CMS Region 7 Updates – 06/11/2018

Table of Contents

New Medicare Card Updates

New Medicare Card, Same Old Scammers

Drop-in Article

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.

###

New Medicare Cards are mailing – Beware of Scams

PSA Script:30

Medicare is mailing new cards with a new, more secure Medicare Number to all people with Medicare. The card is free, there's nothing you need to do to get it, and your Medicare benefits don't change. But watch out for scammers. If someone calls saying you need to give your Social Security Number, Medicare Number or bank information to get the new card, or if they threaten to cancel your health benefits, hang up! If you get a suspicious call, contact 1-800-MEDICARE. Watch your mail for your new card.

###

CMS Unveils Scorecard to Deliver New Level of Transparency within Medicaid and CHIP Program

New Scorecard highlights CMS's commitment to a new era of accountability in Medicaid by monitoring and publishing state and federal Medicaid and CHIP outcomes

The Centers for Medicare & Medicaid Services (CMS) released the first ever Medicaid and Children's Health Insurance Program (CHIP) Scorecard, a central component of the Administration's commitment to modernize the Medicaid and CHIP program through greater transparency and accountability for the program's outcomes. For the first time, CMS published state Medicaid and CHIP quality metrics along with federally reported measures in a Scorecard format.

"Despite providing health coverage to more than 75 million Americans at a taxpayer cost of more than $558 billion a year, we have lacked transparency in the performance and outcomes of this critical program." said CMS Administrator Seema Verma. "The Scorecard will be used to track and display progress being made throughout and across the Medicaid and CHIP programs, so others can learn from the successes of high performing states. By using meaningful data and fostering transparency, we will see the development of best practices that lead to positive health outcomes for our most vulnerable populations."

The first version of the Scorecard includes measures voluntarily reported by states, as well as federally reported measures in three areas: state health system performance; state administrative accountability; and federal administrative accountability. The metrics included in the first Scorecard reflect important health issues such as well child visits, mental health conditions, children's preventive dental services, and other chronic health conditions. The Scorecard represents the first time that CMS is publishing state and federal administrative performance metrics - which include measures like state/federal timeliness of managed care capitation rate reviews, time from submission to approval for Section 1115 demonstrations, and state/federal state plan amendment processing times. The Scorecard falls in line with President Trump's commitment to "cut the red tape" by aligning existing reporting requirements with these other data sets and incorporating new data over time.

The Scorecard is a key component of Administrator Verma's new vision for Medicaid and CHIP that was announced during the NAMD conference in November 2017. "Our vision for the future of Medicaid is to reset the federal-state relationship and restore the partnership, while at the same time modernizing the program to deliver better outcomes for the people we serve," said Administrator Verma. "We need to ensure that we are building a Medicaid program that is sound and sustainable to help all beneficiaries reach their highest potential."

CMS has delivered on its commitment to resetting the state-federal partnership by offering states unprecedented flexibility to design health programs that meet the needs of their residents. This includes updates to our Medicaid 1115 demonstration website, new guidance to offer states more flexibility to address the opioid crisis through Medicaid, and a new opportunity for states to test community engagement incentives to help lift adult Medicaid beneficiaries from poverty. As CMS continues to approve groundbreaking Medicaid demonstrations, the agency has maintained a focus on enhancing our evaluation of state health system performance and outcomes.

In addition to ensuring robust evaluations of demonstration projects, CMS will also continue to emphasize the importance of measuring a broad set of health outcome metrics across states. Given its important role in covering over 35 million children across the country, paying for approximately 50% of the country's births, and as the single greatest payer for long-term care services for the elderly and people with disabilities, public reporting of core quality metrics maintains an important responsibility of states and the federal government.

Through its release, the initial Scorecard demonstrates the importance of transparency within Medicaid and CHIP. The data offered within the Scorecard begins to offer taxpayers insights into how their dollars are being spent and the impact those

dollars have on health outcomes. In future years, the Scorecard will be updated annually with new functionality and new metrics, including opioid-related and home and community based services-related quality metrics, as well as the ability to compare spending patterns. CMS will continue to work with states to encourage greater reporting across a broader set of metrics to improve consistency across states.

Through a strengthened partnership with states, CMS will advance policies and projects that increase flexibility, improve accountability and enhance program integrity and are designed to fulfill the Medicaid program's promise to help Americans lead healthier, more fulfilling lives. As states continue to seek greater flexibility from CMS, the Scorecard will serve as an important tool in ensuring that CMS is able to collect and report on critical outcome metrics.

The Scorecard may be found at: https://www.medicaid.gov/state-overviews/scorecard/index.html

For more information, visit the fact sheet here: https://www.medicaid.gov/state-overviews/downloads/scorecard/factsheet.pdf

###

Message to Beneficiaries and Providers on Quick Response (QR) code on Some New Medicare Cards

Message for Beneficiaries:
Your New Medicare card may have a square code on the front or the back. This is a machine-readable code called a QR code. If your card has this code on it, don't worry. It's there so Medicare can make sure you get the right card.

Message for Providers:
Both CMS- and RRB-issued new Medicare cards may have a QR code on either the front or the back of the card. If you see a card with this QR code, it is a legitimate (official) Medicare card. The QR code (a type of machine-readable code) can only be read by the contractor who prints the cards to ensure the right card goes to the right person who gets Medicare or RRB benefits.

###

New Medicare Card Wave 2 Mailing Update

CMS started mailing new Medicare cards to people with Medicare who live in Wave 2 states and territories: Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, and Oregon. CMS continues to mail new cards to people who live in Wave 1 states, as well as nationwide to people who are new to Medicare.

On June 1, the Railroad Retirement Board (RRB) will mail the new RRB card to all people who get RRB benefits, nationwide.

Once people with Medicare get their new Medicare cards, they should start using them right away. Healthcare providers and suppliers can use either the former Social Security-based HICN or the new alpha-numeric Medicare Beneficiary Identifier through December 31, 2019.

To view updates, beneficiary and stakeholder resources, visit: The Outreach & education page: https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/Outreach-and-education.html

For a full list of the mailing waves, please see CMS' mailing strategy, available here: Mailing map: https://www.medicare.gov/newcard/

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.

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

CMS is committed to mailing new cards to all people with Medicare over the next year.

###

ACA/Marketplace Updates

2019 Assister Training Update

As we prepare to release the 2019 Assister Certification Training, the 2018 Assister Certification Training that is hosted on the Marketplace Learning Management System (MLMS) will be taken offline at 6:00 p.m. (EST) on Monday June 18, 2018. During this "go-dark" period, assisters will not be able to access the certification training. We anticipate that the 2019 Assister Certification Training will be available to CACs in July and to Navigators after the next round of Navigator grants are awarded to align with the grant cycle. Assisters who need to take the current training before the 2019 training is available should begin the 2018 Assister Certification training prior to June 11, 2018 to allow for enough time to complete the training before it is removed June 18th.

###

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.

###

Now Available for Public Comment: Draft 2019 CMS QRDA III Implementation Guide for Eligible Clinicians and Eligible Professionals

Visit the JIRA Website to Submit Official Comments by June 20, 2018

The draft 2019 CMS Quality Reporting Document Architecture (QRDA) Category III Implementation Guide (IG) for Eligible Clinicians and Eligible Professionals has been posted for public comment.

The public comment period starts on **May 30, 2018** and ends on **June 20, 2018**. The 2019 CMS QRDA III IG will help eligible clinicians and eligible professionals report electronic clinical quality measures (eCQMs) starting in the calendar year 2019 reporting period

How to Submit Comments

- Ticket number: QRDA-691.
- A JIRA account is required to submit a comment.
- Comments will be accepted until 5:00 p.m. ET on **June 20, 2018**.

The draft 2019 CMS QRDA III IG contains the following high-level changes/corrections as compared with the 2018 CMS QRDA III IG:

- Increased alignment with its base standard, the HL7 QRDA III STU R2.1 IG
- Now shows the template changes from the base HL7 QRDA III STU R2.1 IG only
- Updated eCQM Universally Unique Identifiers (UUIDs) for the 2019 performance period eCQMs that were released on May 4th, 2018. Please note, measures will not be eligible for 2019 reporting unless and until they are proposed and finalized through notice-and-comment rulemaking for the applicable program.
- Changes to Performance Period Reporting:
  1. Requires performance period reporting, as defined by CMS, at the level of individual measure for Quality (for MIPS) and at the level of individual activity for Improvement Activities (IA).
  2. Performance period reporting for Promoting Interoperability (formerly Advancing Care Information) will remain at the category level. For CPC+ reporting, the performance period for Quality remains at the category level.

- New CMS program name code "MIPS_VIRTUALGROUP" to support MIPS virtual group reporting

Please note, this is a draft document and the contents are subject to change. Content may change based on the Final rule and updated measure tables are anticipated post-final rule publication.

Additional QRDA-Related Resources: Additional QRDA-related resources, as well as current and past implementation guides, are found 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.

We look forward to receiving your feedback on the draft 2019 CMS QRDA III IG.

###

Quality Payment Program Exceeds Year 1 Participation Goal

By: Administrator, Seema Verma, Centers for Medicare & Medicaid Services

I'm pleased to announce that 91 percent of all clinicians eligible for the Merit-based Incentive Payment System (MIPS) participated in the first year of the Quality Payment Program (QPP) – exceeding our goal of 90 percent participation. Remarkably, the submission rates for Accountable Care Organizations and clinicians in rural practices were at 98 percent and 94 percent, respectively. What makes these numbers most exciting is the concerted efforts by clinicians, professional associations, and many others to ensure high quality care and improved outcomes for patients.

Meeting the Challenges Ahead

Even with this high rate of participation, we are committed to removing more of the regulatory burdens that get in the way of doctors and other clinicians spending time with their patients. After only eight months, we've made significant progress through our Patients over Paperwork initiative: streamlining our regulations, increasing efficiencies, and improving care for patients. At the same time, we continue to put patients first by protecting the safety of our beneficiaries and strengthening the quality of healthcare they receive.

For example, we reviewed many of the MIPS requirements and developed policies for 2018 that continue to reduce burden, add flexibility, and help clinicians spend less time on unnecessary requirements and more time with patients.

In particular we have:

- Reduced the number of clinicians that are required to participate giving them more time with their patients, not computers.
- Added new bonus points for clinicians who are in small practices, treat complex patients, or use 2015 Edition Certified Electronic Health Record Technology (CEHRT) exclusively as a means of promoting the interoperability of health information.
- Increased the opportunity for clinicians to earn a positive payment adjustment.
- Continued offering free technical assistance to clinicians in the program.

Under the Bipartisan Budget Act of 2018 we have additional authority to continue our gradual implementation of certain requirements for three more years to further reduce burden in areas of MIPS.

We're also eager to improve the clinician and patient experience through our Meaningful Measures initiative so that clinicians can spend more time providing care to their patients and improving the quality of care their patients receive. Within MIPS, we are adopting measures that improve patient outcomes and promote high-quality care, instead of focusing on processes.

Working with the Healthcare Community

We want to express our gratitude to all of the clinicians who collaborated with us as part of the voluntary Clinician Champions Program and the Clinician Voices initiative. We also want to thank all of you who participated in our various listening sessions and user groups throughout the year. Your input and feedback opened a dialogue, highlighted opportunities for improvement, and helped us identify ways to continue to reduce burden within the Quality Payment Program.

We deeply appreciate the contributions professional associations, consumer advocates and other important stakeholders have made to help engage their members and prepare them for success. We also want to acknowledge the networks supporting the free technical assistance available to clinicians, specifically the Small, Underserved, and Rural Support

initiative, Quality Innovation Networks, and the Transforming Clinical Practice Initiative, who worked tirelessly to help clinicians familiarize themselves with the program so they can successfully participate. Together with our stakeholders and technical assistance networks, we hosted over 6,000 Quality Payment Program events last year. We used these events to describe requirements, offer tips, listen to you, and act on your feedback.

And, we're proud to announce that our free technical assistance received a 99.8 percent customer satisfaction rating by over 200,000 clinicians and practice managers. The technical assistance networks also responded to 98.7 percent of initial referrals for additional support from the Quality Payment Program Service Center and Centers for Medicare & Medicaid Services (CMS) Regional Offices within 1-business day. We believe that there is an obligation to respond quickly, so clinicians can spend less time trying to figure out the program and more time with their patients.

Additionally, our Quality Payment Program Service Center complemented the technical assistance effort by fielding more than 130,000 inquiries and delivering world class customer support.

Better yet, all of the free and customized support from the technical assistance networks and the Quality Payment Program is still available to clinicians in the 2018 performance year!

Moving Forward Together

While we're proud of what has been accomplished, there is more work to be done. CMS remains committed to listening to the healthcare community and exploring ways to reduce clinician burden, strengthen quality, introduce new payment models, develop meaningful measures including for patient safety, and promote interoperability. We look forward to continuing to hearing from you to make sure that we focus on patients, not paperwork.

###

Medicare and Medicaid Updates

CMS Sends Clear Message to Plans: Stop Hiding Information from Patients

Part of the continued roll-out of American Patients First, CMS sends letter to Part D plans explaining that gag clauses that keep patients from knowing how to get the best deal are completely unacceptable

The Centers for Medicare & Medicaid Services (CMS) sent a letter to companies that provide Medicare prescription drug coverage in Part D explaining that so-called "gag clauses" are unacceptable, as part of the Administration-wide "American Patients First" initiative to lower prescription drug costs.

In Part D, Medicare pays prescription drug plans to cover medicines, which beneficiaries buy at a pharmacy. Gag clauses are provisions in contracts that insurance plans and their pharmacy benefit managers enter into with pharmacies. These clauses prevent pharmacists from telling patients when they could pay less for a drug by paying cash, instead of billing their insurance and paying the required copay or deductible.

"President Trump and Secretary Azar are committed to lowering drug prices, and CMS today took another important step to help patients who are feeling the pain," said CMS Administrator Seema Verma. "Many patients don't know that some drugs are actually more expensive when they use their insurance. What's worse is that some pharmacy benefits managers are preventing pharmacists from telling patients when this is happening, because they get a share of the transaction when the patient uses their insurance. Today we are taking a significant step towards bringing full transparency to all the back-end deals that are being made at the expense of patients."

A copy of the letter that was sent to all Part D Plan Sponsors today is included below, and to learn more about the President's blueprint to lower prescription drug costs, please visit: http://hhs.gov/drugpricing.

###

Medicare Eligible Hospitals: Submit a Hardship Exception Application by July 1, 2018

As a result of the American Recovery and Reinvestment Act of 2009, the Centers for Medicare & Medicaid Services mandates that payment adjustments be applied to Medicare eligible hospitals and critical access hospitals (CAHs) that are not meaningful users of certified electronic health record technology under the EHR Incentive Programs (now called the Promoting Interoperability (PI) Programs).

Eligible hospitals and CAHs may be exempt from Medicare penalties if they can show that demonstrating meaningful use would result in a significant hardship. To be considered for an exemption and avoid a payment adjustment, health care providers **must** complete a hardship exception application and provide proof of hardship. If approved, the hardship exception is valid for only **one** payment year.

Hardship Exception Application Details

Here are additional details for submitting the 2019 Eligible Hospital Hardship Exception Application:

- The deadline for eligible hospitals to submit application is **July 1, 2018**.
- The completed application and all support documentation must be attached to an email and sent to ehrhardship@cms.hhs.gov.
- All hardship exception determinations will be returned via email from ehrhardship@cms.hhs.gov to the email address provided on the application.

For more information about payment adjustments and hardship information, click here. For more information on the PI Programs, visit the PI Programs landing page.

###

Extension of Equitable Relief

CMS continues to offer assistance for certain individuals who have premium-free Medicare Part A and are currently, or were previously, dually-enrolled in both Medicare and the Health Insurance Exchange for individuals and families. We wanted to share that CMS has expanded the equitable relief to include certain individuals who could have enrolled in

Medicare Part B, but did not do so during their Special Enrollment Period. The relief will be considered on a case-by-case basis.

Eligible individuals still have until September 30, 2018 to request enrollment in Part B without penalty or to request to have their Part B late enrollment penalty reduced.

This assistance will be considered on a case-by-case basis for current or previously dually-enrolled beneficiaries. Attached is a tip sheet outlining the details of this assistance, information about who is eligible, and how to request it.

Individuals who believe they are eligible for this assistance should contact Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) no later than September 30, 2018.

###

Assistance for Individuals with Medicare Part A and Exchange Coverage Information for SHIPs and Exchange Assisters

CMS is offering assistance to Medicare beneficiaries currently enrolled in Medicare Part A and the individual market health insurance Exchange (also referred to as the Marketplace) for individuals or families. This assistance does not apply to individuals enrolled through a small business health options Exchange through their employer (also referred to as SHOP). This assistance provides eligible individuals with an opportunity to enroll in Medicare Part B without incurring penalties that would otherwise apply.

Further, CMS is offering assistance to eligible individuals who were dually enrolled in Medicare Part A and the Exchange and subsequently enrolled in Part B with a penalty. This assistance provides these individuals an opportunity to request a reduction in their Part B late enrollment penalty. CMS is offering this assistance through September 30, 2018.

What's New: CMS is expanding the assistance to include certain individuals who could have enrolled in Part B during their special enrollment period (SEP), but chose Exchange coverage instead of Part B. This tip sheet explains the assistance, eligibility criteria and steps for Medicare beneficiaries if they want to enroll in Part B or request a penalty reduction.

Q1. Why is CMS offering this assistance?
Coverage under Medicare Part A (including those who elect coverage through Part C/Medicare Advantage) meets the legal requirement for minimum essential coverage, sometimes called qualifying health coverage (QHC). Thus, individuals with Part A are not eligible to receive premium and cost-sharing assistance (often referred to as advanced payments of the premium tax credit (APTC) or income-based cost-sharing reductions (CSRs)) to help pay for an Exchange plan premium and covered services to make the costs of an Exchange plan more affordable. Individuals receiving ATPC while dually-enrolled in the Exchange and Medicare may have to pay back all or some of the APTC received for months an individual was enrolled in both Exchange coverage with APTC and Medicare Part A when they file their federal income tax return.

Some people may have had coverage through the Exchange (and possibly receiving APTC or CSRs) before being eligible for Medicare. When first eligible for Medicare, these individuals may have refused or dropped Part B coverage because the costs for Exchange coverage was more affordable than Part B, and they believed they were (or continue to be) eligible for APTC and CSRs.

In addition, some people with Part A coverage may have enrolled in the Exchange believing it was an alternative way to get medical coverage equivalent to Part B at a more affordable cost. These individuals may not have found out they enrolled in the wrong program prior to the end of their Medicare Initial Enrollment Period (IEP) or Part B Special Enrollment Period (SEP) for the working aged or disabled, resulting in them either 1) staying in their Exchange plan because of the more affordable cost for that coverage; or 2) enrolling in Part B during the Medicare General Enrollment Period (GEP) and being assessed a Part B late enrollment penalty.

CMS believes that these individuals did not receive the information necessary at the time of their Medicare IEP, Part B SEP for the working aged or disabled, or initial enrollment in the Exchange to make an informed decision regarding their Part B enrollment.

Q2. What is the assistance/equitable relief?
CMS is offering assistance to certain individuals enrolled in both Medicare Part A (and/or Part C) and the Exchange for individuals and families to drop their Exchange coverage and enroll in Part B without penalty. Further, CMS is offering

assistance to certain individuals who dropped or lost their coverage from the Exchange and are paying a Part B late enrollment penalty from their subsequent enrollment into Part B. These eligible individuals can have their penalty reduced. Individuals can apply for the special enrollment and reduction in late enrollment penalties during a limited time – it is available now and ends September 30, 2018.

Q3. Who is eligible for the assistance?
Eligible individuals are individuals who could have enrolled in Medicare Part B, but did not do so during their Medicare IEP or Part B SEP for the working aged or disabled, and currently are or were enrolled in the Exchange for individuals or families. To be eligible for the assistance, the individual must:

- Have an IEP that began April 1, 2013 or later; or
- Have an Part B SEP that ended October 1, 2013 or later; or
- Have been notified of retroactive free Part A on October 1, 2013 or later.

To be eligible for the opportunity to enroll in Part B, the individual must currently have premium- free Medicare Part A and not be enrolled in Part B. To be eligible for the penalty reduction, the individual must be assessed a Part B late enrollment penalty from enrolling in the 2015, 2016, 2017, or 2018 GEP. In some instances, the penalty may be eliminated.

Individuals must request the assistance and provide documentation showing enrollment in the Exchange for individuals and families. Only individuals who are eligible for Medicare can enroll in Medicare.

Notes:

- Individuals who received the CMS notice regarding their dual enrollment may be eligible for this assistance, even if they enrolled in the 2015, 2016, 2017, or 2018GEP. The eligibility criteria outlined above must be met.
- Individuals currently in their IEP or Part B SEP for the working aged or disabled are not eligible for this assistance as they can currently enroll in Part B without a late enrollment penalty. This assistance cannot change the Part B coverage start date for individuals in their IEP or Part B SEP.
- Individuals enrolled in an Exchange SHOP plan are not eligible for this assistance, as they have employer-sponsored group health plan coverage and have a statutory special enrollment period (SEP) available to them to obtain Part B coverage without penalty.
- •Individuals paying a premium for Part A are not eligible for this assistance because they are required by law to also be enrolled in Part B. These individuals can choose to terminate their premium Part A coverage and get their coverage from the Exchange (with APTC and income-based CSRs, if eligible for that program).

Q4. Why can't people whose IEP started on or before March 1, 2013 get the assistance? These individuals are not eligible for the assistance because the Exchange (and related subsidies) weren't available to them during their IEP nor a factor in their decision to refuse or drop Part B coverage.

Q5. Why can't people whose Part B SEP for the working aged of disabled ended on or before September 30, 2013 get the assistance?
These individuals are not eligible for the assistance because the Exchange (and related subsidies) weren't available to them during their Part B SEP for the working aged or disabled nor a factor in their decision to refuse of drop Part B.

Q6. Does the assistance apply to people with Medicare based on age and other reasons, such as disability?
Yes. The basis for an individual getting Medicare isn't a criterion for this assistance.

Q7. What type of documentation does the person need to provide?
To be eligible for this assistance, individuals must show documentation reflecting their enrollment in the Exchange for individuals or families. Acceptable documentation includes:

- A periodic data match (PDM) notice mailed to dually-enrolled beneficiaries (those enrolled in both Medicare and an individual Exchange plan);
- An Exchange eligibility determination notice (can be accessed via the consumer's Exchange Account);
- IRS Form 1095-A that demonstrates months of coverage and/or subsidy amounts;
- Exchange premium invoices;
- Receipt of premium binder payment effectuating Exchange enrollment; or
- Other documentation that clearly reflects the person was enrolled in the Exchange for individuals or families.

In addition, individuals who enrolled in the Exchange instead of Part B during their SEP will also need to provide evidence of group health plan (GHP) coverage based on current employment via Form CMS-L564 (Request for Employment Information).

Q8. How long is the offer of assistance available?

The assistance is available now through September 30, 2018. To be eligible for the assistance, individuals must request it by September 30, 2018.

Q9. Why is CMS offering this assistance?
CMS continues to believe that many individuals did not receive the information necessary at the time of their Medicare IEP, Part B SEP for the working aged or disabled, or initial enrollment in the Exchange to make an informed decision regarding their Part B enrollment. As a result, many individuals refused or dropped Part B. To address these underlying issues, we are extending this offer of relief until September 30, 2018.

Q10. Why is CMS expanding the offer of assistance?
CMS is expanding the offer of assistance to ensure equitable treatment for beneficiaries who could have enrolled in Part B during their SEP for the working aged or disabled, but erroneously chose Exchange coverage instead of Part B.

Q11. If someone enrolls in Part B through this assistance, when will coverage begin?
For most individuals, Part B coverage will begin the month the individual enrolls. To ensure there are no gaps in coverage, we encourage individuals to enroll in Part B using this assistance first, and continue Exchange coverage until they are notified of their confirmed Part B enrollment.

Some people who received the CMS notice in summer 2016 dropped their APTC, but remained in the Exchange. These individuals may have found their Exchange plan premiums unaffordable without that premium tax credit assistance and may have been terminated from their Exchange coverage for non-payment of premiums. Per Exchange disenrollment rules, these individuals could lose their Exchange coverage with up to two months of retroactivity. Thus, those individuals have the option to request that Part B coverage start two months back from when they complete their request. Premiums must be paid for all months of Part B coverage, even if retroactive.

Q12. Will people be notified of the offer for assistance?
In June 2017, CMS mailed a notice to all beneficiaries entitled to Medicare Part A who were also enrolled in an individual market qualified health plan in an Exchange using the federal eligibility and enrollment platform, and with or without subsidies. In addition to information about the loss of eligibility for APTC, this notice advised beneficiaries that they may be able to enroll in Part B without penalty or having to wait for the GEP. Likewise, in March 2018, CMS mailed a notice to these dually-enrolled beneficiaries conveying similar information, and advising individuals with Part B coverage that they may be able to have their late enrollment penalty reduced.

In summer 2018, CMS plans to send additional notices to individuals receiving financial assistance (i.e., APTC) enrolled in both Medicare Part A and the Federally-facilitated Exchange. The future notices will also include the offer of assistance, so that these individuals can enroll in Part B without penalty.

Individuals who already terminated their Exchange coverage and enrolled in Part B with a penalty will not be notified at this time.

Q13. What should people do to take advantage of this offer for assistance?
Individuals who were notified or believe they are eligible for the assistance should contact Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) or visit their local Social Security office and request to take advantage of the offer of assistance. They can ask for "equitable relief" when they make their request for Medicare Part B enrollment or penalty removal. Individuals should mention that they were dually enrolled in Medicare free Part A and the Exchange and provide the information listed above.

Individuals requesting to enroll in Part B should complete a Part B enrollment form (Form CMS-40B) available online on Medicare.gov, CMS.gov and SSA.gov. They can complete this form and take it to Social Security with them when they request the assistance.

Individuals who didn't enroll in Part B during their SEP working aged or disabled also need to show evidence of group health plan (GHP) coverage based on current employment via Form CMS-L564 (Request for Employment Information). Individuals requesting penalty reduction should mention this assistance (equitable relief) when they visit Social Security. ALL individuals must bring their documentation of Exchange enrollment and provide it to Social Security when making their request.

To request this assistance, individuals can:
- Call SSA at 1-800-772-1213 (TTY users should call 1-800-325-0778); or
- Visit SSA.gov to find a local Social Security office

Q14. Will people who drop Exchange coverage or enroll in Part B get an SEP to enroll in Part C or Part D?
Yes. Individuals have an SEP to enroll in a Medicare Advantage plan (with or without prescription drug coverage) when they are notified by SSA confirming their Part B enrollment. Because the equitable relief provides for an effective date to be the month of application or retroactive up to two months, notification of the Part B enrollment will occur after the Part B coverage starts. As such, this SEP begins the month the individual receives notice of the Part B enrollment confirmation and ends two months later. The effective date of coverage for this SEP depends on the individual's situation, but it may be retroactive back to the first day of the month in which the individual received the notice from SSA.
Individuals who decide to not enroll in a Medicare Advantage plan with prescription drug coverage should enroll in a stand-alone Medicare Part D plan if they don't have another form of creditable prescription drug coverage. Individuals also have an SEP to enroll in Part D. The SEP begins the month in which the Exchange coverage terminates and ends two months later. The effective date of coverage for this SEP is the first of the month after the plan receives the enrollment request. Prescription drug coverage offered by Exchange plans may be considered creditable coverage. Individuals should verify whether the coverage they have through their Exchange plan is creditable. If the Exchange plan coverage is creditable, individuals should include their dates of coverage under the Exchange as creditable coverage, if asked by the plan, so that the months the person had prescription drug coverage in the Exchange are not counted towards any possible assessment of a Part D late enrollment penalty.

As individuals will be assessed a Part D late enrollment penalty if they go without Part D or other creditable coverage for 63 days or more, we encourage individuals to enroll in a Part D plan (either a stand-alone Part D plan or a Medicare health plan with Part D coverage) as soon as they drop their Exchange coverage.

To find Medicare health and prescription drug plans offered in your area, visit Medicare.gov/find-a-plan.

Q15: What if people have problems affording the monthly Medicare premiums?
A13: If consumers have limited income and resources, they may qualify for help paying their Medicare costs. The Medicare Savings Programs help pay for Medicare Part A and B costs. Consumers apply through their State Medicaid Offices.
Extra Help helps pay for Medicare prescription drug coverage (Part D). Some consumers automatically receive Extra Help -- those with Medicaid, the Medicare Savings Programs, or Supplemental Security Income. All others must complete an application at Social Security (https://secure.ssa.gov/i1020/start)

Q16. How can I help?
CMS encourages SHIPs and Exchange Navigators to share the availability of this offer of assistance with Medicare-eligible individuals you assist.

- Encourage individuals with Medicare free Part A to enroll in Part B;
- Remind individuals to enroll in Part D if they do not have another form of creditable coverage; and
- Advise individuals soon to be eligible for Medicare of the need to drop Exchange and enroll in Medicare during their IEP.

All these items will help individuals make informed decisions regarding their healthcare coverage.

For more information:
- Go to https://marketplace.cms.gov/applications-and-forms/notices.html and scroll to the section called "Periodic Data Matching Notices" for a sample of the notice.
- See examples of other documentation to show enrollment in the Exchange for individuals and families.

###

Update to the Required Prior Authorization List of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items That Require Prior Authorization as a Condition of Payment (CMS-6080-N)

The Centers for Medicare & Medicaid Services (CMS) announced the addition of 31 Healthcare Common Procedure Coding System (HCPCS) codes to the Required Prior Authorization List of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items that require prior authorization as a condition of payment beginning nationwide on September 1, 2018. The Healthcare Common Procedure Coding System (HCPCS) codes added to the list are currently included in the Prior Authorization of Power Mobility Devices (PMDs) Demonstration, which is scheduled to end on August 31, 2018.

Click here to view at the *Federal Register*: https://www.federalregister.gov/documents/2018/06/05/2018-11953/medicare-program-update-to-the-required-prior-authorization-list-of-durable-medical-equipment

For additional information click here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html

###

CMS leverages Medicaid Program to combat the Opioid crisis

States provided guidance in designing treatment options for Opioid Epidemic

The Centers for Medicare & Medicaid Services CMS released guidance aimed at building on our commitment to partner with states to ensure that they have flexibilities and the tools necessary to combat the opioid crisis. This new guidance provides information to states on the tools available to them, describes the types of approaches they can use to combat this crisis, ensures states know what resources are available, and articulates promising practices for addressing the needs of beneficiaries facing opioid addiction. Notably, CMS released an Informational Bulletin that provides states with information they can use when designing approaches to covering critical treatment services for Medicaid eligible infants with Neonatal Abstinence Syndrome (NAS). Additionally, CMS issued a letter to states on how they may best use federal funding to enhance Medicaid technology to combat drug addiction and the opioid crisis.

"The number of American infants born dependent on opioids each day is heartbreaking," said HHS Secretary Alex Azar. "Today's announcement reflects the Trump Administration and HHS's commitment to helping states use Medicaid to support treatment for this condition and other challenges produced by our country's crisis of opioid addiction. State-level innovation, including in the use of prescription drug monitoring programs and electronic health records, has been and will be a key piece of ending this crisis."

Addressing Neonatal Abstinence Syndrome

Medicaid services can play a critical role in helping ensure access to treatment for these vulnerable infants who have Neonatal Abstinence Syndrome (NAS). Neonatal Abstinence Syndrome (NAS) is a postnatal drug withdrawal syndrome that occurs primarily among opioid-exposed infants shortly after birth. Experts consider NAS to be an expected and treatable result of women's prenatal opioid or other substance use, although long term ramifications for the infants are still unknown. As of 2012, there was an average of one infant born with NAS every 25 minutes in the United States and roughly 80 percent of infants treated for NAS receive their care through Medicaid.

"NAS is a significant and rapidly growing public health concern," said Tim Hill, Acting Director for the Center for Medicaid and CHIP Services. "The number of infants born with a diagnosis of NAS is increasing significantly. This rapid growth is directly related to the opioid crisis facing this country. Through discussions with states, we have recognized their growing challenge in providing treatment services to the expanding number of infants with NAS. We have also recognized that states may not be fully aware of available options under Medicaid that can play a critical role in the care of these infants, as well as the limitations on Medicaid coverage."

Appropriate treatment using the best evidence-based practices can help these infants withdraw from opioids and other substances and lead healthier lives. NAS treatment may occur not only in hospitals, but also in other settings. In addition to Medicaid-covered treatment for infants, it is important for states to involve mothers and other caregivers in the infant's care, as appropriate. The use of interventions like swaddling, quiet environments, little stimulation, skin-to-skin contact, and other environmental approaches are critical first line care for these infants.

States may also seek to cover initial or ongoing SUD treatment services for Medicaid-eligible mothers and/or fathers concurrently with NAS treatment services directed at the infant. Services that begin at this critical time, and continue to follow and support the infant and caregiver when the infant returns home, provide the highest likelihood for optimal health status and positive outcomes for infants born with NAS. Medicaid services can play a critical role in helping ensure access to treatment for these vulnerable infants and their families.

Enhancing Medicaid Technology

The opioid technology guidance advises states on which funding authorities may support health information technology efforts that could be used for the prevention and treatment of negative opioid outcomes.

The guidance falls in line with the President's Commission on Combating Drug Addiction and the Opioid Crisis final report released on November 1, 2017. Specifically, this report singles out telemedicine and prescription monitoring tools as useful in the effort to combat the opioid crisis.

States may access enhanced federal funding to integrate innovative substance abuse treatment in areas facing provider shortages, particularly in rural areas, such as virtual treatment centers or remote counseling, into Medicaid care coordination technologies. The letter also describes how states can draw federal support for shared electronic care plans, which allows patients and providers to view and update a shared care plan describing goals for pain management regimens and counseling, and could complement Medication Assisted Therapy (MAT).

Support for Patient-facing technology in the form of apps and remote monitoring technology is also mentioned as possible state technology investments eligible for funding. Further, states may reduce provider burden by creating a single sign-on interoperability between Electronic Health Records (EHRs) and prescription drug monitoring programs, allowing physicians to e-prescribe in the same platform where electronic health records are held.

Enhanced technologies, which might support the development of public health surveillance, may also be developed that can help strengthen the understanding of the crisis through better public health data and reporting. Most notably, the letter describes how states might draw federal financing to support recommendations from the President's Commission final report, such as integrating prescription drug monitoring systems data into EHRs and supporting interstate data sharing and electronic prescribing of controlled substances. In addition, the letter shows how states might use systems and funding to support advanced analytics for those looking to leverage data sources to create prediction models of patients at risk for opioid dependency and connect them with appropriate case management.

"Today's guidance further builds on CMS' commitment to provide states with the tools and approaches available within the Medicaid program to accelerate states' ability to respond to the national opioid crisis" said Hill, "By leveraging and improving the technological capabilities of state Medicaid programs, we are providing Medicaid agencies, providers, and patients with the tools they need to improve health outcomes associated with addiction."

Both sets of guidance compliment a State Medicaid Director (SMD) letter, "Strategies to Address the Opioid Epidemic" (SMD 17-003), issued on November 1, 2017 that outlines state flexibility in addressing the opioid crisis via demonstration projects under section 1115 of the Social Security Act. There are a number of ways technology might support those efforts, but a state need not be participating in a section 1115 demonstration project to take advantage of the enhanced federal funding opportunities described in today's SMD. To date, CMS has approved SUD-related section 1115 demonstration projects in Louisiana, West Virginia, Indiana, New Jersey, Kentucky, Utah, Illinois, and Vermont to allow these states to improve access to the full spectrum of quality SUD care and treatment for Medicaid beneficiaries.

For more information regarding the Neonatal Abstinence Syndrome Informational Bulletin please visit https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf

For more information on the Medicaid Technology Letter please visit https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf

###

Declines in Hospital-Acquired Conditions Save 8,000 Lives and $2.9 Billion in Costs

National efforts to improve patient safety showing continued progress

Data released by the Agency for Healthcare Research and Quality (AHRQ) show continued progress in improving patient safety, a signal that initiatives led by the Centers for Medicare & Medicaid Services (CMS) are helping to make care safer. National efforts to reduce hospital-acquired conditions, such as adverse drug events and injuries from falls helped prevent an estimated 8,000 deaths and save $2.9 billion between 2014 and 2016, according to the report.

The *AHRQ National Scorecard on Hospital-Acquired Conditions* estimates that 350,000 hospital-acquired conditions were avoided and the rate was reduced by 8 percent from 2014 to 2016. Federal experts note that the gains in safety among hospital patients echoed earlier successes, including 2.1 million hospital-acquired conditions avoided between 2010 and 2014.

CMS has set a goal of reducing hospital-acquired conditions by 20 percent from 2014 through 2019. Through the work of the Hospital Improvement Innovation Networks (HIINs), CMS drives this aim through intensive, focused quality improvement assistance to more than 4,000 of the nation's 5,000 hospitals by spreading best practices in harm reduction. The HIINs,

together with federal agencies, private partners and patient advocacy organizations work collaboratively to make hospital care safer. Once the 20 percent reduction goal is met, AHRQ projects that during 2015 through 2019 there would be 1.8 million fewer patients with hospital-acquired conditions, resulting in 53,000 fewer deaths and saving $19.1 billion in hospital costs from 2015 through 2019.

Examples of hospital-acquired conditions include adverse drug events, catheter-associated urinary tract infections, central-line associated bloodstream infections, pressure injuries, and surgical site infections, among others.

"Today's results show that this is a tremendous accomplishment by America's hospitals in delivering high-quality, affordable healthcare," said CMS Administrator Seema Verma. "CMS is committed to moving the healthcare system to one that improves quality and fosters innovation while reducing administrative burden and lowering costs. This work could not be accomplished without the concerted effort of our many hospital, patient, provider, private, and federal partners—all working together to ensure the best possible care by protecting patients from harm and making care safer."

To that end, CMS supports multiple programs and initiatives focused on making care safer. Among them are the Quality Improvement Network – Quality Improvement Organizations (QIN-QIOs), activities of the HIINs, and the ESRD (End Stage Renal Disease) Network Program. These networks provide direct technical assistance and support the spread of evidence-based best practices to reduce HACs via systematic quality improvement work.

AHRQ analyzes data on these conditions and calculates rates to help HHS track efforts to reduce patient harm by 20 percent from 2014 to 2019.

"Estimates in the new National Scorecard identify important goals for ongoing efforts to protect patients," said AHRQ Director Gopal Khanna, MBA. "These data not only help us track how we're doing, but they help us set the target for where we need to go. We continue to work with HHS and others to develop tools and resources hospitals and clinicians can use to reach those goals."

Updated estimates in AHRQ's new National Scorecard were based on a new, expanded population set of hospital patients and were calculated despite recent changes in medical coding. In addition to developing this measurement strategy, AHRQ developed many of the tools used by hospitals to reduce hospital-acquired conditions.

Data in the new National Scorecard showed that overall harms decreased in several categories, such as infections and adverse drug events, which dropped 15 percent from 2014—2016. Opportunities for further improvement exist for reducing some harms, such as pressure injuries (pressure ulcers), which increased from 2014—2016.

The newly measured declines in hospital-acquired conditions parallel earlier gains. Hospital-acquired conditions overall dropped 17 percent from 2010 to 2014, saving $19.9 billion in health care costs and preventing 87,000 deaths. Preliminary data for 2017 are expected within the next year to determine if the reductions seen in 2014—2016 have continued.

The HHS agencies will continue their support of front-line providers in furthering these promising results—improving patient safety and reducing healthcare costs while helping providers deliver the best, safest possible care to patients.

To view the AHRQ report, please visit: https://www.ahrq.gov/professionals/quality-patient-safety/pfp/index.html

For a fact sheet on CMS-led patient safety efforts, please visit:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-06-05.html

###

LTCH/IRF Provider Preview Reports- Now Available

Long-term Care Hospital (LTCH) and Inpatient Rehabilitation Facility (IRF) Provider Preview Reports have been updated and are now available. Providers have until June 30, 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.

New LTCH Assessment-based measures:

- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)

New LTCH Claims-based measures:

- Medicare Spending Per Beneficiary-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
- Discharge to Community- Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
- Potentially Preventable 30-Days Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

New IRF Assessment-based measures:

- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)

New IRF Claims-based measures:

- Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP
- Discharge to Community–PAC IRF QRP
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP
- Potentially Preventable Within Stay Readmission Measure

The update also includes the removal of the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals measure and the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Inpatient Rehabilitation Facilities measure.

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

###

LTCH & IRF Compare Refresh Now Available

The June 2018 quarterly Long-term Care Hospital (LTCH) and Inpatient Rehabilitation Facility (IRF) Compare refresh, including quality measure results based on data submitted to CMS between Q3 2016 – Q2 2017, is now available. We invite you to visit LTCH Compare and IRF Compare to view the data.

For more information, view the CMS LTCH Quality Public Reporting and CMS IRF Quality Public Reporting webpage.

###

Upcoming Webinars and Events and Other Updates

Join CMS for a Webinar to Learn More about the MIPS Promoting Interoperability Performance Category

Tuesday, June 12, 2018, 1:00 – 2:00 p.m. ET
Registration Link: https://engage.vevent.com/index.jsp?eid=3536&seid=1111

CMS is hosting a webinar on **Tuesday, June 12 at 1:00 PM ET** to provide information about the Promoting Interoperability (PI) performance category (formerly the Advancing Care Information performance category) of the Merit-based Incentive Payment System (MIPS).

During the webinar, CMS subject matter experts will:

- Provide a brief overview of MIPS requirements in 2018
- Discuss the renaming of the PI performance category
- Explain the PI performance category requirements for 2018
- Review PI scoring
- Address questions from participants at the end of the webinar, as time allows.

The audio portion of this webinar will be broadcast through the web. You can listen to the presentation through your computer speakers. CMS will open the phone line for the Q&A portion. If you cannot hear audio through your computer speakers, please contact CMSQualityTeam@ketchum.com.

###

Join CMS for a Webinar Focused on Quality Measures

Wednesday, June 13, 2018; 12:00-1:00pm ET and Thursday, June 14, 2018; 4:00-5:00pm ET

Registration Links: June 13; 12:00-1:00pm, ET
https://battellemacra.webex.com/battellemacra/onstage/g.php?MTID=ea6790ccacf388df754e44783d623fc7f

June 14th; 4:00-5:00pm, ET
https://battellemacra.webex.com/battellemacra/onstage/g.php?MTID=eeb8a20586920854654d3d5a73bbdedba

We are committed to improving quality, safety, accessibility, and affordability of healthcare for all and excited to offer an opportunity to learn more about quality measures.

On **June 13, from 12:00-1:00pm, ET**, CMS will host the second webinar, of a two-part series, that covers an introduction to quality measures, overview of the measure development process, and how providers, patients, and families can be involved. If you are unable to attend during this time, the same session will be offered again on **June 14, from 4:00-5:00 pm, ET.** CMS is looking for your feedback and participation in the quality measure community, so please join us during the webinar to hear updates and how you can be a part of the process!

Please note that the two opportunities listed are for the same session; we ask that you only register for one of the sessions.

###

Join CMS for a QCDR Measures Workgroup

Thursday, June 14, 2018, 2:00-4:00 p.m. ET
Registration Link: To register for the webinar, enter your email information at the bottom of this page.
Audience: Current and Prospective Qualified Clinical Data Registries

On **Thursday, June 14, 2018 at 2:00 p.m. ET**, CMS will host a webinar that will provide an overview of the development, criteria, and evaluation of QCDR measures. Among the topics to be presented during the webinar, CMS will provide information regarding:

- How to identify meaningful quality actions (numerators)

- How to construct QCDR measures that will align with the goals and priorities of the Merit-based Incentive Payment System (MIPS) program
- How to understand the structure of multi-strata measures
- How to appropriately apply measure analytics
- Provide an opportunity to ask questions

The audio portion of this webinar will be broadcast through the web. You can listen to the presentation through your computer speakers. If you cannot hear audio through your computer speakers, please contact CMSQualityTeam@ketchum.com. Phone lines will be available for the Q&A portion of the webinar.

###

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.

###

Rural Communities Opioid Response Funding Opportunity/HRSA-18-116

HRSA's Federal Office of Rural Health Policy plans to award up to 75 grants to rural communities as part of a new Rural Communities Opioid Response initiative that will support treatment for, and prevention of, substance use disorder with a focus on the 220 counties identified by the Centers for Disease Control and Prevention (CDC) as being at risk, as well as other high risk rural communities. It is anticipated the Notice of Funding Opportunity will be available on Grants.gov later this Spring 2018.

###

Direct Services for Survivors of Torture/HHS-2018-ACF-ORR-ZT-1356

The Office of Refugee Resettlement (ORR) within the Administration for Children and Families (ACF) announces the availability of funds for the fiscal year 2018 Direct Services for Survivors of Torture (DS SOT) grant program. The purpose of the DS SOT program is to increase access to strengths-based, trauma-informed services for survivors of torture and their families to assist them in the healing and recovery process. All of these services are provided directly by the grantee and/or indirectly through partner organizations or affiliates. Read here to learn more.

###

Sexual Risk Avoidance Education (SRAE) Program/HHS-2018-ACF-ACYF-SR-1358

The goals of SRAE program are to empower participants to make healthy decisions, and provide tools and resources to prevent pregnancy, STIs, and youth engagement in other risky behaviors. Read here to learn more about this grant opporutunity.

###

Basic Center Program/ HHS-2018-ACF-ACYF-CY-1354

The Basic Center Program (BCP) works to establish or strengthen community-based programs that meet the immediate needs of runaway and homeless youth up to 18 years of age and their families. BCPs provide youth with emergency shelter,

food, clothing, counseling and referrals for health care. Basic centers can provide temporary shelter for up to 21 days for youth and seeks to reunite young people with their families, whenever possible, or to locate appropriate alternative placements. Additional services may include: street-based services, home-based services for families with youth at risk of separation from the family, and drug abuse education and prevention services. Read here to learn more.

###

HHS Partnership Center Resources on the Opioid Epidemic

Educational Webinars: The HHS Partnership Center's YouTube® channel (http://bit.ly/CFBNP-YouTube)

Updated Toolkit for download: http://bit.ly/Opioid-Toolkit

Opioid Epidemic Practical Toolkit: Helping Faith and Community Leaders Bring Hope and Healing to Our Communities : This toolkit, developed by The Partnership Center, contains practical steps your organization can take to bring hope and healing to the millions suffering the consequences of opioid use disorder.

Medicare Learning Network

News & Announcements

- New Medicare Card: MBI Look-up Tool Available through your MAC
- Declines in Hospital-Acquired Conditions Save 8,000 Lives and $2.9 Billion
- 2017 Quality Payment Program Year 1 Submission Results
- DMEPOS Prior Authorization List Additions
- Draft QRDA III Implementation Guide: Submit Comments by June 20
- IRF and LTCH Provider Preview Reports: Review Your Data by June 30
- SNF Provider Preview Report: Review Your Data by June 30
- Hospice Provider Preview Reports: Review Your Data by June 30
- Eligible Hospitals: Submit a Hardship Exception Application by July 1
- PEPPER for Short-term Acute Care Hospitals
- View Your MIPS Preliminary Performance Feedback Data
- Physician Compare Downloadable Database: 2016 Performance Scores
- New Medicare Card Project — Card Mailing Update
- 2016 Physician and Other Supplier PUF
- 2016 Referring Provider DMEPOS PUF
- MIPS Promoting Interoperability Performance Category
- Proposals for New Measures for Promoting Interoperability Program: Deadline June 29
- Targeted Probe and Educate Video
- Hospice Compare Quarterly Refresh
- CQM Annual Update
- Break Free from Osteoporosis

Provider Compliance

- Bill Correctly for Device Replacement Procedures — Reminder
- Provider Minute Video: The Importance of Proper Documentation
- Medicare Hospital Claims: Avoid Coding Errors — Reminder

Claims, Pricers & Codes

- July 2018 Average Sales Price Files
- FY 2019 ICD-10-PCS Procedure Codes

Upcoming Events

- MIPS Promoting Interoperability Performance Category Webinar — June 12

- IMPACT Act: Frequently Asked Questions Call — June 21 MIPS Promoting Interoperability Performance Category Webinar — June 12
- CMS Quality Measures: Development, Implementation, and You Webinar — June 13 or 14
- Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
- IMPACT Act: Frequently Asked Questions Call — June 21
- Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
- Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28
- Comparative Billing Report on Knee Orthoses Referring Providers Webinar — July 11

Medicare Learning Network® Publications & Multimedia

- New Q Code for In-Line Cartridge Containing Digestive Enzyme(s) MLN Matters Article — New
- July 2018 Update of the Ambulatory Surgical Center Payment System MLN Matters Article — New
- Claim Status Category and Claim Status Codes Update MLN Matters Article — New
- Settlement Conference Facilitation Call: Audio Recording and Transcript — New
- E/M Service Documentation Provided by Students MLN Matters Article — Revised
- New Medicare Beneficiary Identifier: Get It, Use It MLN Matters Article — New
- Quarterly Update to the Medicare Physician Fee Schedule Database MLN Matters Article — New
- Quarterly Update for the DMEPOS CBP MLN Matters Article — New
- Quarterly ASP Part B Drug Pricing Files and Revisions to Prior Files MLN Matters Article — New
- MCReF System Webcast: Video Presentation — New
- Quality Payment Program Call: Audio Recording and Transcript — New
- Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients MLN Matters Article — Revised
- RARC, CARC, MREP, and PC Print Update MLN Matters Article — New
- Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE MLN Matters Article — New
- Removal of KH Modifier from Capped Rental Items MLN Matters Article — Revised
- Changes to the ESRD Claim to Accommodate Dialysis Furnished to Beneficiaries with AKI MLN Matters Article — Revised
- World of Medicare Web-Based Training Course — Revised
- Your Office in the World of Medicare Web-Based Training Course — Revised
- Your Institution in the World of Medicare Web-Based Training Course — Revised

###

World of Medicare Web-Based Training Course — Revised

With Continuing Education Credit

A revised World of Medicare Web-Based Training course is available through the Learning Management System. Learn about:

- Fundamentals of the program
- Parts A, B, C, and D
- Beneficiary health insurance options

###

Your Office in the World of Medicare Web-Based Training Course — Revised

With Continuing Education Credit

A revised Your Office in the World of Medicare Web-Based Training course is available through the Learning Management System. Learn about:

- Impact of regulations, Medicare policies, and Federal law on office practices
- How to locate forms and resources related to different provider types

###

Your Institution in the World of Medicare Web-Based Training Course — Revised

With Continuing Education Credit

A revised Your Institution in the World of Medicare Web-Based Training course is available through the Learning Management System. Learn about:

- Beneficiary health insurance options
- Eligibility and enrollment
- How Medigap and Medicaid work with the Medicare Program

###

Intimate Partner Violence Toolkit

Widely regarded as a private issue, Intimate Partner Violence (IPV) has an enormous impact on the broader public: raising incidence of chronic disease, reducing worker productivity and driving up health care costs – more than $8 billion in clinical, physical and mental health care services. In September 2017, the Health Resources and Services Administration (HRSA) launched *The HRSA Strategy to Address Intimate Partner Violence*, an agency-wide initiative to integrate IPV screening and prevention into key programs through coordinated action and activities spanning from 2017-2020.

The strategy includes a step-by-step IPV Toolkit tailored for HRSA grantees and other providers by the nonprofit Futures Without Violence. Using the Toolkit, healthcare providers and social service organizations can build partnerships, adopt evidence-based interventions, promote patient education around IPV, and enhance practice policies, procedures, and capacities to improve long-term health and safety outcomes for women and their families.

The IPV Toolkit can be used to build a comprehensive and sustainable response to IPV in your healthcare setting, in partnership with social service organizations.

###

School-Based Telehealth Networks: Lessons from the Field

Thursday, June 21, 2018 / 2pm – 3pm EDT

The Health Resources and Services Administration's (HRSA) Mid-Atlantic Telehealth Resource Center is hosting a free webinar featuring experts that have developed telehealth-enabled school health centers in rural communities. These health centers are providing telehealth services for rural children that focus on asthma, obesity reduction and prevention, behavioral health, diabetes, and oral health. During this webinar, you will hear about the successes, challenges, and lessons learned from their HRSA-supported telehealth network grant project.

Registration is available here. For more information, contact Carlos Mena at cmena@hrsa.gov

This webinar is part of HRSA's Telehealth Learning Webinar Series. The series' goal is to highlight successful projects/best practices as well as resources to promote and further the use of telehealth technologies for health care delivery, education, and health information services.

We look forward to your participation!

###

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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.