CMS Region 7 Updates – 06/29/2018

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New Medicare Card Updates

New Medicare Card Update

We've started mailing new Medicare cards to people with Medicare who live in **Wave 3** states: Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota and Wisconsin. We continue to mail new cards to people who live in **Wave 2** states and territories (Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon), as well as nationwide to people who are new to Medicare.

At this time, we've finished mailing most cards to people with Medicare who live in **Wave 1** states: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia. If someone with Medicare says they didn't get a card, you should instruct them to:
- Sign into MyMedicare.gov to see if we mailed their card. If so, they can print an official card.
- Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

In order to ensure no disruption in services to people with Medicare, healthcare providers and suppliers can use either the former Social Security number-based HICN or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

Check this website as the mailings progress. Continue to direct people with Medicare to Medicare.gov/NewCard for information about the mailings and to sign up to get email about the status of card mailings in their state.
We're committed to mailing new cards to all people with Medicare by April 2019.

Press releases for Iowa, Kansas and Nebraska are available from Julie Brookhart at Julie.Brookhart@cms.hhs.gov.

Recent web updates include:
- Medicare.gov/newcard campaign page:
  - Wave 3 states are "mailing now"
  - Wave 2 states continue to show "mailing now"
  - Wave 1 states are flipped to "finished mailing"
  - Note: RRB card language remains

- CMS.gov/newcard:
  - Mailing wave chart - Wave 3 "Beginning June 2018"; also Wave 1 "complete"
  - New provider resource to help direct beneficiaries who are still waiting for their card (also in Spanish). *Note you can use these same key messages to direct beneficiaries in future waves or in waves where mailing is still happening.*

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New Medicare Card Mailing Update – Wave 3 Begins, Wave 1 Ends

We started mailing new Medicare cards to people with Medicare who live in Wave 3 states: Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota and Wisconsin. We continue to mail new cards to people who live in Wave 2 states and territories (Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon), as well as nationwide to people who are new to Medicare.

We finished mailing most cards to people with Medicare who live in Wave 1 states: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. If someone with Medicare says they did not get a card:

- Print and give them the "Still Waiting for Your New Card?" handout (in English or Spanish).

- Or tell them to call 1-800-Medicare (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

All Medicare Administrative Contractor (MAC) secure portal Medicare Beneficiary Identifier (MBI) look-up tools are ready for use. If you do not already have access, sign up for your MAC's portal to use the tool. Once we mail the new Medicare card with the MBI to your patient, you can look up MBIs for your Medicare patients when they do not or cannot give them. If the tool indicates the card has not been mailed for your Medicare patient who lives in a geographic location where the card mailing is finished, tell your patient to call 1-800-Medicare (1-800-633-4227).

To ensure people with Medicare continue to get health care services, continue to use the Health Insurance Claim Number (HICN) through December 31, 2019 or until your patient brings in their new card with the new number.

Check this website as the mailings progress. Continue to direct people with Medicare to Medicare.gov/NewCard for information about the mailings and to sign up to get email about the status of card mailings in their state.

We're committed to mailing new cards to all people with Medicare by April 2019.

Information on the transition to the new Medicare Beneficiary identifier:

- New MBI Get It, Use It MLN Matters® Article (Updated 6/25/18)
- Transition to New Medicare Numbers and Cards MLN Fact Sheet
- New Medicare Card information website

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ACA/Marketplace Updates

Stand-Alone Dental Plan (SADP) Voluntary Reporting

The Centers for Medicare & Medicaid Services (CMS) released the summary of the results of the voluntary reporting information reported by issuers that intend to offer Exchange-certified stand-alone dental plans (SADPs) for plan year 2019 through the Exchange in states with Federally-facilitated Exchanges (FFEs), including states performing plan management functions.

Each year, CMS provides issuers of stand-alone dental plans (SADPs) an opportunity to voluntarily report their intention to submit SADPs for Exchange certification for the following year. When an SADP is available through an Exchange, other QHPs may be certified even if they do not provide coverage of the pediatric dental essential health benefits (EHB).

Click here for more information on the Voluntary SADP Reporting Guidance for 2019 (Updated June 18, 2018) or here: https://www.qhpcertification.cms.gov/s/Published%20Guidance%20and%20Regulations

###

CMS Statement: Administrator Verma Applauds Greater Access to Health Coverage under New Rule

"The Trump Administration took important steps today to help small business employees and their families, who were left out of Obamacare, gain access to higher quality, more affordable health coverage. The number of small businesses that offer health coverage has been declining for years and Obamacare did nothing to reverse this trend. The rule released today levels the playing field between small and large employers by providing new opportunities for small employers to band together to gain the same health insurance options as large employers. Association Health Plans will provide broader access to better health coverage for small business employees and their families. We are pleased to partner with the Department of Labor in this important work."

Please see related Department of Labor (DOL) Press Release on
AHPs: https://www.dol.gov/newsroom/releases/osec/osec20180619

###

Special Enrollment Period (SEP) Reference Chart

In a recently finalized rule, the Centers for Medicare & Medicaid Services (CMS) made several changes to special enrollment periods that took effect on June 18. To reflect these changes, we have updated our Special Enrollment Period Reference Chart.

SEP Reference Chart
↓ Download chart (PDF)

View the chart

Changes include:

- **SEP for loss of pregnancy-related coverage provided through CHIP.** An SEP is now available for the loss of coverage provided through the Children's Health Insurance Program (CHIP) "unborn child" option, which only covers pregnancy-related services and is not considered minimum essential coverage.
- **Additional exemption from the prior coverage requirement for people living in bare counties.** Some SEPs require that a person be enrolled in some form of minimum essential coverage for at least 1 day in the 60 days prior to experiencing a qualifying event. People who live in a service area with no plans sold in the Marketplace during the most recent available open or special enrollment period or during the 60 days prior to a qualifying event are exempt from this prior coverage requirement.
- **Coverage effective date change for SEP for birth/adoption/placement in foster care/court order.** People eligible for this SEP can now choose to begin new coverage on the first day of the month following plan selection (instead of the first day of the month following the birth/adoption/placement in foster care/court order).

In addition, we removed a column in the chart outlining plan selection restrictions for current Marketplace enrollees because those restrictions are not in effect at this time. Plan selection restrictions based on the metal level of an enrollee's current Marketplace plan that will apply when an enrollee uses certain SEPs to change plans will not take effect until 2019 in states using Healthcare.gov. These restrictions will not apply to all SEPs and will not apply in the individual market outside of the Marketplace. States with State-Based Marketplaces may take longer to implement these restrictions. We will update the chart once these rules are in place.

For more resources, please visit our Health Reform: Beyond the Basics website at www.healthreformbeyondthebasics.org. If you have any questions or concerns, don't hesitate to reach out to us at beyondthebasics@cbpp.org.

###

MACRA/Quality Payment Program (QPP) Updates

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program Exchange Function Analyses Report Now Available

The Centers for Medicare & Medicaid Services (CMS) has released a technical report to provide additional details on the empirical analyses that were considered when developing and finalizing the logistic exchange function that will be used to translate Skilled Nursing Facility (SNF) performance scores into incentive payments for the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program. CMS has adopted the logistic exchange function as the method that will be will be used to translate SNF performance scores into value-based incentive payments beginning in October 2018 (FY 2019).

The report includes CMS' analysis of historical Skilled Nursing Facility Readmission Measure (SNFRM) (NQF #2510) data, of the estimated effects that result from using other methodologies as part of our overall scoring process, and analyses of other exchange function forms. We concluded that the logistic function provided the largest percentage of SNFs with net-positive value-based incentive payments.

To view the full technical report on our exchange function methodology and analyses, please visit: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP-exchange-function-analysis.pdf

For more information about the SNF VBP Program, please visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html and refer to the FY 2018 SNF PPS final rule.

If you have additional questions, please email them to: SNFVBPinquiries@cms.hhs.gov

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Important Information on Upcoming Promoting Interoperability Program Deadlines

The Centers for Medicare & Medicaid Services (CMS) would like to remind health care professionals about the following upcoming Promoting Interoperability (PI) Program deadlines:

Formal Comments on the FY 2019 Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Proposed Rule

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

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

Measure Proposals for Medicare Promoting Interoperability Program

CMS encourages you to submit measure proposals for the Annual Call for Measures for eligible hospitals and critical access hospitals (CAHs) participating in the PI Program. Proposals must be submitted to CMSCallforMeasuresEHR@Ketchum.com by **Friday, June 29, 2018**.

EHR Hardship Exception Application

Medicare eligible hospitals and CAHs may be considered exempt from Medicare penalties and avoid a payment adjustment, if they can show that demonstrating meaningful use would result in a significant hardship. To be considered,

health care providers **must** submit the [2019 Eligible Hospital Hardship Exception Application](#) to ehrhardship@cms.hhs.gov and provide proof of hardship by **Sunday, July 1, 2018**.

For More Information

For more information about these deadlines, please visit the [PI Programs website](#).

<p style="text-align:center">###</p>

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 5:00 p.m. today, June 25

Comments on the FY 2019 IPPS and LTCH proposed rule are due no later than **5 p.m. ET today, June 25, 2018.** The public can submit comments [electronically](#) through the "submit a comment" instructions on the Federal Register.

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 aim to 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 Calendar Year 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 2019 and 2020 a minimum of any continuous 90-day period.

For More Information

To learn more, review the [proposed rule](#) and visit the [CMS website](#).

<p style="text-align:center">###</p>

Quality Payment Program Participation Lookup Tool with Predictive Qualifying APM Participant Status

In April, the Centers for Medicare & Medicaid Services (CMS) released the initial 2018 participation status for Merit-based Incentive Payment System (MIPS) eligible clinicians by updating the MIPS Participation Lookup Tool. Today, CMS release updates that tool by renaming it the [Quality Payment Program (QPP) Participation Lookup Tool](#) and adding predictive Qualifying APM Participant (QP) status.

Eligible clinicians in Advanced Alternative Payment Models (APMs) who meet certain criteria are considered QPs and are excluded from MIPS. A priority for the QPP has been to provide eligible clinicians their QP status as soon as possible to minimize clinician confusion and provide clarity on what they need to do to meet reporting requirements. Clinicians will now be able to check their participation status in the QPP through one tool.

For more information click here: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Predictive-QP-Methodology-fact-sheet.pdf

<p style="text-align:center">###</p>

CMS Advances Demonstration to Waive MIPS Requirements for Clinicians in Certain At-Risk Medicare Advantage Plans

The Centers for Medicare & Medicaid Services (CMS) is advancing the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration, which, when approved and adopted, would waive Merit-Based Incentive Payment System (MIPS) requirements for clinicians who participate sufficiently in certain Medicare Advantage plans that involve taking on risk. CMS seeks public comment on the information collection burdens associated with the demonstration, which is under consideration for formal approval.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provides clinicians with two tracks for payment under Fee-for-Service Medicare: MIPS, which requires clinicians to report quality data to CMS and have their payment adjusted accordingly; and Advanced Alternative Payment Models (Advanced APMs), which require clinicians to take on risk for their patients' healthcare spending.

Some Medicare Advantage plans are developing innovative arrangements that resemble Advanced APMs. However, without this demonstration, physicians are still subject to MIPS even if they participate extensively in Advanced APM-like arrangements under Medicare Advantage.

"The MAQI Demonstration aligns with the Agency's goal of moving to a value-based healthcare system, and aims to put Medicare Advantage on a more equal playing field with Fee-for-Service Medicare," said CMS Administrator Seema Verma. "CMS intends to test whether MIPS exemptions provided to clinicians under MAQI will increase participation in Medicare Advantage plans that are similar to Advanced APMs, and thereby accelerate the transition to a healthcare system that pays for value and outcomes."

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LTCH/IRF Provider Preview Reports - One Week Left to Review Your Data!

Long-term Care Hospital (LTCH) and Inpatient Rehabilitation Facility (IRF) Provider Preview Reports have been updated and are now available. Providers have until July 1, 2018 to review their performance data on quality measures based on Quarter 4 -2016 to Quarter 3 - 2017 data, prior to the September 2018 LTCH Compare and IRF Compare site refreshes, during which this data will be publicly displayed. Corrections to the underlying data will not be permitted during this time. However, providers can request a CMS review during the preview period if they believe their data scores displayed are inaccurate. The updates include two additional assessment-based measures for both LTCHs and IRFs, three new claims-based measures for LTCHs and four new claims-based measures for IRFs.

 For more information:

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

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SNF Provider Preview Reports - One Week Left to Review Your Data!

Skilled Nursing Facility (SNF) Provider Preview Reports have been updated and are now available. Providers have until July 1, 2018 to review their performance data prior to public display on the Nursing Home Compare (NHC) site. Corrections to the underlying data will not be permitted during this time. However, providers can request a CMS review during the preview period if they believe their data scores displayed are inaccurate.

The SNF Provider Preview Report includes performance data on the following quality measures based on the subsequent Quarterly data:

Quarter 1 – 2017 to Quarter 4 – 2017 data

1. Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (#0674)
2. Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)
3. Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (#2631).

Quarter 4 – 2016 to Quarter 3 – 2017 data

1. Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure
2. Discharge to Community- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

Quarter 4 – 2015 to Quarter 3 – 2017 data

1. Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

For more information:
- SNF Quality Public Reporting webpage, NHC Compare and Preview Report Access Instructions

CMS Announces Agency's First Blue Button 2.0 Developer Conference

The Centers for Medicare & Medicaid Services (CMS) announced it is hosting the first-ever Blue Button® 2.0 Developer Conference. This event is being held in Washington, D.C. at the General Services Administration national headquarters on Monday, August 13, 2018. The Blue Button® 2.0 Developer Conference will provide a networking opportunity that brings together developers to learn, build software, and share insights on how Medicare claims data can be leveraged to improve health outcomes. In addition, the conference will help further advance the work of the MyHealthEData, a government-wide initiative led by the White House Office of American Innovation.

MyHealthEData is designed to empower patients around a common aim - giving every American control of their medical data to enable them to make better choices for value driven healthcare. MyHealthEData will also help to break down the barriers that prevent patients from having electronic access and true control of their own health records from the device or application of their choice. This allows patients to choose the provider that best meets their needs and then give that provider secure access to their data, leading to greater competition and reducing costs.

"The inaugural Blue Button® 2.0 Developer Conference will bring together application developers in the technical community to help build and develop new tools to help patients understand their health data," said Administrator Verma. "This conference is the perfect venue for developers to network with each other and with leaders in the federal government to collaborate on ways to engage Medicare beneficiaries to make informed healthcare decisions."

Developers will have an opportunity to get real-time feedback and meet the CMS engineering team up. This event will include hands-on sessions for the technical community to create or build upon their Blue Button 2.0 application, with guidance and feedback from the Blue Button 2.0 team, patient advocates, and other experts. Attendees will also have the opportunity to see the many ways in which organizations are integrating with Blue Button 2.0 to improve health outcomes for Medicare beneficiaries through application demonstrations.

As part of MyHealthEData, CMS has securely released four years of Medicare Part A, B and D data for 53 million Medicare beneficiaries. This data contains a variety of information about a beneficiary's health, including type of Medicare coverage, drug prescriptions, primary care treatment and cost. This release allowed Medicare beneficiaries to have full control over how their data can be used and by whom, with identity and authorization controlled by MyMedicare.gov to ensure their information remains secure and private. With the release of this data, CMS wants to work with developers to create new applications that help make this data more helpful and meaningful for patients.

To get more information and to register for this event, please visit the Blue Button® 2.0 Developer Conference website.

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Medicare and Medicaid Updates

CMS Announces Initiatives to Strengthen Medicaid Program Integrity
Agency actions will help ensure the sustainability of vital safety net program for all beneficiaries

The Centers for Medicare and Medicaid Services (CMS) announced new and enhanced initiatives designed to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools.

"The initiatives released today are essential to help strengthen and preserve the foundation of the program for the millions of Americans who depend on Medicaid's safety net. With historic growth in Medicaid comes an urgent federal responsibility to ensure sound fiscal stewardship and oversight of the program," said CMS Administrator Seema Verma. "These initiatives are the vital steps necessary to respond to Medicaid's evolving landscape and fulfill our responsibility to beneficiaries and taxpayers."

Recent years have seen a rapid increase in Medicaid spending driven by several factors, including Medicaid expansion, from $456 billion in 2013 to an estimated $576 billion in 2016. Much of this growth came from the program's federal share that grew from $263 billion to an estimated $363 billion during that period. While the responsibility for proper payments in Medicaid primarily lies with the states, oversight of the Medicaid program requires a partnership. CMS plays a significant role in supporting state efforts to meet high program standards.

Administrator Verma has set forth three pillars to guide CMS' work in the Medicaid program: Flexibility, Accountability, and Integrity. Emphasizing these, she expanded on the role of CMS saying, "As we give states the flexibility they need to make Medicaid work best in their communities, integrity and oversight must be at the forefront of our role. Beneficiaries depend on Medicaid and CMS is accountable for the program's long-term viability. As today's initiatives show, we will use the tools we have to hold states accountable as we work with them to keep Medicaid sound and safeguarded for beneficiaries."

The initiatives announced today include stronger audit functions, enhanced oversight of state contracts with private insurance companies, increased beneficiary eligibility oversight, and stricter enforcement of state compliance with federal rules.

<u>**Important New Initiatives**</u>

1. Emphasize program integrity in audits of state claims for federal match funds and medical loss ratios (MLRs). Audits are central to CMS' partnership with states—not only encouraging compliance but also revealing how to improve integrity at all levels. Under this initiative, CMS will begin auditing some states based on the amount spent on clinical services and quality improvement versus administration and profit. The MLR audits will include reviewing states' rate setting. Overall, audits will address issues identified by the Government Accountability Office (GAO) and Office of Inspector General (OIG), as well as other behavior previously found harmful to the Medicaid program.

2. Conduct new audits of state beneficiary eligibility determinations. CMS will audit states that have been previously found to be high risk by the OIG to examine how they determine which groups are eligible for Medicaid benefits. These audits will include assessing the effect of Medicaid expansion and its enhanced federal match rate on state eligibility policy. Current regulations will allow CMS to begin to issue potential disallowances to states based on Payment Error Rate Measurement (PERM) program findings in 2022. The PERM program measures improper payments in the Medicaid program and the Children's Health Insurance Program (CHIP) on a rolling three year cycle and produces national and state-specific improper payment rates.

3. Optimize state-provided claims and provider data: CMS will utilize advanced analytics and other innovative solutions to both improve Medicaid eligibility and payment data and maximize the potential for program integrity purposes. The Trump Administration has made partnering with states a priority. CMS is committed to work closely with states to ensure that the agency and oversight bodies have access to the best, most complete and accurate

Medicaid data. For the first time, every state plus Washington, D.C. and Puerto Rico are now submitting enhanced data to CMS. Over the course of the coming months, we will be validating the quality and completeness of the data.

Ongoing Integrity Work

Working with states to ensure Medicaid provides high-quality care for our most vulnerable people is a central part of CMS' mission. To learn about noteworthy efforts in place to protect Medicaid's integrity—including provider screening and education, streamlined access to data, and an enhanced Medicaid Scorecard—see https://www.medicaid.gov/state-resource-center/downloads/program-integrity-strategy-factsheet.pdf

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CMS Approves State Proposal to Advance Specific Medicaid Value-Based Arrangements with Drug Makers
First-of-its-kind approval for Oklahoma Medicaid will drive value

The Centers for Medicare & Medicaid Services (CMS) issued the first-ever approval of a state plan amendment proposal to allow the state of Oklahoma to negotiate supplemental rebate agreements involving value-based purchasing arrangements with drug manufacturers that could produce extra rebates for the state if clinical outcomes are not achieved. The state plan amendment proposal submitted by Oklahoma will be the first state plan amendment permitting a state to pursue CMS-authorized supplemental rebate agreements involving value-based purchasing arrangements with manufacturers.

"Oklahoma's plan for value-based drug contracts is an important example of how states can innovate to bring down drug costs," Secretary Alex Azar said, "The Trump Administration is committed to giving states the flexibility they need to make healthcare more affordable, and strongly supports innovations like value-based purchasing for prescription drugs."

Value-based purchasing can link the payment of a drug to its effectiveness and the outcomes it achieves. Promoting value-based payment is one many initiatives outlined in the Administration's American Patients First Blueprint, which President Trump's sweeping plan to address the high drug prices facing Americans. Oklahoma submitted to CMS an amendment that added value-based supplemental rebate agreement (SRA) language to their state Medicaid plan. Today, CMS approved the state plan amendment Oklahoma proposed, permitting the state to enter into tailored agreements with manufacturers on a voluntary basis. The state and each manufacturer can now jointly agree on benchmarks based on health outcomes and the specific populations for which these outcomes-based benchmarks will be measured and evaluated.

"President Trump is committed to lowering prescription drug prices and working with states in their pursuit towards innovative state health plans. We want to ensure we are giving states all the tools they need to better negotiate with manufacturers," said CMS Administrator Seema Verma. "We applaud Oklahoma's proposal for a state-plan amendment, which is an innovative approach to reform how we pay for prescription drugs and will lead to better deals for our beneficiaries and our program."

About supplemental rebate agreements

Almost every state Medicaid plan includes the authority of the state to negotiate supplemental rebate agreements (SRAs) with drug manufacturers that provide rebates at least as large as those set forth in the Medicaid national drug rebate agreement. Since Medicaid is a federal and state partnership, CMS reviews all state plan amendments, including SRAs. Consistent with regulations at 42 CFR 447.505(c)(7), SRAs are exempt from the Medicaid "best price" rule that requires drug manufacturers to extend the lowest price for a drug they negotiate with any other buyer to all states in the Medicaid program.

For more information, visit the following links:

State Medicaid Coverage of Drugs Approved by the FDA under Accelerated Approval Pathway: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/rx-releases/state-releases/state-rel-185.pdf.

State Plan Amendment: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OK/OK-18-08.pdf.

Announcement of Important Changes Impacting Medicare Coverage of Continuous Glucose Monitors

The Centers for Medicare & Medicaid Services (CMS) announced important changes in its written policies regarding how Medicare covers continuous glucose monitors (CGMs). These changes are consistent with the Agency's approach of putting patients first and incentivizing innovation and use of e-technology. Stakeholders have raised concerns regarding the local coverage article related to continuous glucose monitors (CGMs), which currently prohibits coverage of supplies and accessories with non-DME devices (e.g., smart phones and tablets). Medicare beneficiaries have not been able to use smart phone aps with their CGMs and currently must only use a durable CGM receiver. CMS will be posting information to our website to alert people that we have instructed the MACs through a Technical Direction Letter (TDL) to allow beneficiaries to use smart phones etc. "in conjunction" with the durable receiver.

For more information click on the spotlight section of the DME Center page here: https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html

Establishment of Medicare Fees for Newly Covered Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) "2018 Gap Fill"

CMS is taking steps today to increase flexibility when innovative new medical equipment becomes available. These steps will support more accurate pricing for new technology and support innovation. Specifically, today, we are announcing a revised DMEPOS gap-filling methodology for establishing the price for newly covered DMEPOS items. This update will appear in the Medicare Claims Processing Manual.

Currently, CMS bases the price for a newly covered DMEPOS item on: (1) the fee schedule amount for a comparable item in the DMEPOS fee schedule, or (2) supplier price lists or retail price lists, such as mail order catalogs. Under the revised policy released today, CMS will now allow the use of verifiable information from non-Medicare payer data and supplier invoices as potential appropriate sources for commercial pricing for gap-filling purposes.

This update means that, in establishing a price for DMEPOS items that are newly covered, CMS will also be able to provide more flexibility and allow use of new sources of information. In regards to the Optune device by Novocure, the company would still need to apply for a coverage redetermination (and be approved) before CMS could begin the process of establishing a price, but we expect today's announcement to be received as good news.

For more information click on the spotlight section of the DME Center page https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html

CMS will not update *Hospital Compare* Overall Hospital Quality Star Ratings Data in July 2018

The Centers for Medicare & Medicaid Services (CMS) will not update the Overall Hospital Quality Star Ratings for July 2018, as previously scheduled. CMS has decided to postpone the July star ratings update to give time for additional analysis of the impact of changes to some of the measures on the star ratings and to address stakeholder concerns. CMS is dedicated to transparency of quality and cost information for consumers, and committed to holding providers accountable for patient

outcomes. When changes are made to the underlying measures it is vital to take the time needed to understand the impact of those changes and ensure we are giving consumers the most useful information. As part of this process, CMS will seek feedback from a multi-disciplinary Technical Expert Panel, a Provider Leadership Workgroup, and a public comment period.

QualityNet News:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=12287766144 55

Please submit questions related to Star Ratings to cmsstarratings@lantanagroup.com

Other additional information on Hospital Compare can be found here:
https://www.medicare.gov/hospitalcompare/search.html

Deadline to Submit Proposed Measures for the Medicare PI Program is June 29, 2018

The Centers for Medicare & Medicaid Services (CMS) would like to remind clinicians that the measure proposals for the Annual Call for Measures for eligible hospitals and critical access hospitals participating in the Medicare Promoting Interoperability (PI) Program Measures are due by **tomorrow, June 29.**

Proposals can be found on the Promoting Interoperability Programs website and must be submitted to CMSCallforMeasuresEHR@Ketchum.com. Criteria to consider:

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

For More Information

For more information about these deadlines, please visit the PI Programs website.

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Upcoming Webinars and Events and Other Updates

CMS National Training Program Workshops - Registration is OPEN

You asked, and we listened! At the 2018 CMS National Training Program (NTP) Workshops, you can expect 2½ days of tailored training to meet a variety of learning needs. Whether you're building a foundation of basic Medicare knowledge, or you want to expand your expertise, there's something for everyone. You're welcome to attend the entire 2½-day workshop, or you can choose to attend only the days that meet your varied interests and needs. Day 1 provides the basics, Day 2 has cross-cutting information including legislative and program updates, and Day 3 provides a deeper dive into more advanced topics. It will be helpful if you bring a laptop or tablet to participate in the casework activities.

The locations and dates for the workshops are listed below. You are invited to attend the location of your choice. **There is no fee to attend.**

REGISTER NOW

Region	Date	Location
VII—Kansas	July 31–August 2	The Westin Kansas City at Crown Center 1 E Pershing Road Kansas City, MO 64108
II—New York	August 6–8	New York Hilton Midtown 1335 6th Avenue New York, NY 10019
X—Seattle	August 14–16	The Artic Club Seattle 700 3rd Avenue Seattle, WA 98104
IV—Atlanta	September 5–7	Loews Atlanta Hotel 1065 Peachtree St NE Atlanta, GA 30309
VIII—Denver	September 11–13	Marriott Westminster 7000 Church Ranch Boulevard Westminster, CO 80021

The NTP training materials will be available for download on the registration website prior to the workshops. If you would like hard copies, please download and print. You can also download the materials to your tablet, laptop, or on a USB.

NOTE: Registration requests will be considered on a first-come, first-served basis until each meeting reaches capacity. The number of attendees from the same organization may be limited.

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2018 Medicare National Training Program (NTP) Workshop - St. Louis Missouri

The Centers for Medicare & Medicaid Services (CMS) Kansas City Regional Office invites you to attend the **2018 Medicare National Training Program (NTP) Workshop in St. Louis Missouri**.

While the workshop in Kansas City will be 2 ½ days, the workshops in St. Louis will be 2 full days. The same information will be provided at the workshop.

If you have registered for the Workshop in Kansas City and would prefer to attend the workshop in St. Louis, please register at the link below and then let me know so I can cancel your registration for the Kansas City workshop.

Tuesday, August 28, 2018   8:30AM – 5:00PM   (Registration at 8:00AM)
Wednesday, August 29, 2018   8:30AM – 5:00 PM   (Registration at 8:00AM)
Register: https://www.eventbrite.com/e/2018-cms-national-training-program-workshop-st-louis-mo-registration-47310136893

Please make sure your email address in your registration is correct.

In addition, if you register for a Workshop and then later determine you are unable to attend please access Eventbrite and cancel your ticket so others can attend or email Lorelei at lorelei.schieferdecker@cms.hhs.gov. Those who register and do not attend may be placed on a wait list for future CMS events.

As always, there will be no charge to you for the training; however, CMS will not be able to provide food or drinks.

Topics to be covered are:
- Understanding Medicare - Explains the Medicare Program including what it is, coverage and costs, coverage choices, enrollment, coordination of benefits, and how to fight fraud and abuse.
- Medicare Supplement Insurance (Medigap) Policies - Explains how Medigap policies work with Medicare, what Medigap policies cover, how they are structured, and when to buy a Medigap policy.
- Medicare Advantage and Other Medicaid Health Plan - Explains Medicare health plan options other than Original Medicare.
- Medicare Prescription Drug Coverage - Provides an overview of Medicare prescription drug coverage under Part A (Hospital insurance), Part B (Medical Insurance), and Part D (Prescription Drug Coverage).
- Medicare and Other Programs for People with Disabilities/SSA - Explains Medicare, Social Security benefits and other programs for people with disabilities.
- Medicare and Medicaid Fraud and Abuse Prevention - Explains Medicare and Medicaid fraud and abuse prevention, detection, reporting, recovery and the Office of the Inspector General's role in fighting healthcare fraud including showcasing resolved fraudulent Medicare and Medicaid cases.
- Medicaid and the Children's Health Insurance Program - Describes eligibility, benefits, and administration of Medicaid; Define eligibility, benefits, and administration of the Children's Health Insurance Program (CHIP).
- Casework - Hands-on experience working through case scenarios pertaining to Medicare.
- Current Topics - Explains new policies, innovations, and legislation.

- CMS Program Resources - Outlines key websites, associated resources, and tools for the programs administered by CMS—Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace.
- Opportunities to network with CMS staff and subject matter experts and other organizations working with the Medicare/Medicaid population.

We look forward to your participation. If you have any questions or have difficulty registering, please contact Lorelei Schieferdecker at Lorelei.Schieferdecker@cms.hhs.gov or Julie.Brookhart@cms.hhs.gov

Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 E 12th Street
Kansas City, MO 64106
Ph: 816.426.5233

Applications for the New Health Information Technology Advisory Committee Now Open

Want to contribute to future heath IT policies and standards? You may now apply to become a member of the new Health Information Technology Advisory Committee (HITAC). Applications for the Department of Health and Human Services appointments on the committee will be accepted until noon (EST) on August 4, 2017. We encourage interested professionals to fill out a Health IT Advisory Committee Membership Application to be considered as a committee or future task force member.

The 21st Century Cures Act requires the Secretary of Health and Human Services to appoint three members; one shall be a representative of HHS and one shall be a public health official. The remaining members will be appointed by the Comptroller General of the United States and the majority and minority leaders of the Senate, and the speaker and minority leader of the House of Representatives.

To learn more, read the Federal Register notice that was put on display July 24, 2017.

Medicare Learning Network

News & Announcements

- New Medicare Cards May Have QR Codes
- Continuous Glucose Monitors: Changes Impacting Medicare Coverage
- Quality Payment Program Look-Up Tool Updated
- Quality Payment Program Website Includes 2018 MIPS Measures and Activities
- Hospice Provider Preview Reports: Review Your Data by June 30
- IRF and LTCH Provider Preview Reports: Review Your Data by July 1
- SNF Provider Preview Report: Review Your Data by July 1
- CMS Leverages Medicaid Program to Combat the Opioid Crisis

Provider Compliance

- Payment for Outpatient Services Provided to Beneficiaries Who Are Inpatients of Other Facilities — Reminder

Medicare Learning Network® Publications & Multimedia

- July Quarterly Update for 2018 DMEPOS Fee Schedule MLN Matters Article — New
- Qualified Medicare Beneficiary Call: Audio Recording and Transcript — New

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Monthly Learning Series Webinar
June 14, 2018   1:00 – 2:30 pm ET

Join us to learn about resources available to people with Medicare, including:
- MyMedicare.gov
- Blue Button

To register for the webinar, visit events-CMS.webex.com/events-cms/onstage/g.php?MTID=e9c0c1c53933ea9f76770695b32aeaaf7.

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New / Updated CMS Publications
How Medicare Prescription Drug Coverage works with a Medicare Advantage Plan or Medicare Cost Plan

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Newly Posted Training Materials
Module 3: Medigap (Spanish)

Module 7: Preventive Services (English and Spanish)

Module 8: CMS Program Resources

Job Aid: CMS National Training Program—About Us

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Did You Know?
The CMS National Training Program (NTP) has a NEW Medicare Learning Management System (LMS)? Check out an entire library of NTP Medicare training modules, job aids and other resources at CMSnationaltrainingprogram.cms.gov/.

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Rural Communities Opioid Response-Planning Program
Deadline: July 30, 2018

What the Funding Will Do

Through its parent agency, the Health Resources and Services Administration (HRSA), the Federal Office of Rural Health Policy (FORHP) will make awards of up to $200,000 each to support one year of community-level planning for prevention and treatment of opioid use disorder in approximately 75 high-risk rural communities. Successful awardees will **partner with at least three other separately-owned entities** and develop plans to implement opioid use disorder prevention, treatment, and recovery interventions. This program is part of a multi-year, $130 million opioid-focused effort by HRSA. In FY 2019 and beyond, there will be additional funds available to provide continued support, including additional grants and National Health Service Corps (NHSC) Loan Repayment Program awards.

Read HRSA's Press Release

Eligibility

Eligible applicants include domestic public or private entities, nonprofit and for-profit, including faith-based and community-based organizations, tribes, and tribal organizations. **All services must be provided in HRSA-designated rural areas.** See Section III - Eligibility Information in the Notice of Funding Opportunity for more details on eligibility and consortium specifications.

How to Apply

The Notice of Funding Opportunity is available on Grants.gov.

It's important to know that **you cannot apply for a HRSA grant until three registrations are completed:**

1. DUNS Number (What is DUNS?)
2. System for Awards Management (What is SAM?)
3. Grants.gov

More information about the registration process can be found on the Grants section of HRSA's website.

FORHP will hold an hour-long webinar for applicants on Thursday, **June 28, 2018 at 1:00 pm ET.** A recording will be made available for those who cannot attend. To get the dial-in and other information about this funding opportunity, **write to ruralopioidresponse@hrsa.gov**.

Federal Resources for the Opioid Crisis That May Help
- U.S. Department of Health & Human Services
- Health Resources and Services Administration
- U.S. Department of Agriculture

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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.