your MAC's secure portal MBI look-up tool: Learn about and sign up for the Portal to use the tool when it is available no later than June 2018. If the new Medicare card has been mailed to your patient, you can look up their MBI if they do not have the new card when they come for care
- Check your Remittance Advice (RA): Starting in October 2018 through the end of the transition period we will return MBIs on RAs when you submit claims with valid and active Health Insurance Claim Numbers.

Railroad Retirement Board (RRB) Mailing:

On June 1, RRB will mail new Medicare cards to their beneficiaries. CMS will return a message on the eligibility transaction response for every RRB patient MBI inquiry that will read, "Railroad Retirement Medicare Beneficiary."

The new RRB card will still have the RRB logo in the upper left corner and "Railroad Retirement Board" at the bottom, but you cannot tell from looking at the MBIs if these patients are eligible for Medicare because they are railroad retirees.

###

Enhanced "Drug Dashboards" to Increase Transparency on Drug Prices

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See the full text of this excerpted CMS Press Release (issued May 15), including a list of drugs that accounted for $39 billion in total spending by Medicare and Medicaid in 2016.

###

SPEECH: Remarks by Administrator Seema Verma at the Medicare Advantage and Prescription Drug Plan Spring Conference

(As prepared for delivery - May 9, 2018)

Welcome to CMS and thanks for joining us today, as we look ahead to 2019 for the Medicare Advantage and Part D programs. It's a pleasure to be here with you and to provide an update on all that we have been doing to strengthen and improve these important programs for our nation's seniors and the disabled.

As you know, Medicare Advantage is playing an ever-increasing and important role in delivering high-quality and cost-effective care to Medicare beneficiaries. Enrollment in Medicare Advantage has more than doubled from 13% of all Medicare beneficiaries in 2005 to 33% in 2017. Part D plans have been stable in recent years and are **actually lower** this year than they were last year. In fact total government spending on Part D has been far lower than was originally expected. ---- I'm also proud to note that we have already finalized many important changes for both Part D and Medicare Advantage that will help lower the costs of prescription drugs even more for beneficiaries.

During my tenure at CMS, I have been impressed by the level of private sector innovation and creativity that plans have brought to our beneficiaries and I know this personally because both my parents are enrolled in an Medicare Advantage plan, and they can't stop talking about them. Today, I want to take some time to review all of the important steps CMS is taking to support Medicare Advantage, Part D, and empower our beneficiaries.
This year, CMS launched a Coverage Wizard to help people learn about their options. CMS is undertaking several consumer-friendly improvements for Medicare Open Enrollment so that people with Medicare can make an informed choice between Original Medicare and Medicare Advantage. Some of the improvements include changes in the Medicare handbook to help beneficiaries understand their coverage options.

The handbook is now designed to clearly highlight the benefits of joining a Medicare Advantage plan, such as protection from high out of pocket expenses and access to important additional benefits.

And establishing a help wizard on Medicare.gov website will better point to resources to help beneficiaries make informed healthcare coverage decisions.

For this open enrollment CMS will be offering new tools and features to help people with Medicare including:

- A stand alone, mobile optimized out of pocket cost calculator which will provide information on both overall costs and specific prescription drugs
- An improved coverage wizard which will integrate the out of pocket costs to help beneficiaries compare options at a deeper level including cost as a way to decide if Original Medicare or MA is right for them
- A simplified log in for the Medicare Plan Finder tool using their online account (instead of the current cumbersome process of entering 5 pieces of information to authenticate)
- We will be piloting webchat for a portion of users within the Medicare Plan Finder (this has been requested by many advocates)
- Several new updates based on consumer testing to the Medicare&You Handbook –including checklists and flowcharts to simplify decision making

For all of our beneficiaries, it is critical that we unleash the potential of Medicare Advantage and Part D, so we at CMS have been listening to providers, plans, and other stakeholders about their experiences with the program.

One thing we have heard time and time again is that unnecessary administrative burden is contributing to rising costs as well as taking focus away from taking care of patients. Overregulation is something that has been happening for years all over the federal government, and to combat this the President Issued an Executive Order that directs federal agencies to "cut red tape" to reduce burdensome regulations. Following his leadership, we have launched our own initiative we call "Patients over Paperwork" -– to reduce burden.

Patients over Paperwork brought changes to Medicare Advantage and Part D. Our changes for 2019 include significant new flexibility for offerings to Medicare Advantage beneficiaries. **For the first time ever**, Medicare Advantage beneficiaries can access **significant** new flexibility for additional benefits that can help them live healthier, more independent lives. These plans can offer benefits that compensate for physical impairments, diminish the impact of injuries or health conditions, or reduce avoidable emergency room utilization. This means Medicare Advantage beneficiaries will be provided adult day care services, respite care for caregivers, and in-home assistance with activities like dressing, bathing and managing medications. Additionally, Medicare Advantage beneficiaries will have access to safety devices to better prevent injury in the home, including stair rails, grab bars, and temporary mobility ramps. This will dramatically help any person or family members in this situation.

Beneficiaries will also have tailored plans that better meet their needs. Plans will be able to improve care and outcomes for beneficiaries by reducing cost sharing for certain benefits, offering different deductibles, and offering supplemental benefits that are tailored to specific conditions.

We are also looking forward to 2020, when plans and providers will have even more flexibility on how to deliver care with the implementation of the Bipartisan Budget Act provision that allows telehealth services to be provided as a basic benefit in Medicare Advantage.

Our final rule also makes common-sense changes that allow electronic delivery of certain bulky documents if beneficiaries choose to receive information digitally. As a new generation come into the program who are may be more accustomed to working with digital files, it just makes sense that we allow them to be in the driver's seat regarding how they receive information. But of course, paper documents will still be available for those who prefer it.

And finally, we improved transparency in our Star Ratings to provide you with more information about what we're measuring each year and why. Historically, we have announced star ratings changes through the Call Letter. We know there is a need for greater transparency in our decision-making. And in response, we codified the framework for the star ratings in the 2019 regulation which will provide greater lead time to tailor your efforts to improve quality.

Additionally, these changes will give beneficiaries more reliable information about each plan quality by giving greater weight to patient experience and access measures, so beneficiaries have the information they need to choose a plan that's right for them.

There has been a lot of discussion on drug pricing and President Trump and Secretary Azar have made lowering drug prices a major priority, and at CMS we are following their leadership to deliver results for our beneficiaries. With the Part D policies that we finalized for 2019 and published last month, we are making lower-cost generic drugs available to beneficiaries regardless of when the drugs became available, meaning that beneficiaries can realize these savings *without* having to wait for another enrollment period.

We also made it easier for low-income beneficiaries by lowering the maximum amount they pay for certain innovative medicines, making sure that the latest drugs are available to all. Specifically, we have reduced the maximum amount that low-income beneficiaries pay for new medicines known as "biosimilars." In addition to reducing costs for beneficiaries, this policy alone is expected to generate savings to the Medicare program of $10 million in 2019.

And finally, by removing unnecessary requirements that certain Part D plans be different from each other, plans have the flexibility they need to give patients more choice.

Another key priority for the President, Secretary Azar, and myself is to move our healthcare system from one that pays for procedures and sickness to one that is value-based — one that rewards outcomes over mere volume.

But we know we can't achieve value-based care until we put the patient in the driver's seat of our healthcare system. And that requires empowering patients with the data they need to make informed decisions as healthcare consumers. Ultimately, the cornerstone of a patient centered system is data – quality data, cost data, and a patient's own data.

As this Administration drives toward building a value-based health care system, we understand the vital role that digital data will play. And let me tell you about what we've already done to increase, improve, and allow greater access to data; and how we are reshaping CMS's vision for the future, while continuing to ensure data security and privacy.

As you may have heard, this administration launched the MyHealthEData Initiative. MyHealthEData is a government-wide initiative that breaks down the *barriers that contribute* to preventing patients from being able to access and control their medical records. MyHealthEData makes it clear that patients should have the ability to share their data with whomever they want, making the patient the center of our health care system. Patients need to be able to control their information and know that it's secure and private. Having access to their medical information will help them make decisions about their care, and have a better understanding of their health.

MyHealthEData will unleash data to trigger innovation, and advance research to cure diseases and provide more evidence-based treatment guidelines that ultimately will drive down costs and improve health outcomes.

Imagine a world in which your health data follows you wherever you go and you can share it with your doctor, all at the push of a button. Imagine if you could track your medical history from your birth throughout your life, aggregating information from each health visit, your claims data, and the health information created every second through wearable technology.

Imagine if our health records weren't just used by our doctors in their workflow, but rather if EHRs allowed third-party applications to access and leverage that data in innovative ways for both the patient and doctor. Imagine if patients could authorize access to their records to researchers from all over the country who could not only develop specific

treatments for their needs, but the researchers could also use that information to develop cures that could save millions of lives. This is our vision at CMS, and why we're so committed to the goals of MyHealthEData.

You may have also heard about another action that we took for the Medicare population. Through Blue Button 2.0, we are providing beneficiaries in FFS Medicare with the ability to connect their claims data to third party applications, services, and research programs. CMS's Blue Button 2.0 is now in production and at last count there were over 200 innovative developers experimenting with the API. I encourage you to attend today's special break-out session to learn more about we are doing to help beneficiaries access and use their data.

I have encouraged the healthcare industry to embrace the notion that patients must have ready access to their health records. I have now repeatedly called on all insurers, including Medicare Advantage plans, to do what we've done and give patients their claims data electronically.

In 2019, in the Call Letter, we **strongly** encouraged and are considering rulemaking to require Medicare Advantage to adopt data release platforms

What we've undertaken at CMS are great steps—but they are steps to build on, and not to rest on. That's why CMS is undertaking a new strategy that recognizes that we need better data. I call it "Data Driven Patient Care." This strategy is based on the understanding that data doesn't mean anything unless it's accessible and usable, and that making strides with data is key to moving towards value.

Our Data Driven Patient Care strategy will help ensure that CMS can be an industry leader in unleashing the power of data to drive system transformation—enhancing efficiency, improving quality, and reducing cost.

The strategy is based on three cornerstones:

- Putting patients first
- Increasing the amount of available data
- And taking an API-first approach for sharing data.

I'd like to discuss with you some of the steps we're taking to make our strategy a reality.

First, we're very excited about expanding the data we make available to researchers in our Virtual Research Data Center.

As you're probably aware, CMS has a large amount of data on our current 130 million beneficiaries and our previous enrollees. The VRDC provides timely access to CMS program data—including Medicare fee-for-service claims data—in an efficient, secure, and cost-effective manner. If you've seen a study that references Medicare data, it probably came from an analysis of data in the VRDC.

Researchers have direct access to approved privacy-protected data files, and they're able to conduct their analyses within a CMS environment that is safe and secure.

I recently announced that, for the very first time, we'll be releasing Medicare Advantage encounter data to researchers.

And we recognize that Medicare Advantage data is not perfect, but we have determined that the quality of the available Medicare data is adequate to support research. And although this is our first release, going forward, we plan to make this data available annually.

And we're not stopping with Medicare Advantage data. Next year, we expect to make the Medicaid and Children's Health Insurance Program data available. This means researchers will have access to data on another 70 million patients, which represent a ***different*** profile as compared to Medicare.

Of course, we recognize that across all of our efforts, we have to look at privacy at the front end and ensure informed consent. Patients must always be aware of how their data is being used and shared. Americans demand this of us. And in response, we'll be strengthening controls around access to all data.

Medicare Advantage and Part D have never been more popular, proving the value of providing our beneficiaries with choice. We plan to unleash the potential of these programs to the best of our abilities. The popularity of these programs and with the various new flexibilities and burden reduction changes that have been adopted, we expect plan choices to be even more robust in 2019.

I thank you for all the hard work you do and hope you enjoy the rest of this afternoon's session. I look forward to continuing our strong partnership.

Thank you.

###

CMS Safeguards Patient Access to Certain Medical Equipment and Services in Rural and Other Non-contiguous Communities

CMS issued an interim final rule with comment period to increase the fee schedule rates from June 1 through December 31, 2018, for certain durable medical equipment items and services and enteral nutrition furnished in rural and non-contiguous areas of the country not subject to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program (CBP). "This action will help Medicare beneficiaries in rural areas continue to access life-sustaining durable medical equipment, like oxygen equipment," said CMS Administrator Seema Verma.

We continue to engage with stakeholders regarding the CBP, including the national mail-order program and payment for items and services furnished in non-bid areas for 2019 and beyond.

See the full text of this excerpted CMS Press Release (issued May 9).

###

Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — Reminder

The Advance Beneficiary Notice (ABN) of Noncoverage Interactive Tutorial Educational Tool is available. Learn about:

- Completing the ABN
- Form CMS-R-131

###

Medicare Advance Written Notices of Noncoverage Booklet — Reminder

The Medicare Advance Written Notices of Noncoverage Booklet is available. Learn about:

- Prohibitions and frequency limits
- Collecting payment / financial liability
- Claim reporting modifiers
- When you should not use the notice

###

CMS Safeguards Patient Access to Certain Medical Equipment and Services in Rural and Other Non-Contiguous Communities

Interim final rule delivers relief to providers through increased fee schedule rates throughout 2018

On the heels of the Rural Health Strategy released yesterday, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment period (IFC) to increase the fee schedule rates from June 1, 2018, through December 31, 2018, for certain durable medical equipment (DME) items and services and enteral nutrition furnished in rural and non-contiguous areas (Alaska, Hawaii, and U.S. territories) of the country not subject to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP).

Today's action aims to protect access to needed durable medical equipment in rural and non-contiguous areas that are not subject to the DMEPOS CBP, helping beneficiaries to maintain their health, mobility, and overall quality of life.

Stakeholders have raised concerns about significant financial challenges the current adjusted DME fee schedule rates pose for suppliers, including many small businesses, and that the number of suppliers in certain areas continues to decline.

"This action will help Medicare beneficiaries in rural areas continue to access life-sustaining durable medical equipment, like oxygen equipment," said CMS Administrator Seema Verma.

In 2016 and 2017, information from the DMEPOS CBP was used to adjust Medicare payments for certain DME and enteral nutrition in certain areas of the county where the CBP did not occur ("non-bid areas"). The CBP has not been implemented in rural areas comprising about half the volume of the volume of items and services furnished in non-bid areas subject to the adjustments. Beginning January 1, 2017, the fully adjusted fee schedule rates were on average 50 percent lower than the unadjusted rates in these non-bid areas based on the average reduction in payment for all of the items and services subject to the adjustments, weighted by volume.

In 2016, prior to the fully adjusted fee schedule rates going into effect, blended rates of 50 percent of the amount based on the competitive bid rates and 50 percent of the traditional fee schedule amounts were implemented for the transitional year period. Today's action resumes these blended rates from June 1, 2018, to December 31, 2018, in rural and non-contiguous areas not subject to the CBP.

CMS is continuing to engage with stakeholders regarding the CBP, including the national mail-order program, and payment for items and services furnished in non-bid areas. Going forward, CMS will continue to review data and information about rates for DMEPOS items and services, as required under section 16008 of the 21st Century Cures Act. CMS intends to undertake subsequent notice-and-comment rulemaking to address the rates for durable medical equipment and enteral nutrition furnished in 2019 and beyond.

For more information on Durable Medical Equipment Fee Schedule, Adjustments to Resume the Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and Non-Contiguous Areas (CMS-1687-IFC) or to submit a comment on or before July 9, 2018, please visit: http://www.regulations.gov.

###

Healthcare Fraud Prevention Partnership's (HFPP) White Paper

"Examining Clinical Laboratory Services: A Review by the Healthcare Fraud Prevention Partnership"

CMS has posted a collaborative white paper and shared related media materials with its HFPP Partners, including CMS, to supplement awareness efforts. The approved white paper addresses clinical laboratory services and provides foundational information, details and challenges that can potentially lead to fraud and abuse, and discusses specific schemes and areas of concern identified by HFPP Partners. HFPP White paper (PDF) can be accessed online at: https://go.cms.gov/hfppClinicalLabPaper

###

Medicare Diabetes Prevention Program (MDPP)

Medicare Advantage Fact Sheet & Frequently Asked Questions (FAQs)

The Centers for Medicare & Medicaid Services (CMS) released and updated fact sheet and updated Frequently Asked Questions (FAQs) for prospective Medicare Diabetes Prevention Program (MDPP) that outlines important information about Medicare Advantage that MDPP suppliers should be aware of when furnishing services to Medicare Advantage enrollees.

For more information click here: https://innovation.cms.gov/Files/fact-sheet/mdpp-ma-fs.pdf

Additional information can be found here:
https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/

Press Release (PDF) or click here: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-05-09.html

Fact Sheet (PDF) or click here: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-05- 09.html

DMEPOS Fee Schedule Adj to 50/50 Blended Rates (CMS-1687-IFC) at Federal Register: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-10084.pdf and on 05/11/2018 will be available online at https://federalregister.gov/d/2018-10084

###

Provide Feedback on Changes to the Promoting Interoperability Programs Released in the FY 2019 IPPS and LTCH Proposed Rule

On April 24th, the Centers for Medicare & Medicaid Services (CMS) issued the FY 2019 Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) proposed rule.

Submit a Formal Comment by June 25

Comments on the FY 2019 IPPS and LTCH proposed rule are due no later than 5 p.m. ET **Monday, June 25, 2018.** The public can submit comments in several ways:

- By regular mail
- By express or overnight mail
- By hand or courier
- Electronically: Through the "submit a comment" instructions on the Federal Register

Please review the proposed rule for specific instructions for each method and submit comments by one method ONLY.

More Information on the FY 2019 IPPS and LTCH Proposed Rule

The IPPS and LTCH Proposed Rule with comment period includes a number of proposed changes that would shift the Promoting Interoperability (PI) Programs' focus to interoperability and reducing clinician burden by:

- Eliminating a total of 19 measures acute care hospitals are currently required to report across the five hospital quality and value-based purchasing programs.
- Changing the electronic clinical quality measure (CQM) reporting period to one, self-selected quarter for CY 2019.
- Beginning with the 2020 reporting period, removing 8 of the 16 CQMs to produce a smaller set of meaningful measures.
- Making the PI reporting period in CY 2019 and CY 2020 a minimum of any continuous 90-day period.

To learn more, review the proposed rule and visit the CMS website.

###

CMS Announces Agency's First Rural Health Strategy

Interagency effort seeks to improve access and quality of care for rural Americans

The Centers for Medicare & Medicaid Services (CMS) released the agency's first Rural Health Strategy intended to provide a proactive approach on healthcare issues to ensure that the nearly one in five individuals who live in rural America have access to high quality, affordable healthcare.

"For the first time, CMS is organizing and focusing our efforts to apply a rural lens to the vision and work of the agency," said CMS Administrator Seema Verma. "The Rural Health Strategy supports CMS' goal of putting patients first. Through its implementation and our continued stakeholder engagement, this strategy will enhance the positive impacts CMS policies have on beneficiaries who live in rural areas."

The agency-wide Rural Health Strategy, built on input from rural providers and beneficiaries, focuses on five objectives to achieve the agency's vision for rural health:

- Apply a rural lens to CMS programs and policies
- Improve access to care through provider engagement and support
- Advance telehealth and telemedicine
- Empower patients in rural communities to make decisions about their healthcare
- Leverage partnerships to achieve the goals of the CMS Rural Health Strategy

Approximately 60 million people live in rural areas – including millions of Medicare and Medicaid beneficiaries. CMS recognizes the many obstacles that rural Americans face, including living in communities with disproportionally higher poverty rates, having more chronic conditions, being uninsured or underinsured, as well as experiencing a fragmented healthcare delivery system with an overworked and shrinking health workforce, and lacking access to specialty services.

This new strategy focuses on ways in which the agency can better serve individuals in rural areas and avoid unintended consequences of policy and program implementation.

"This Administration clearly understands that one of the keys to ensuring that those who call rural America home are able to achieve their highest level of health is to advance policies and programs that address their unique healthcare needs," said Administrator Verma.

Although released today, work on the strategy is already underway. For example, to strengthen access to care, especially for those living in rural communities, CMS is transforming access to telehealth by paying for additional services and making it easier for providers to bill Medicare.

CMS will also continue to collaborate with agencies across the U.S. Department of Health and Human Services (HHS) including, Federal Office of Rural Health Policy at the Health Resources and Services Administration (HRSA) to implement this strategy.

"HRSA is excited to see CMS spell out a strategy to better serve rural populations that was informed by rural stakeholders who have a unique lens on the issues in their communities," said HRSA Administrator George Sigounas, MS, Ph.D. "This builds on our long-standing collaboration with CMS and will highlight key issues for rural safety net providers like rural hospitals and community health centers for CMS and HHS."

For more information on the Rural Health Strategy, please visit: http://go.cms.gov/ruralhealth. There is also a fact sheet available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-05-08.html.

Other materials are available online:

- Rural Health Strategy Guide (PDF) also found here: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf
- Rural Health Infographic (PDF/JPEG) also found here: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/rural-health-infographic-PDF.pdf
- External FAQs (PDF) also found here: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-FAQ-2018.pdf

###

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.

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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.

###

An Executive Order on Faith and Opportunity

President Trump signed an Executive Order to ensure that faith-based and community organizations have strong advocates in the White House—and throughout the rest of the Federal Government. The signing coincided with the annual National Day of Prayer at the White House.

The order creates a White House Faith and Opportunity Initiative within the Executive Office of the President. Among its tasks will be to reduce burdens on the free exercise of religion in America, as well as apprise the Administration of any failures of the executive branch to comply with religious liberty protections under law.

"Across the government, we have taken action to defend the religious conscience of doctors, nurses, teachers, students, and groups like the Little Sisters of the Poor," the President said yesterday. He added that his "Administration has spoken out against religious persecution around the world."

- Factsheet about President Trump's newest Executive Order.
- Video highlights of the President leading the National Day of Prayer 2018.
- Text of the Executive Order

###

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.

###

National Training Program

May 2018

The New Medicare Learning Management System (LMS) is Open for Business!

The new Medicare Learning Management System (LMS) is open for business!

Check it out at cmsnationaltrainingprogram.cms.gov/.

Get ready for a variety of exciting new self-paced courses on Medicare, based on real-life scenarios you face in your work. You'll master the topics (with a little help from engaging animations) and check your knowledge with fun interactive questions. You'll get Continuing Education Units (CEUs) for some courses, and certificates of completion for others.

First course on enrollment available now – with more to come

We're building our curriculum on enrollment issues first, as requested by you, our trusted partners. Each course is designed to show specific beneficiary profiles, letting you see how things like age, current coverage, legal status, and disability can affect the enrollment experience. We'll let you know as more courses are added.

NTP LMS is your one-stop shop

Let cmsnationaltrainingprogram.cms.gov/ be your one-stop shop to help you help others make informed healthcare decisions!

Watch for invitations to live virtual training events coming soon. You'll also be able to access recordings of trainings you may have missed.

###

New / Updated CMS Publications

Getting a Second Opinion Before Surgery

Medicare & Clinical Research Studies

###

Newly Posted Training Materials

Module 3: Medigap (Spanish)

Module 7: Preventive Services (English and Spanish)

2018 Understanding Medicare (videos are embedded: no internet access required)

###

Did You Know?

May is National Osteoporosis Awareness and Prevention Month. Watch our short video to learn more about how Medicare can help you protect your bones.

May is National High Blood Pressure Education Month. Your "Welcome to Medicare" preventive visit and yearly "wellness" visits includes blood pressure checks at no cost to you.

May is Mental Health Month. Learn more about depression screening as well as Medicare cost and coverage of mental health care.

###

Emergency Response Webinar for the Faith Community

Supporting the Emotional Wellbeing of First Responders, Emergency Managers & Disaster Relief Personnel
Date: Tuesday, May 15, 2018
Time: 1:00 – 2:00p.m. (ET)
Presenter Organizations include:

- New Brunswick Theological Seminary
- U.S. Department of Justice, Office of Justice Programs
- National Voluntary Organizations Active in Disasters, Emotional and Spiritual Care Committee
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration (SAMHSA)

Please register to receive a recording of this webinar.

How to Join the Webinar:

- Please register for the event using the Adobe Connect registration web link.
- Be sure to test your Adobe Connect connection prior to the meeting.
- This webinar will offer captioning
- For more information, please contact FEMA-Prepare@fema.dhs.gov.

###

Opioid Webinar for the Faith Community

Getting Back to Work: Employment, Recovery, and the Opioid Epidemic
Wed. May 16, 12:00 – 1:00 p.m. ET, Register here.
The Office of the U.S. Surgeon General is focused on the intersection between health and the economy for good reason. Businesses thrive by investing in the health of their employees and communities and the recovery of individuals, and their families, is strengthened by gainful employment and self-sufficiency. Join the HHS Partnership Center and hear directly from the nation's **Surgeon General VADM Jerome M. Adams**, M.D., M.P.H. about the value of employment and supporting employees in the nation's recovery from the opioid epidemic. We'll also hear from **Charles Collins**, President and CEO of the YMCA of San Francisco, on the Y's comprehensive approach to workforce development, as well as from **Travis Lowe**, pastor of Crossroads Church in Bluefield, West Virginia, on collaborative efforts between faith leaders and local businesses inspiring entrepreneurship, hope, and healing in their community.

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Medicare Learning Network

News & Announcements

- New Medicare Card: MBI Look-up Tool Clarification and RRB Mailing
- Enhanced "Drug Dashboards" to Increase Transparency on Drug Prices
- CMS Safeguards Patient Access to Certain Medical Equipment and Services in Rural and Other Non-contiguous Communities
- Quality Payment Program: Check 2018 MIPS Clinician Eligibility at the Group Level
- Medicare Diabetes Prevention Program Resources
- Hospital Outpatient Quality Reporting Spring 2018 Newsletter
- Talk to Your Patients about Mental Health

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Upcoming Events

- Settlement Conference Facilitation Expansion Call — May 22
- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6
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Medicare Learning Network® Publications & Multimedia

- ICD-10 and Other Coding Revisions to National Coverage Determinations MLN Matters Article — New
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment MLN Matters Article — New
- Updates to Publication 100-04 to Replace RARC MA61 with N382 MLN Matters Article — New
- IPPS and LTCH PPS Extensions per the ACCESS Act MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Quarterly HCPCS Drug/Biological Code Changes – July 2018 Update MLN Matters Article — Revised
- Medicare Preventive Services National Educational Products — Revised
- Power Mobility Devices Booklet — Reminder
- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — Reminder
- Medicare Advance Written Notices of Noncoverage Booklet — Reminder
- Long-Term Care Hospital Prospective Payment System Booklet — Reminder
- Medicare Disproportionate Share Hospital Fact Sheet — Reminder
- Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Reminder

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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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