CMS Region 7 Updates – 10/05/2018

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New Medicare Card Updates

New Medicare Card: MBI on Remittance Advice October 1

For Remittance Advices generated after October 1 through the end of the transition period, CMS will return both the new Medicare Beneficiary Identifier (MBI) and Health Insurance Claim Number (HICN) when you submit a claim with a valid and active HICN. We will report the MBI in the same place you get the "changed HICN" today. You can also get the MBI by asking your patients for their new Medicare card or using your Medicare Administrative Contractor's MBI look up tool through their portal; sign up if you do not have access.

To ensure your Medicare patients continue to get care, you can use either the HICN or MBI for all Medicare transactions through December 31, 2019.

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New Medicare Card: Replacement Card

If your patients accidentally threw away their new Medicare card, ask them to call 1-800-MEDICARE and request a replacement. Your patients can also sign into MyMedicare.gov to print an official card. They must create an account if they do not already have one.

ACA/Marketplace Updates

Minimum Participation Rate Calculator

The Small Business Health Options Program (SHOP) is open year-round for small businesses who meet the participation requirements in their states!

The Minimum Participation Rate (MPR) calculator helps you determine if you meet the SHOP participation requirement.

To use the calculator, have this information ready:

- State where your main business office is located
- The number of employees accepting your SHOP coverage offer
- The number of employees not accepting your SHOP coverage offer who do not have another type of health insurance
- The number of employees not accepting the SHOP coverage offer who are covered by another type of health insurance

Use the MPR Calculator

Note: In most states the SHOP Minimum Participation Rate is 70%. If you do not meet the minimum participation rate, you can still enroll between November 15 and December 15 when the minimum participation rate is waived.

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

###

The First Week of Assister Readiness Webinar Series Modules Are Now Posted

Modules for the first week of the 2019 Assister Readiness Webinar Series are now posted and ready to view! You can find them at: https://marketplace.cms.gov/technical-assistance-resources/assister-readiness-webinar-series.html

As a reminder, The 2019 Assister Readiness Webinar Series is a supplement to the 2019 web-based Assister Certification Training. This month-long series will be delivered in weekly installments and will help get you ready to serve Marketplace consumers during the 2019 open enrollment period. Each installment will include several viewable, on-demand educational modules, **and** a corresponding LIVE Friday webinar that will recap the week's topics and give you a chance to ask questions.

- This first week's modules cover Assister Roles and Responsibilities. *(Please note that these webinars will reference a LIVE webinar recap for October 5th - this has been moved to October 12th.* ***There will be no webinar on October 5th****.)*
- The second week's modules provide an overview of the 2019 Individual Marketplace;
- The third week's modules cover Helping Consumers Apply for & Enroll in Coverage;
- The fourth week's modules focus on Making Coverage Accessible.

And remember to please join us each Friday for the LIVE webinar at 2pm Eastern Time where we'll recap that week's modules and give you an opportunity to ask live questions. **Our first Live Webinar will be Friday October 12th to recap the first week's modules on Assister Roles and Responsibilities. Please stay tuned for the webinar invitation!**

###

Kansas Insurance Department releases 2019 open enrollment overview

The Kansas Insurance Department has released more 2019 health insurance open enrollment information, including a department overview of the health plans for Kansas consumers.

The open enrollment period for the 2019 plan year begins November 1 and ends December 15, 2018, according to Ken Selzer, CPA, Commissioner of Insurance. The time period applies to plans sold on and off the federal marketplace.

Insurance companies who are offering plans in 2019 are Blue Cross and Blue Shield of Kansas, Medica and Ambetter from Sunflower State Health Plan. The companies signed their final issuer agreements for participation in 2019. There are at least two companies selling plans in each Kansas county.

"Those choosing a new health plan for coverage beginning January 1, 2019, also have several other factors to consider," Commissioner Selzer said. "Making sure your providers — doctors, hospitals and other health care providers — are within the plan's network is important. Secondly, you should note that networks can vary within the same company, depending on where you live. Finally, you should understand that companies may change the type of policy they sell from one year to the next."

For 2019, companies selling in Kansas will offer policies with the following types of network arrangements: Exclusive provider organizations (EPO) or health maintenance organization (HMO) plans. Definitions of each network are in the department's issue brief, "2019: Overview of the Health Insurance Market in Kansas," which can be accessed at https://www.ksinsurance.org/documents/healthlife/health/KID-Issue-Brief.pdf.

The Commissioner said if you purchase a health insurance policy through the federal marketplace, your cost may be reduced if you are eligible for an advance premium tax credit (APTC). Those credits are available *only* if you buy insurance on the marketplace. They are not available for off-marketplace individual purchase, or if you purchase insurance through your employer.

Kansans who have questions regarding association health plans (AHPS) or short-term limited-duration insurance should contact an insurance agent for more information.

"If you need more assistance, contact our Consumer Assistance Division at the insurance department (800-432-2484) for answers to general health insurance questions, or use our online chat feature at www.ksinsurance.org ," Commissioner Selzer said.

###

New Missouri DOI Coverage Map for OE6

The Missouri Department of Insurance has a map showing - PRELIMINARILY - which insurers will offer plans in which counties for the sixth open enrollment period.

View the map here:
https://insurance.mo.gov/industry/filings/healthrates/documents/2019CountyMapUpdated09192018.pdf

###

CMS Open Sources Quality Payment Program Claims to Quality Code

CMS Open Sources Code for Developers that Calculates QPP Quality Measures from Claims Data

In keeping with the Centers for Medicare & Medicaid Services' (CMS) commitment to public transparency, CMS is proud to open-source the Quality Payment Program (QPP) code responsible for calculating quality measures from Medicare claims data submitted by eligible clinicians via Quality Data Codes (QDCs). This code is intended for developers interested in the calculation mechanism supporting QPP Claims to Quality.

CMS uses modern data processing techniques to improve the way it processes quality measures submitted via Medicare claims and to allow eligible clinicians frequent visibility into their individual scores.

All required claims data is processed from the Integrated Data Repository on a regular basis and all seventy-four QPP claims measures are calculated. The scores are then translated to a JSON format and submitted via an Application Programming Interface (API). The results are used to determine eligible clinicians' quality performance category scores, which then are used as part of the calculation of eligible clinicians' QPP final scores.

Details for Developers

The code available is a showcase of the calculation mechanism behind QPP Claims to Quality measures. Access to the production databases was removed so the code is not plug and play. However, developers can use the code to run calculations by using calculate_measure_from_csv.py or by building their own script.

The repository can be accessed publicly on GitHub here: https://github.com/CMSgov/qpp-claims-to-quality-public. We welcome issue creation to notify of bugs, errors, or ask questions. The repository is not intended for direct contribution, but some may be reviewed. Find out more by reading CONTRIBUTING.

License & Usage

The code is licensed under CC0 1.0 Universal. As such, there is no limitation on usage, but also no warranty and support. You can access the complete license here.

###

2019 Eligible Hospital eCQM Flows are Available Now

The Centers for Medicare & Medicaid Services (CMS) developed and published the 2019 reporting period electronic clinical quality measure (eCQM) flows for eligible hospitals and critical access hospitals (CAH) to the eCQI Resource Center. This is a new resource for eligible hospital and CAH eCQMs for the 2019 reporting period, developed in response to stakeholder feedback.

The eCQM flows are designed to assist in interpretation of the eCQM logic and calculation methodology for reporting rates. These flows provide an overview of each of the population criteria components and associated data elements that lead to the inclusion or exclusions into the eCQM's quality action (numerator).

The eCQM flows supplement eCQM specifications for eligible hospitals and CAHs for the following programs:

- **Medicare and Medicaid Promoting Interoperability (PI)**
- **Hospital Inpatient Quality Reporting (IQR)**

These flows are intended to be used as an additional resource when implementing eCQMs and should not be used in place of the eCQM specification or for reporting purposes. A "Read Me First" guide to understanding

the flows is also available to assist users as they navigate this new resource. The guide can be found on the eCQI Resource Center website within the eCQM flows zip file.

Questions on the eCQM flows should be directed to the ONC eCQM Issue Tracker available at https://oncprojectracking.healthit.gov/support/secure/Dashboard.jspa.

###

Virtual Groups Election Period for MIPS 2019 Performance Year Now Open

If you're interested in forming a virtual group for the 2019 Merit-based Incentive Payment System (MIPS) performance year, the election period is now open. To form a virtual group, you must follow an election process and submit your election to CMS via e-mail **by December 31, 2018**.

Who Can Join a Virtual Group?

You can participate in a virtual group if you are **either**:

- A **solo practitioner** eligible for MIPS who exceeds the low-volume threshold; is not a newly Medicare-enrolled clinician; is not a Qualifying Participant (QP) in an Alternative Payment Model (APM); and is not a partial QP choosing not to participate in MIPS.
- A **group** that exceeds the low-volume threshold at the group level (i.e., clinicians under a single Taxpayer Identification Number (TIN) who collectively exceed the low-volume threshold); and has 10 or fewer clinicians (including at least one clinician who is MIPS eligible) that have reassigned their billing rights to the TIN.

Please note: TIN size is based on the total number of clinicians, or National Provider Identifiers (NPIs), billing under a TIN, which includes clinicians who are and are not MIPS eligible.

What is the Virtual Group Election Process?

There is a two-stage election process for forming a virtual group:

Stage 1 (optional):

- Contact your Quality Payment Program Technical Assistance organization for information regarding TIN size to help you determine if you meet the TIN size criteria to join or form a virtual group.

Stage 2 (required):

As part of Stage 2 of the election process, you must:

- Have a formal written agreement;
- Name an official virtual group representative;
- Submit the virtual group's election via e-mail to CMS at MIPS_VirtualGroups@cms.hhs.gov by December 31, 2018; and
- Determine if you meet the TIN size criteria and exceed the low-volume threshold

Download the 2019 Virtual Groups Toolkit to learn more about the election process and how to participate in MIPS as a virtual group for the 2019 performance year. The toolkit also contains sample templates for the submission e-mail and the virtual group formal agreement.

Why Join a Virtual Group?

Forming a virtual group gives you the opportunity to effectively and efficiently coordinate resources to achieve and meet requirements under each MIPS performance category, and potentially increase your performance. You can choose the size and composition of your virtual group, and your virtual group may be formed based on location, specialty, or shared patient population.

2018 Virtual Groups - Participation in MIPS

For the 2018 performance year, only a couple of elections for virtual group formation were received as clinicians explored the benefits of virtual groups. Although only a few participated, we were able to gain valuable insights into important considerations for virtual groups. We recognize that the formation of a virtual group requires time and coordination among the small practices within a virtual group. To support the establishment and implementation of virtual groups, free, one-on-one technical assistance is available. We continue to create and provide useful resources and tools that are easily accessible and available for virtual groups. Currently, virtual groups are diligently operationalizing and preparing for the submission of data to meet MIPS requirements.

Need Help?

- Request technical assistance from on-the-ground organizations that can provide no cost support.
- Contact Quality Payment Program by
- Email: QPP@cms.hhs.gov or
- Phone: 1-866-288-8292/ TTY: 1-877-715-6222

###

The Deadline to Submit a MIPS Targeted Review Request is Less than 2 Weeks Away

If you participated in MIPS in 2017, your MIPS score and performance feedback are available on the Quality Payment Program website. The payment adjustment you will receive in 2019 will be based on your score. A positive, negative, or neutral payment adjustment will be applied to the Medicare paid amount for covered professional services furnished under the Medicare Physician Fee Schedule in 2019.

MIPS eligible clinicians or groups (along with their designated support staff or authorized third-party intermediary), including those who are subject to the APM scoring standard, may request for CMS to review their performance feedback and score through a process called targeted review if they believe an error has been made in the 2019 payment adjustment calculation.

Please note, on September 13, 2018, CMS updated MIPS 2017 performance feedback for clinicians affected by scoring issues previously identified through the targeted review process. Additionally, to ensure that we maintain the budget neutrality required by law under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), some clinicians will see slight changes in their payment adjustment factor. **If you believe an error exists in your 2019 MIPS payment adjustment calculation, you can request a targeted review by the extended deadline of October 15 at 8:00 PM EDT- which is less than 2 weeks away**. To learn more, view this 2017 MIPS Performance Feedback Statement.

When to Request a Targeted Review

The following are examples of circumstances in which you may wish to request a targeted review:

- Errors or data quality issues on the measures and activities you submitted
- Eligibility issues (e.g., you fall below the low-volume threshold and should not have received a payment adjustment)
- Being erroneously excluded from the APM participation list and not being scored under APM scoring standard
- Not being automatically reweighted even though you qualify for automatic reweighting due to the 2017 extreme and uncontrollable circumstances policy

This is not a comprehensive list of circumstances. CMS encourages you to contact the Quality Payment Program if you believe a targeted review of your 2019 MIPS payment adjustment (or additional MIPS payment adjustment) is warranted. We'll help you to determine if you need to submit a targeted review request.

How to Request a Targeted Review

You can access your 2017 MIPS score and performance feedback and request a targeted review by:

- Going to the Quality Payment Program website
- Logging in using your Enterprise Identity Management (EIDM) credentials; these are the same EIDM credentials that allowed you to submit your MIPS data. Please refer to the EIDM User Guide for additional details.

When evaluating a targeted review request, we will generally require additional documentation to support the request. If your targeted review request is approved, CMS will update your score and payment adjustment factor for 2019 (if applicable), as soon as technically feasible. CMS will determine the amount of the 2019 upward payment adjustments after the conclusion of the targeted review submission period. **Please note that targeted review decisions are final and not eligible for further review**.

For More Information

To learn more about the steps for requesting a targeted review, please review the following:

- How to Request a Targeted Review Demo Video
- Targeted Review of 2019 MIPS Payment Adjustment User Guide
- Targeted Review of the 2019 Merit-based Incentive Payment System Payment Adjustment Fact Sheet

Questions?

If you have questions about your MIPS performance feedback or 2017 MIPS score, or whether you should submit a targeted review request, please contact the Quality Payment Program by:

- Phone: 1-866-288-8292/TTY: 1-877-715-6222; or
- Email: QPP@cms.hhs.gov

###

CMS Publishes 2018 List of Quality Measures Impacted by ICD-10 Updates

In the CY 2018 Quality Payment Program final rule (82 FR 53716), CMS finalized a process to stabilize measure data throughout the performance period when a measure is impacted by ICD-10 updates mid-performance period. ICD-10 code updates are effective annually on October 1st. An annual review process was established to analyze and assess the quality measures to determine which measures are significantly impacted (determined by a 10% threshold) by ICD–10 code changes during the performance period. If a quality measure is impacted by 10% or more ICD-10 code changes, the performance score for the quality measure will be based only on the first 9 months of the 12-month performance period for those identified measures. CMS has published a list of 2018 quality measures that have been identified as impacted by this update in the Quality Payment Program resource library.

###

Register Now for the 2019 MIPS Performance Period Self-Nomination Virtual Office Hours Session

Join CMS on October 11th for a Virtual Office Hours Session Regarding the 2019 MIPS Self-Nomination Process

During the 2019 Performance Period Self-Nomination period, CMS will offer a 2019 Merit-Based Incentive Payment System (MIPS) Performance Period Self-Nomination Virtual Office Hours session. The purpose of this session is to allow current and potential Qualified Clinical Data Registries (QCDRs) and Qualified Registries the opportunity to participate in a question and answer session regarding the self-nomination process and its related tasks.

Qualified Registries and QCDRs are CMS-approved vendors that collect clinical data on behalf of clinicians for data submission to CMS for the MIPS program. Please note that eligible clinicians wishing to report for the 2019 performance period of the MIPS program via the Qualified Registry or QCDR reporting mechanism do NOT need to self-nominate. Only entities wishing to participate (and who meet the requirements) as a Qualified Registry and/or QCDR need to complete and submit the self-nomination form. Please attend the session on **October 11th from 1-2:30 pm ET** if your organization plans to self-nominate as a Qualified Registry or QCDR and you have questions regarding the Self-Nomination process and its related tasks. Participation in this session is **optional**.

Webinar Details

- **Title:** Self-Nomination Virtual Office Hours Session Webinar
- **Date:** Thursday, October 11, 2018
- **Time:** 1-2:30 p.m. ET
- **Description:** During this session, CMS will provide a Question & Answer Session regarding the self-nomination process and related tasks.
- **Audience:** EHR Vendors, Qualified Registries, QCDRs, Vendor Technology Product Leads, Regional Collaboratives, Specialty Societies, or Large Healthcare Systems
- **Event Registration:** Click here to register.

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.

###

CMS Announces Participants in New Value-Based Bundled Payment Model

Participation is robust in Administration's Bundled Payments for Care Improvement-Advanced model, which is designed to improve quality and reduce costs for inpatient & outpatient care

The Centers for Medicare & Medicaid Services (CMS) announced that 1,299 entities have signed agreements with the agency to participate in the Administration's Bundled Payments for Care Improvement – Advanced (BPCI Advanced) Model. The participating entities will receive bundled payments for certain episodes of care as an alternative to fee-for-service payments that reward only the volume of care delivered.

The Model participants include 832 Acute Care Hospitals and 715 Physician Group Practices – a total of 1,547 Medicare providers and suppliers, located in 49 states plus Washington, D.C. and Puerto Rico. Of note, BPCI Advanced qualifies as an Advanced Alternative Payment Model (Advanced APM) under MACRA, so participating providers can be exempted from the reporting requirements associated with the Merit-Based Incentive Payment System (MIPS).

"To accelerate the value-based transformation of America's healthcare system, we must offer a range of new payment models so providers can choose the approach that works best for them," said CMS Administrator Seema Verma. "The Bundled Payments for Care Improvement – Advanced model was the Trump Administration's first Advanced Alternative Payment Model, and we are proud to announce robust participation. We look forward to launching additional models that will provide an off-ramp to the inefficient fee-for-service system and improve quality and reduce costs for our beneficiaries."

Under the traditional fee-for-service payment system, Medicare pays providers and suppliers for each individual service they perform. However, under this new episode payment model, participants can earn an additional payment if all expenditures for a beneficiary's episode of care are less than a spending target, which factors in measures of quality. Conversely, if the expenditures exceed the target price, the participant must repay money to Medicare.

The BPCI Advanced Model was publicly announced in January 2018, and runs from October 1, 2018 through December 31, 2023. It builds on the Bundled Payments for Care Improvement (BPCI) Initiative, which ended on September 30, 2018.

Some key differences between the BPCI initiative and the new BPCI Advanced Model are:

· BPCI Advanced offers bundled payments for additional clinical episodes beyond those that were included in BPCI, including – for the first time – outpatient episodes.

· BPCI Advanced provides participants with preliminary target prices before the start of each model year to allow for more effective planning. The target prices are the amount CMS will pay for episodes of care under the model.

· BPCI Advanced qualifies as an Advanced APM. Participating clinicians assume risk for patients' healthcare costs and also meet other requirements including meeting quality thresholds, potentially qualifying them for incentive payments and exempting them from the MIPS program.

BPCI Advanced will initially include 32 bundled clinical episodes - 29 inpatient and 3 outpatient. Currently, the top three clinical episodes selected by participants are: Major joint replacement of the lower extremity, congestive heart failure, and sepsis.

CMS also released the fifth evaluation report for Models 2-4 of the original BPCI Initiative. To view the report, please use this link - https://downloads.cms.gov/files/cmmi/bpci-models2-4-yr5evalrpt.pdf

To view the accompanying "Findings At-A-Glance" document for the BPCI Initiative Models 2-4 fifth evaluation report, please use this link - https://innovation.cms.gov/Files/reports/bpci2-4-fg-evalyrs1-3.pdf

The BPCI Initiative had encouraging results. CMS designed the BPCI Advanced Model taking into account evaluation results and lessons learned from other Innovation Center models, industry experience with bundled payment, and stakeholder input from healthcare providers at acute care hospitals, physician group practices, and other providers and suppliers.

For more information about the BPCI Advanced Model, please visit: https://innovation.cms.gov/initiatives/bpci-advanced.

###

CMS Accelerates Innovation and Promotes Patient Access to Medical Technology

Reforms to Medicare's Local Coverage Determination process will increase transparency and patient engagement in order to ensure that Medicare beneficiaries have access to the latest therapies and devices

As part of broader efforts to modernize the Medicare program and bring the latest technologies and innovations to Medicare beneficiaries, the Centers for Medicare & Medicaid Services (CMS) announced changes to the way contractors decide which technologies are covered by publishing a revision to Medicare's Program Integrity Manual.

Medicare Administrative Contractors (MACs) determine which healthcare items and services meet requirements for Medicare coverage — taking into account local variations in the practice of medicine — through "local coverage determinations" or LCDs. LCDs are issued when national determinations do not exist, or when MACs need to further define a national determination. The updated manual responds to Congress' requirement in the 21st Century Cures Act for more transparency in the LCD process and aims to ensure an open LCD process that meets patients' needs. The changes will clarify and simplify the process, helping to ensure that companies can get therapies and devices to patients more efficiently.

"The Trump Administration is committed to strengthening Medicare and bringing the latest medical technologies to beneficiaries, and we cannot allow outdated processes and administrative barriers to stand in the way of this," said CMS Administrator Seema Verma. "The redesigned local coverage determination process will pave the way to expanded access to new medical technologies. Coverage decisions will be made more transparently with an explanation of the clinical evidence that supports them, and with input from beneficiaries who are affected. This is just the beginning of our efforts to further accelerate medical innovation, improve the quality of care and lower costs for our beneficiaries."

The Medicare Program Integrity Manual includes instructions, policies and procedures that MACs use to administer the Medicare fee-for-service program. Chapter 13 of the manual addresses LCDs. The manual revisions announced are the first revisions since August 2015.

CMS has revamped the format of the manual so it can be used as a "roadmap" for the LCD process. The manual now helps stakeholders effectively engage in the process and lays out CMS's expectations for MACs.

Important changes to the manual include:

- Requiring a consistent, standardized summary of the clinical evidence supporting LCD decisions
- Including a beneficiary representative and other healthcare professionals in addition to physicians (e.g. nurses, social workers) on Contactor Advisory Committees that inform LCDs
- Ensuring that Contractor Advisory Committee meetings are open to the public

The new process takes further steps to be responsive to patient needs by allowing patients to request a new LCD, and by holding open meetings virtually (e.g., by webinar) instead of in-person to allow for broader participation.

As part of CMS's Patients Over Paperwork initiative, the agency has engaged stakeholders directly through Requests for Information (RFIs) to solicit ideas of ways to reduce administrative burden. Feedback from these RFIs informed the LCD process improvements reflected in the changes to the Program Integrity Manual.

As part of CMS's commitment to continuous improvement, the agency invites interested stakeholders to submit feedback on their experiences with the revised LCD process. CMS will collect feedback via submissions to LCDmanual@cms.hhs.gov and will consider additional revisions based on the feedback.

For a full list of changes to the manual, refer to fact sheet: https://www.cms.gov/newsroom/fact-sheets/summary-significant-changes-medicare-program-integrity-manual-chapter-13-local-coverage

For a blog from Administrator Seema Verma, click here: https://www.cms.gov/blog/modernizing-medicare-take-advantage-latest-technologies

###

Medicare and Medicaid Updates

CMS announces new streamlined user experience for Medicare beneficiaries

The Centers for Medicare & Medicaid Services (CMS) announced a multi-year initiative that will empower patients and update Medicare resources to meet beneficiaries' expectation of a more personalized customer experience. The eMedicare initiative will modernize the way beneficiaries get information about Medicare and create new ways to help them make the best decisions for themselves and their families.

The eMedicare initiative's goal is to provide a seamless online health care experience to meet the growing expectations for this generation of Medicare beneficiaries. CMS has a cohesive, multi-year strategy of consumer data integration and web product development to modernize Medicare.gov and improve access to personal health care data. The road map for this program will enhance opportunities to go digital, offer additional self-serve options, and create a seamless multi-channel customer service experience.

"Since day one, President Trump has been committed to strengthening the Medicare program—eMedicare puts his leadership into action by giving Medicare beneficiaries a simpler, more intuitive customer experience," CMS Administrator Seema Verma said. "Our intent is not to replace traditional channels that beneficiaries trust and depend on, but to improve and enhance them with the emerging digital options to create a user-centered, seamless consumer experience."

Some of the new eMedicare initiatives that CMS is launching ahead of Medicare Open Enrollment are:

- An improved coverage wizard to help beneficiaries compare options at a deeper level as a way to decide if Original Medicare or Medicare Advantage is right for them;
- A stand alone, mobile optimized out of pocket cost calculator that will provide information on both overall costs and prescription drug costs;
- A simplified log in for the Medicare Plan Finder (https://www.medicare.gov/find-a-plan/questions/home.aspx) tool using their online account (instead of the current process of entering 5 pieces of information to authenticate);
- A webchat option, which will be available within the Medicare Plan Finder for some beneficiaries; and
- New easy to use surveys available across Medicare.gov so beneficiaries can continue to tell us what they want.

These changes are building on previous improvements including:

- Giving beneficiaries the ability to print their Medicare card online;
- Re-designing the Mymedicare.gov homepage for easier navigation;
- Launching consumer-facing Blue Button (https://www.medicare.gov/manage-your-health/medicares-blue-button-blue-button-20) features in Mymedicare.gov;
- Providing an online version of the Medicare & You Handbook (https://www.medicare.gov/medicare-and-you) in a mobile-friendly format. We've also added simple, graphical explanations at the beginning of the Medicare & You handbook;
- Improving email communications. Medicare emails more than 8 million beneficiaries with information about Open Enrollment, preventive benefits, money saving tips, and fraud prevention.
- Enhancing social media presence—Medicare's Facebook page (https://www.facebook.com/medicare/) has grown to almost a half-million followers;
- Distributing the electronic version of the Medicare Summary Notice, allowing people with Medicare to view their explanation of benefits in a more timely manner online at Mymedicare.gov (https://www.mymedicare.gov/); and
- The eMedicare initiative will expand and improve upon current consumer service options. People with Medicare will continue to have access to paper copies of the Medicare & You handbook and the Medicare Summary Notice.

CMS launched the initiative with a new video (https://youtu.be/YUiHOnmun8s) that includes insights from Medicare beneficiaries on what they expect from Medicare and remarks from Administrator Verma outlining her vision for modernized program. Approximately 10,000 people join Medicare each day. The Medicare population is expected to increase to more than 80 million beneficiaries in 2030, up from 54 million in 2015. As of 2016, about two-thirds of Medicare beneficiaries indicate they use the Internet daily or almost daily (65%).

Read a Medicare.gov blog about eMedicare: https://www.medicare.gov/blog/emedicare-another-step-to-strengthening-medicare.

For a royalty-free, downloadable image of the updated Medicare.gov homepage to use for republishing, please visit: https://www.cms.gov/sites/drupal/files/MGOV-hmpg-highres-press_1.png

###

Advance Beneficiary Notices (ABNs) and Dual Eligible Beneficiaries: Special Guidelines

When Advance Beneficiary Notices (ABNs) are issued to dual eligible beneficiaries, including Qualified Medicare Beneficiaries (QMBs), distinct billing limitations apply. See QMB Billing Requirements FAQs pages 6 and 7 for special instructions and guidelines.

For More Information:

- QMB Program webpage
- ABN webpage

###

Better Data Will Serve as the Foundation in Modernizing the Medicaid Program

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

Between 2013 and 2016, Federal spending on Medicaid grew by over $100 billion. The program is often the first or second largest line item in state budgets. Just recently, CMS' independent Office of the Actuary released their Medicaid financial report, confirming what we have already known for quite some time – that our healthcare spending, particularly in Medicaid – is forecast to continue growing, averaging 5.7% annually over the next 10 years to reach over $1 trillion by 2026.

Yet as program costs have continued to rise, we have failed to deliver a level of transparency and accountability for achieving positive outcomes commiserate with our significant investment. But this is finally beginning to change. Over the last several years, CMS has collaborated with states to improve how we collect and use data to modernize and measure the Medicaid and CHIP program. Through strong data and systems, CMS and states can drive toward better health outcomes and improve program integrity, performance, and financial management in Medicaid and CHIP. These efforts will provide the foundation that enables CMS to deliver on its commitment to usher in a new era of Medicaid centered on state flexibility, stronger accountability, and improved program integrity.

As one example, CMS has worked with stakeholders to identify two core sets of health care quality measures that can be used to assess the quality of health care provided to children and adults enrolled in Medicaid and CHIP. These core sets are tools states can use to monitor and improve the quality of health care provided to Medicaid and CHIP enrollees. Under statute, state reporting on these measure sets is voluntary. In the future, we aim to increase the number of states reporting on a uniform set of measures and to support states in using these measures to drive quality improvement for the beneficiaries they serve. And ultimately, this move toward

greater transparency will start an important conversation about how and when states should be held accountable for the outcomes their programs produce.

Last week, we released the latest Federal Fiscal Year 2017 quality measurement data from the Medicaid and CHIP Child and Adult Core Sets that states have voluntarily reported to CMS. We greatly appreciate the work our state partners have endured to report these measures. CMS recognizes that quality reporting can present a significant administrative burden for both states and providers, and has taken steps to reduce this burden through our Meaningful Measures initiative. In the future, we hope to leverage existing and more automated data reporting systems to generate these Medicaid measures on behalf of states, thereby reducing reporting burden while also improving data consistency, comparability, and comprehensiveness.

States have worked with CMS over the last few years to modernize the way in which administrative data is collected by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, claims, and encounters. It is the foundation of a national analytic data infrastructure to support programmatic and policy improvements and program integrity efforts and will help advance reporting on outcomes. It also enhances the ability to identify potential fraud and improve program efficiency.

I am pleased to say that all states, the District of Columbia, and Puerto Rico are now successfully submitting T-MSIS data, marking a significant and exciting milestone in the history of the Medicaid program.

With these data in hand, we are shifting our efforts to continuous data quality review and improvement--a collaboration we will sustain with states. CMS' ongoing goal is to use advanced analytics and other innovative solutions to both improve T-MSIS data and maximize its potential for performance measurement, health care quality improvement, and program integrity, all while reducing state reporting burden.

I appreciate our continued partnership with states. Programs as important as Medicaid and CHIP require robust, timely, and accurate data in order to ensure the highest financial and program performance, support policy analysis and ongoing improvement, identify potential fraud or waste, and enable data-driven decision making.

We are committed to collaborating with states on improving their data submissions.

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Remarks by Administrator Seema Verma at the 2018 Medicaid Managed Care Summit

It is great to be back in front of a room full of professionals dedicated to improving the lives of Medicaid beneficiaries. For me, it's a little like coming home. I see the faces of the people out working on the front lines, of transforming the American health care system, working to making Medicaid a stronger and more sustainable program.

Medicaid is more than a safety-net program. It's our nation's commitment to care for our most vulnerable citizens. And I believe that societies, throughout history, should not just be judged by their wealth and influence, but they should also be judged by how they treat those who are less fortunate. Since its inception Medicaid has served as a powerful tool in making sure that our nation's most vulnerable can get the care they need.

People tell me that I am a realist. I guess you have to be to take on this job.

And the reality at CMS … is pretty refreshing right now. We are making great progress on a goal I set nearly a year ago as I outlined an aggressive agenda aimed at transforming Medicaid…the largest program at CMS serving more than 80 million beneficiaries. Our strategy is centered on 3 key pillars:

- Flexibility
- Accountability, and

- Integrity

Those central themes have been our guiding strategy as we've worked to deliver on our early commitments to ushering in a new day in the Medicaid program.

So let's begin with Flexibility. Giving states the flexibility is more than just paying for health care – it's empowering them to act on what works best for the citizens in their community. And this is necessary if we are truly serious about improving the health outcomes of the most vulnerable Americans. State and local officials know much more about the unique needs of their friends and neighbors than Washington DC does.

To this end, we are proposing modifications to a few of our regulations; including the Medicaid Access to Care Rule and the Medicaid Managed Care Rule, and with each of these proposed rules, we have worked closely with states in an unprecedented manner to promote individual choice and local control – leading to better health outcomes for Americans on Medicaid.

But we cannot regulate our way to innovation.

To elicit meaningful reform, the best thing that CMS can do is create a fertile ground for states to serve as the laboratories of innovation in Medicaid policy...and then get out of their way. And that's why we've opened opportunities for states to seek demonstrations to test new and exciting reforms.

And under our more flexible approach to waivers, CMS has approved 10 additional Substance disorder demonstrations – these include:

Indiana
New Jersey
Kentucky
Utah
Louisiana
Illinois
Vermont
New Hampshire
Pennsylvania and
Washington State

– which with the prior approvals means that more than a quarter of the states have committed to building out a more complete continuum of services to help individuals fighting addiction.

Additionally, in January, we released a groundbreaking new demonstration opportunity in response to state requests to test work and community engagement incentives among able-bodied adult beneficiaries. This guidance was followed by four approvals of innovative Medicaid demonstrations.

We are committed to this issue and we are moving closer to approving even more state waivers.

As such, I'm happy to share with you that we have finalized the terms for our next innovative community engagement demonstration, which we expect to deliver to the state very soon. So stay tuned!

But this is not a policy that is without controversy. I have heard the criticisms… and felt the resistance…but I reject the premise, and here is why: it is not compassionate to trap people on government programs, or create greater dependency on public assistance as we expand programs like Medicaid.

True Compassion is giving people the tools necessary for self-sufficiency… allowing able-bodied, working age adults to experience the dignity of a job, of contributing to their own care, and gaining a foothold on the path to independence.

From my experience working directly with indigent patients in the early phases of my career, I saw first-hand that no one sets out in life with the goal of relying on the government. Personal responsibility and self-sufficiency are bedrock American values.

And there is clear evidence that people are happier and healthier when they are working and leading independent, self-sufficient lives. Arthur Brooks of the American Enterprise Institute, wrote a book about the concept of earned success. The idea that we value what we earn much more than we value what is given to us. The drive to earn propels us to new heights, whereas dependency limits us.

The problem too often is that the most well-meaning government policies trap people in a hopeless cycle of poverty, making it too difficult to escape, and too easy to become more dependent. Instead, we ought to insist that the able-bodied participate in earning benefits.

To quote from Arthur's Book, the Conservative Heart:

"Work gives people something welfare never can. It's a sense of self-worth and mastery, the feeling that we are in control of our lives. This is a source of abiding joy. There's a reason that Aristotle wrote "happiness belongs to the self-sufficient."

Community engagement requirements are not some subversive attempt to just kick people off of Medicaid. Instead, their aim is to put beneficiaries in control with the right incentives to live healthier independent lives.

When you consider that, less than 5 years ago, Medicaid was expanded to nearly 15 million new working-age adults, it's fair that states want to add community engagement requirements for those with the ability to meet them. It's easier to give someone a card, it's much harder to build a ladder to help people climb their way out of poverty. But even though it is harder, it's the right thing to do.

Between the years 2000 and 2017, the overall work rate for non-disabled working age adults fell by 3.4 percentage points. Over half of this decline occurred before the Great Recession even began.

Historically, childless working age adults were working at a rate much higher than the overall rate for working age, able bodied adults – as you might expect. But that is changing. In 1979, the employment rate for childless adults under 50 was almost 10 percentage points higher than the overall rate. By 2017, it was only 2.6 percentage points higher, and, not surprisingly, this group also experienced the largest increase in welfare.

Put simply, even before the Recession began, childless adults under 50 were on a disturbing trajectory…Depending less on work and self-sufficiency, and more on government assistance.

It is therefore no surprise that, as this group continues on an unsustainable trajectory, states have looked to the Medicaid program to help reverse this trend, increase self-sufficiency, and break the chains of welfare dependence.

And this motivation comes at an incredible time of opportunity. Under President Trump's leadership, we are now experiencing among the lowest rates of unemployment we've seen in over 50 years. The Trump administration has created a booming American economy. Not only are job opportunities on the rise, but wages grew at the fastest rate in August since the Great Recession.

But despite these promising signs, we also know that there is often a skills gap between those needing employment, and the available jobs. Too many live in the shadows of opportunity, instead of its light, because they don't have 21st century skills. That's why this effort is also about helping those individuals find new hope through education and job training opportunities.

And these policies are not blunt instruments. We've worked carefully to design important protections to ensure that states exempt individuals who have disabilities, are medically frail, serve as primary caregivers, or have an acute medical condition that prevent them from successfully meeting the requirement. Some have argued

that a Medicaid demonstration can never advance the program's objectives if the project ultimately reduces Medicaid enrollment or spending.

But I prefer to think of it more like President Reagan, who said, "We should measure welfare's success by how many people leave welfare, not by how many people are added."

As our economy thrives, it can lift up as many Americans as possible, and lift millions off of programs like Medicaid and instead onto private insurance. There will always be a need for a safety net and programs like Medicaid. We want it to be there for those who need it most.

Others believe that any consequences for failing to comply with a program requirement, like disenrollment or periods of non-eligibility, shouldn't be allowed. There is no basis for that contention. CMS has approved demonstrations that include those exact type of incentives for failure to comply with requirements like monthly premiums going back across several federal administrations. Even the Children's Health Insurance Program – or CHIP - allows states to impose premiums and consequences for failure to pay them in certain circumstances.

Some have argued that these demonstrations are unnecessary because nearly all Medicaid beneficiaries are already working. To that I say – great. Then this policy won't impact them, and in fact if you look at Arkansas the vast majority of adults subject to the requirement were ultimately exempted from the monthly reporting requirement because of their steady employment. Nothing to argue about there!

We've also heard that the costs associated with implementing community engagement are too high, in terms of updating eligibility systems and providing the necessary supports. But we view these as important investments, not unlike those we have made in other aspects of the program, that help build capacity for states to address the whole human needs of their beneficiaries, and one that can pay dividends as we aim to end cycles of generational poverty. We have taken steps to ensure that appropriate protections have been designed to shield against unintended consequences.

We've strongly encouraged states to align their Medicaid requirements with similar policies in SNAP and TANF, and to take steps to ensure that if an individual is meeting the requirements of one program, they aren't having to do something different in another.

One of the most encouraging outcomes that I've seen emerge in states participating in this initiative is the level of engagement and partnership between stakeholders.

When I was in Arkansas this spring to hand deliver their signed waiver, I heard directly from these groups about some of the unique work happening to help lift people out of poverty. There, the state is working with community colleges and technical schools to connect Medicaid beneficiaries with new educational opportunities, including partnerships with nursing homes to provide free job training for enrollees.

In July, Arkansas became the first state to go live with their community engagement program. And a few weeks ago, Governor Hutchinson reported that more than 1,000 Arkansas Works enrollees have found jobs since the program began in July. Imagine the impact that this has had on the lives of those individuals and their families. One specific example he cited, was a woman in Harrison, Arkansas. She visited a Workforce Specialist and is now enrolled in LPN school at North Arkansas Community College with financial assistance. In addition to taking classes, she is also gaining real world experience by working at a long-term care facility one day a week.

Governor Hutchinson also described a gentleman in Rogers, Arkansas, who came into a workforce center after receiving his notice in the mail. There, he received an assessment and a referral for employment, and after nearly a year of being unemployed, is now earning over $17 an hour.

This is earned success. It is not granted by government, but realized through sweat, toil and initiative.

These are only a couple of examples – but the fact is that these two lives, and potentially many more, have been steered onto a pathway out of poverty. Over time, the woman in Harrison and the man in Rogers may

begin to earn their health insurance through their employer, and no longer rely on government assistance, and we should all join with them in hoping for this brighter future.

Let me be clear, there is no shame in receiving extra help when it's needed – that's why we have a safety net to care for folks on hard times. But our default position must always be to help and encourage those who are able to lift themselves up and find their footing again.

There is dignity and pride that is derived from work…for paying one's own way…and I believe it is the desire of nearly every American to achieve financial independence.

In America we believe we can be anything we want to be, never dictated by one's station at birth. The migrant farmer still dreams of one day owning the farm. The waiter still aspires to one day own the restaurant. We don't ascribe to the artificial barriers posed by class…because we believe through hard work, we can realize our biggest dreams.

While we've ushered in a new era of state flexibility, we are also committed to enhancing our collective accountability for delivering results on behalf of beneficiaries and taxpayers. So that brings me to our next pillar – Accountability. Despite growing from 10% of state budgets in 1985 to nearly 30% in 2016, Medicaid has never developed a cohesive system of accountability that allows the public to easily measure and check our results.

If we are going to be good stewards of taxpayer dollars and good servants to the 80 million Americans who depend on Medicaid and CHIP, we must be honest with ourselves and honest with all of our stakeholders about how well we are doing. I agree with oversight bodies like the GAO – we need to do better. That's why we've been working to enhance how we evaluate state demonstration projects, including standardizing how certain common types of waivers get evaluated, developing standardized metrics across waivers, and using consistent monitoring and evaluation protocols.

This will hold true for community engagement demonstrations, where we will be closely monitoring their implementation and ensuring thorough independent evaluations are conducted. But we also will not draw rash conclusions after only a few months of data and information.

As we drive toward value across the entire health care delivery system, we believe that greater transparency creates stronger accountability, and we were very excited earlier this summer to publish the first-ever CMS Medicaid & CHIP Scorecard.

If you haven't had a chance to take a look at that yet I strongly suggest you do. We've had about 14 states that have spent six months working diligently with us on crafting this version of the Scorecard.

In addition to displaying health outcome and quality metrics in areas like well-child visits and chronic health conditions, you'll see for the first time public reporting on our administrative performance.

This includes both state and federal performance measures in areas like the speed of processing managed care rate reviews or state plan amendments. Soon the scorecard will begin to reflect some of the real progress we are making on this front. For example, between 2016 and the first quarter of 2018, we saw a 23% drop in the average approval time for Medicaid state plan changes.

84% of those requested changes were approved within the first 90-day period in the first quarter of 2018, a 20% increase over 2016.

And over that same time period, the average time to approve renewals for home and community based waivers decreased by 38%.

And this version of the Scorecard is only the first step in this project. We are already hard at work on the next iteration, which we hope to update annually with new features and expanded measures. Future updates will

include additions like the ability to generate year-to-year comparisons and understand differences in state and regional performance.

We are also working to develop more measures, including ones that look at the areas of cost, program integrity, and beneficiary satisfaction. And, I'd be remiss, if I didn't mention a group to whom we should hold ourselves accountable for serving better – and that is the 12 million Americans who are dually eligible for Medicaid and Medicare. It's essential that we give states and health plans the tools to better integrate the full array of services these individuals rely on.

It is particularly critical that we address this given the facts that dually eligible individuals are among our most expensive beneficiaries for both programs. Despite accounting for 20% of Medicare enrollees and 15% of Medicaid enrollees, they consume 34% of Medicare spending and 33% of Medicaid spending, respectively.

Less than 10% of duals are enrolled in any form of integrated care, and instead have to navigate alone across disconnected delivery and payment systems to get the care they need. We have to change that.

Earlier this year Congress challenged us to do more to promote integrated care through dual eligible special needs plans. Our work is well underway. In the coming year, we will support new models and opportunities for additional states to test innovations to better serve this population. Additionally, we will challenge ourselves and the states to be better business partners to health plans and providers. The administrative burdens and inefficiencies to serving dually eligible beneficiaries are unacceptable. It's time to achieve a level of operational excellence that older Americans deserve.

Which brings us to our final pillar: Program Integrity.

Federal spending on Medicaid has ballooned, growing by over $100 billion between 2013 and 2016, and it often sits at the number 1 or 2 spot in state budgets. We have a responsibility to make sure that taxpayer dollars are spent only on qualified services for those who are truly eligible, even as we return greater control of the Medicaid program to the states.

And just last week, CMS' independent Office of the Actuary released their financial report on the Medicaid program. It confirmed, what we have already known for quite some time – that our healthcare spending, particularly in Medicaid is forecasted to grow at an alarming pace. Since Day One, my top priority has been to ensure programs, such as Medicaid, will always be around to serve those that truly need the program, and that means slowing the growth of spending.

Additionally, in June we launched our new Medicaid Program Integrity strategy that will bring CMS into a new era of enhancing the accountability of how we manage taxpayer dollars. This strategy includes several important new initiatives:

First, we will take a close review of State eligibility determinations. And second, we will take steps to strengthen our oversight of state financial claiming and rate setting.

We are also working to build a stronger regulatory framework to ensure transparency and accountability in Medicaid supplemental payments, with a particular emphasis on promoting integrity in the equity partnership we share with states by ensuring that states put up their fair share of state matching funds only from permissible sources.

Transparency must also extend to our health plan partners. This room understands well that nearly all newly eligible individuals in Medicaid are served through managed care organizations. I'm putting you on notice now - CMS will begin targeted audits to ensure that provider claims for actual health care spending matches what the health plans are reporting financially.

Finally, we are working to strengthen how we use data in the oversight of the program.

For the first time, every state, D.C., and Puerto Rico are now submitting data on their programs to the Transformed Medicaid Statistical Information System (known as T-MSIS), and over the course of the coming months we will be validating the quality and completeness of that data, so that its use for program integrity purposes can be expanded and realized, including plans to release analytic files for research purposes beginning next year.

And as a part of our MyHealthEData Initiative, we have called on everyone who holds patient data, whether it be hospitals, insurers, or Medicaid Managed Care Plans, to give patients control of their records, so that they can be the chief drivers of value in our healthcare system.

I truly believe that best ideas, attuned to the distinct needs of local communities, come from those communities - not DC.

And I greatly appreciate the role that our health plan partners play in delivering quality care to Medicaid beneficiaries all across the country. I have seen firsthand the value that you bring to your partnership with states, and the resources that you can often bring to bear to serve the needs of our enrollees on the front lines.

We must continue to work together, allowing state innovation to drive improvements in services. We must foster greater collaboration among…and between…state agencies, providers, advocates, and beneficiaries - to chart a path forward - because we recognize that what works in Montana won't be a good fit for Rhode Island, but we can all learn from our individual and shared experiences.

But I have said before and I will say it again - until we move away from an open ended entitlement program, and only when states are held accountable to a defined budget - can the federal government finally end our practice of micromanaging every administrative process. I believe that it's our imperative to instead focus on measuring the actual results on the program while unleashing the power of local innovation - so you will see more from us soon on new opportunities to do just that. So stay tuned.

We want every individual to have the opportunity to achieve earned success, and we must encourage every American to strive for better health and well-being. These efforts must be supported, evaluated, and shared – not shunned. Prosperity can never be handed out as a government benefit, but our programs can play an important part in helping people get off the sidelines of American life and find independence and a sense of purpose. Thank you.

###

National Childhood Obesity Awareness Month

This is the last email in our National Childhood Obesity Awareness Month series and we would like to close the series by sharing with you links to a recorded presentation on best practices conducted during the **"Heartland Childhood Obesity Summit - Factors of Health: Addressing the Systems Influencing Childhood Obesity"** and the State of Obesity 2018 Report.

Denise Schmitz, a dietitian with Charles Drew Health Center, Inc., was one of the guest speakers during the Lessons from the Community portion of the Summit. Charles Drew Health Center, Inc. is a Federally Qualified Health Center that provides quality, comprehensive, and convenient primary health care to Omaha, Nebraska's underserved communities. Denise's presentation, **Partnering to Fight Childhood Obesity**, highlighted various programs and efforts Charles Drew Health Center, Inc. is undertaking to address the factors influencing childhood obesity.

You can access a recording of her presentation here and all speaker presentations and other materials on the Resources tab on our summit website.

- **State of Obesity 2018 Report.** The Robert Wood Johnson Foundation and the Trust for America's Health have released the 15th annual State of Obesity report, announcing an "urgent need to increase evidence-based obesity prevention programs." Based on data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System, the report finds that adult obesity rates are at or above 35 percent in seven mostly-rural states: Alabama, Arkansas, Iowa, Louisiana, Mississippi, Oklahoma and West Virginia. Also this week, the U.S. Preventive Services Task Force released a final recommendation on behavioral weight loss interventions.

Please share this information with your colleagues and partners and help us raise awareness about this important topic.

###

CMS to Strengthen Oversight of Medicare's Accreditation Organizations

Agency's website will increase transparency into Accrediting Organization performance, and CMS will streamline and strengthen the validation of Accrediting Organization surveys

The Centers for Medicare & Medicaid Services (CMS) took action to improve quality and safety in healthcare facilities and empower patients with information to make decisions about where to receive care.

". . .we are taking action to improve our oversight of Accrediting Organizations, including by increasing transparency for patients on the organizations' performance," said CMS Administrator Seema Verma. "The public trusts CMS to ensure the quality and safety of patient care, and we take this responsibility very seriously. Today's changes will bolster the processes for overseeing how effective Accrediting Organizations, who work on CMS' behalf, are in evaluating healthcare facilities."

Currently, Medicare-participating healthcare providers and suppliers are surveyed either by State survey agencies or by Accrediting Organizations (AOs) to ensure that they meet CMS' quality and safety standards. AOs receive deeming authority from CMS, which affirms that AOs' health and safety standards meet or exceed those of Medicare. Only facilities and suppliers that have been deemed by state or AO surveyors to meet CMS' standards may receive payments from Medicare. There are currently 10 CMS-approved AOs, each of which surveys one or more different types of facilities.

CMS will enhance and strengthen its oversight and quality transparency of AOs in three ways: 1) the public posting of AO performance data; 2) a redesigned process for AO validation surveys and 3) the release of the Annual Report to Congress. Taken together, these efforts will provide important insights to the public and assist AOs, providers, and suppliers in ensuring patient health and safety.

Posting AO Performance Data Online

To increase transparency for consumers, CMS will post new information on the CMS.Gov website, including: The latest quality-of-care deficiency findings following complaint surveys at facilities accredited by AOs; a list of providers determined by CMS to be out of compliance, with information included on the provider's AO; and overall performance data for AOs themselves. To view AO performance data, visit: https://qcor.cms.gov/hosp_cop/HospitalCOPs.html

Today, the public relies on accreditation status as a way to gauge providers' and suppliers' quality of care. By posting more detail—accredited hospitals' complaint surveys, out-of-compliance information, and performance data for AOs themselves—CMS will offer the public more nuanced information than accreditation status alone provides. The agency is currently prohibited by law from disclosing the actual surveys done by AOs, except for surveys of home health agencies and surveys related to an enforcement action.

Pilot Testing Direct Observation for AO Validation Surveys

CMS is testing a more streamlined, efficient way to assess AOs' ability to ensure that facilities and suppliers comply with CMS requirements.

CMS evaluates the ability of AOs to accurately assess providers' and suppliers' compliance with health and safety standards through a validation survey process. Historically, CMS has measured the effectiveness of AOs by choosing a sample of facilities, performing state-conducted assessment surveys within 60 days following AO surveys, and comparing results of the state surveys with the AO surveys. In a pilot test, CMS will eliminate the second state-conducted validation survey and instead use direct observation during the original AO-run survey to evaluate AOs' ability to assess compliance with CMS's Conditions of Participation.

Direct observation will enable CMS not only to evaluate AO performance more effectively, but also to suggest improvements and address concerns with AOs immediately. This approach will relieve providers from having to undergo the burden of a state's follow up assessment. The approach is another example of the wide-ranging effort at CMS to eliminate duplication and relieve burden, reducing the amount of time that healthcare facilities must spend on compliance activities.

CMS will also analyze and incorporate State complaint investigations of accredited facilities as part of the agency's strengthened validation program. This work will focus on identifying and monitoring accredited facilities that are out of compliance with Medicare health and safety requirements. CMS will use this information as an additional indicator of AO performance.

Posting the Most Recent Annual Report to Congress Regarding AO Performance

CMS has also posted the most recent annual Report to Congress, the "Review of Medicare's Program for Oversight of Accrediting Organizations and the Clinical Laboratory Improvement Validation Program Fiscal Year 2017," on the CMS website. As the changes announced today inform and bolster our oversight of AOs, CMS will continue to publish this report online annually to demonstrate the impact of these changes on the oversight of AOs and to provide greater transparency for the public. The FY 2017 Report to Congress is posted online: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html

###

Medicare provides continued access to high-quality health coverage choices in 2019

CMS releases Star Ratings for 2019 Medicare Advantage and Part D prescription drug plans ahead of Medicare Open Enrollment

The Centers for Medicare & Medicaid Services (CMS) announced that Medicare beneficiaries continue to have access to high-quality health choices for their Medicare coverage as the agency releases the Star Ratings for the 2019 Medicare Advantage and Part D prescription drug plans.

"Medicare Advantage enrollees will continue to have access to high quality plans while plan choices are increasing and premiums are declining," said CMS Administrator Seema Verma. "Along with the steps the Trump Administration has taken to maximize competition and lower out-of-pocket prices, we are committed to empowering Medicare beneficiaries to make informed choices in choosing high-quality plans that best fit their health needs."

As announced last month, Medicare Advantage premiums continue to decline while plan choices and benefits increase. In 2019, Medicare Advantage will be offering approximately 600 more plans with the number of plans available to individuals to choose from across the country is increasing from about 3,100 to about 3,700 – and more than 91 percent of people with Medicare will have access to 10 or more Medicare Advantage plans. On average, Medicare Advantage premiums in 2019 are estimated to decrease by six percent to $28.00, from an average of $29.81 in 2018.

As part of CMS's recently launched eMedicare initiative, Medicare.gov will feature an improved "coverage wizard" to help users compare options at a deeper level to decide if Original Medicare or Medicare

Advantage is right for them. CMS will also provide a stand-alone, mobile optimized out-of-pocket cost calculator that will provide information on both overall costs and prescription drug costs.

Each year, CMS publishes the Part C and Part D Star Ratings to measure the quality of, and reflect the experiences of beneficiaries in, Medicare Advantage and Part D prescription drug plans. In 2019, most areas across the country will have Medicare Advantage and Part D plans with four or more stars. Based on current enrollment, approximately 74 percent of Medicare Advantage enrollees with prescription drug coverage are projected to be in plans with four and five stars in 2019 as compared to 73 percent in 2018. Approximately 45 percent of Medicare Advantage plans that offer prescription drug coverage will have an overall rating of four stars or higher in 2019.

Enrollees in stand-alone Medicare Part D prescription drug plans will also have access to high-quality plans. In 2019, approximately 31 percent of stand-alone prescription drug plans will have a rating of four stars or higher in 2019. The majority of enrollees are in stand-alone prescription drug plans with 3.5 stars or higher.

CMS updates the Star Ratings for Medicare Advantage and Part D prescription drug plans every year to help beneficiaries distinguish between plans. In an effort to continually enhance the Star Ratings, CMS made changes to the measures used for the 2019 ratings for health and drug plans based on industry feedback.

The Star Ratings system helps people with Medicare, their families, and their caregivers compare the quality of health and drug plans being offered. Medicare health and drug plans are given a rating on a 1 to 5 star scale, with 1 star representing poor performance and 5 stars representing excellent performance. Medicare beneficiaries can compare health coverage choices and the Star Ratings through the online Medicare Plan Finder tool available at Medicare.gov (http://www.medicare.gov).

CMS recently launched the eMedicare Initiative that aims to modernize the way beneficiaries get information about Medicare and create new ways to help them make the best decisions for themselves and their families. Medicare Open Enrollment for 2019 Medicare health and drug plans begins on October 15, 2018, and ends December 7, 2018. Plan costs and covered benefits can change from year to year. People with Medicare should look at their coverage choices and decide the option that best fits their health needs. They can visit Medicare.gov (http://www.medicare.gov), call 1-800-MEDICARE, or contact their State Health Insurance Assistance Program (SHIP). Those people with Medicare who do not wish to change their current coverage do not need to re-enroll in order to keep their current coverage.

For more information on the 2019 Medicare Advantage and Part D Star Ratings, including a fact sheet, please visit: http://go.cms.gov/partcanddstarratings.

To view the premiums and costs of 2019 Medicare health and drug plans, please visit: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html.

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Upcoming Webinars and Events and Other Updates

Register Now for the October 9 MACRA Cost Measures Field Testing Webinar

CMS and its contractor, Acumen, LLC, are conducting a field test for 11 episode-based cost measures and two re-evaluated cost measures before consideration of their potential use in the cost performance category of the Merit-based Incentive Payment System (MIPS) of the Quality Payment Program.

Field testing will take place from **October 3 to October 31, 2018**. During this time, clinicians and clinician groups who meet the attribution requirements for at least one of the measures listed below will have the opportunity to view a field test report with information about their cost performance. **All stakeholders are invited to provide feedback on the measures and supplemental documents** through an online survey, which closes October 31 at 11:59 PM ET. Participation in field testing is voluntary.

Measures that will be field tested include:

- **Eleven new** episode-based cost measures currently under development
- **Two** cost measures undergoing re-evaluation

Register for the October 9 MACRA Cost Measures Field Testing Webinar to Learn More

To register for the MACRA Cost Measures Field Testing Webinar please click:

MACRA Cost Measures Field Testing Webinar - Tuesday, October 9, 2018 from 12:00 to 1:30 PM ET

This webinar will provide:

- Information about the field testing of the 11 episode-based cost measures and the two re-evaluated cost measures
- Project background, measure development and re-evaluation process, and field testing activities
- Discussion of the purpose and content of the field test reports, how to access and interpret these reports, and information on the supplemental documentation posted on the MACRA Feedback Page
- Q&A session

Should you have further questions, please contact the Quality Payment Program Service Center via telephone at 1-866-288-8292 or via email at qpp@cms.hhs.gov. The Service Center is available Monday – Friday, 8:00 A.M. – 8:00 P.M. ET.

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Now Available: Accredited Online Course - Quality Payment Program in 2018: Merit-based Incentive Payment System (MIPS) Alternative Payment Models (APMs) Web-Based Training Course — Revised

A revised **Quality Payment Program in 2018: MIPS APMs Web-Based Training Course** is available through the MLN LMS.

Learn about:

- Quality Payment Program in 2018 MIPS APMs
- What is a MIPS APM?
- How to recognize if you are a part of a MIPS APM
- Benefits of the special APM scoring standard for MIPS APM participants
- Criteria for reporting on performance

Participants will gain knowledge and insight on the program all while earning valuable continuing education credit. Keep checking back with us for updates on new courses. First time participants will need to register for

the MLN Learning Management System. Once registered, you will be able to access additional courses without having to register. For information on how to login or find training, please visit our MLN Learning Management System FAQ sheet.

The Centers for Medicare & Medicaid Services designates this enduring material for a maximum of 0.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Credit for this course expires September 26, 2021. AMA PRA Category 1 Credit TM is a trademark of the American Medical Association

Accreditation Statements: Please click here for accreditation statements

###

The Forum 2018

October 12 - 14, 2018
University of Missouri - St. Louis

What is the Forum?
The Forum is a brave space for open dialogue that focuses on Black community members in the Midwest that are impacted and disproportionately affected by HIV and other health disparities

The Forum 2018 Goals

- Create a sense of urgency and responsibility to tackle issues of health disparities
- Define public health and how social inequities/ disparities impact Black communities
- Develop an understanding of what community based organizations do and how they serve our communities
- Mobilize communities to connect and advocate for social justice

Target Audience
The Forum seeks individuals from all backgrounds who are all working towards health equity and social justice.

Call for Abstracts
The scope of The Forum includes, but is not restricted to the following topics:
● HIV and other Health Disparities
● Black Women's Health
● Community Mobilization & Social Justice
● Mental Health
● Trans-Health/Rights
● Biomedical HIV Prevention
● Leadership Development
● Black Gay Men

Abstracts must emphasize the goal and learning objectives of the presentation and should highlight the knowledge or skills that will be acquired by participants. The length of the abstract should not exceed 250 words. It should be submitted to via email to ShowmeForum@gmail.com.

In the abstract header it is necessary to specify:
● The title of the paper
● Name and surname of the author
● Organization/institution and contact details (address, phone, e-mail) of the author

The abstract must contain the following elements:

● The subject of the presentation/session
● Over-all goal and objectives of the presentation/session
● Session outcomes (what the participants will get out of the session)
● Basic themes that will be covered by the presentation/session

Contact Us!!
Email: Showmeforum@gmail.com
Phone: 314-385-1935

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SAVE THE DATE: 16th Annual Missouri Health Policy Summit

Women's Health Policy throughout the Lifespan
Hosted by the Center for Health Policy and Missouri Women's Health Council
October 25, 2018
Stoney Creek Inn, Columbia, MO

Please join the Center for Health Policy and Missouri Women's Health Council for this year's Missouri Health Policy Summit. This year's summit will raise awareness of women's health issues throughout life.
Topics discussed will include women's health in the adolescent years, adulthood and childbearing years, and menopause and later years. Other topics covered will center on substance use disorder and mental health throughout the lifespan.

Practical tools will be shared to promote healthy environments for women in settings ranging from hospitals, workplaces, schools, and communities.

Presented by the MU Center for Health Policy | Missouri Women's Health Council | MU Sinclair School of Nursing
(573) 882-1491 | healthpolicy@missouri.edu

To learn more about the Center for Health Policy, please logon to:
https://medicine.missouri.edu/centers-institutes-labs/health-policy

To learn more about Missouri Women's Health Council, please logon to:
https://health.mo.gov/living/families/womenshealth/

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21st Annual Omaha Women's Health and Wellness Conference

All About You - Shaping Your Wellness Perspective

La Vista Conference Center, 12520 Westport Pkwy, La Vista, NE
Friday, October 12, 2018 from 8 am to 4 pm

General Registration is $59 and nursing registration is $89.

For more information call the Olson Center for Women's Health at 402-559-6345 or go to
https://www.nebraskamed.com/womens_conference

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Introducing the Rural Health Information Hub

The Health Resources and Services Administration, Office of Regional Operations, is hosting a webinar about the Rural Health Information Hub (RHIhub).

Date: October 30, 2018

Time: 11:30 am – 12:30- pm CT

Who Should Attend this Webinar?

This webinar is for rural organizations looking for information, opportunities, and resources on rural health. RHIhub is a national clearinghouse on rural health information and resources to support healthcare and population health in rural communities. Featuring an online library, rural health data, state and topic guides, toolkits, rural program models, custom alerts, and more, the RHIhub is your first stop for rural health information. The RHIhub is funded by the Federal Office of Rural Health Policy, meaning that all of its services are provided free of charge.

Topics at a Glance

- Online Library
- Toolkits and Program Models
- Economic Impact Analysis
- Sustainability Planning
- Funding & Opportunities
- Data Visualization
- Custom Alerts

To register for the webinar, visit

https://rhihub-tool-resources-webinar.eventbrite.com

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Alternatives to Pain Management Symposium

Contact: Jennifer Robertson-Hill, jennifer.robertson-hill@idph.iowa.gov

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Heartland Childhood Obesity Summit - Factors of Health

According to the Centers for Disease Control and Prevention, about 1 in 5 children in the United States are obese. Childhood obesity puts kids at risk for health problems that were once seen only in adults, such as type 2 diabetes, high blood pressure, and heart disease.

September is **National Childhood Obesity Awareness Month and** provides a chance for all of us to learn more about this public health issue. This week, we are honoring this month by sharing links to webinars and resources on this topic.

In June, the Health Resources and Services Administration, Office of Regional Operations, and the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health - Region 7, along with Children's Mercy Hospital, hosted the **"Heartland Childhood Obesity Summit - Factors of Health: Addressing the Systems Influencing Childhood Obesity."** The Summit brought together regional stakeholders from diverse sectors to share knowledge about and discuss the "Factors of Health" – socioeconomic factors, physical environment, health behaviors, and health care – that influence childhood obesity.

Dr. James Sallis, Professor of Family and Preventive Medicine at the University of California, San Diego, was one of the keynote speakers. He presented on his **Ecological Approaches to Promoting Active Living and Preventing Childhood Obesity**. Starting with his hypothesis on chronic disease, he linked the environmental and biological factors to the progressive timeline to sickness and death that is determined by diet, physical activity, and sedentary time. Dr. Sallis' presentation focused on environment and policy research.

Below is an outline of the topics discussed by Dr. Sallis.

- Principles of Ecological Models
- Evidence of environmental roles in active living of youth and obesity
- Environmental disparities
- Using combinations of interventions to be more effective
- Using evidence to more effectively prevent childhood obesity

You can access a recording of his presentation here and all speaker presentations and other materials on the Resources tab on our summit website.

Please share this information with your colleagues and partners and help us raise awareness about this important topic.

###

Save the date: Physician Compare National Provider Call

Be sure to mark your calendars.

The Centers for Medicare & Medicaid Services (CMS) will host a MLN Connects® National Provider Call about Physician Compare on **October 30, 2018** at **1:30 – 3:00 PM ET**. Registration information will be available in early October.

Learn more about Physician Compare and the public reporting of 2017 Quality Payment Program performance information. The Physician Compare preview period allows clinicians and groups to review their performance information before it is publicly reported on the Physician Compare website. This webinar will describe: (1) what to expect during the upcoming 30-day preview period and (2) how to navigate previewing your performance information.

There will be a question and answer session after the presentation, during which attendees will have a chance to ask the Physician Compare team questions about all things Physician Compare.
To learn more about public reporting on Physician Compare, visit our Initiative page where you can find resources and documents, including information about the 2016 performance information currently available on Physician Compare.

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Medicare Learning Network

News & Announcements

- New Medicare Card: MBI on Remittance Advice October 1
- Quality Payment Program: Funding for Quality Measure Development
- Patients Over Paperwork September Newsletter
- Hospice Provider Preview Reports: Review Your Data by October 5
- IRF Provider Preview Reports: Review Your Data by October 8
- LTCH Provider Preview Reports: Review Your Data by October 8
- QRURs and PQRS Feedback Reports: Access Ends December 31
- 2019 Eligible Hospital eCQM Flows
- Connected Care Toolkit
- Development of a Disability Index
- Hurricane Resources from ASPR TRACIE
- Medicare Appeals Council: New Decision Format
- National Cholesterol Education Month and World Heart Day
- New Medicare Card: Replacement Card
- MIPS Targeted Review Request: Deadline October 15
- MIPS Virtual Groups: Election Period Open through December 31
- MIPS: List of Quality Measures Impacted by ICD-10 Updates
- LTCH Compare Refresh
- IRF Compare Refresh
- ABNs and Dual Eligible Beneficiaries: Special Guidelines
- Sickle Cell Disease Data Highlight
- Enteral Device Connectors that Reduce Patient Injury
- October is National Breast Cancer Awareness Month

Provider Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services
- Outpatient Services Payment: Beneficiaries Who Are Inpatients of Other Facilities — Reminder

Claims, Pricers & Codes

- FY 2019 IPPS and LTCH PPS Claims Hold

Upcoming Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — October 15
- Patient Relationship Categories and Codes Webcast — October 17

Medicare Learning Network® Publications & Multimedia

- New Waived Tests MLN Matters Article — New
- HCPCS Drug/Biological Code Changes: October Update MLN Matters Article — Revised
- Influenza Resources for Health Care Professionals: 2018-2019 MLN Matters Article — New
- HPSA Bonus Payments: 2019 Annual Update MLN Matters Article — New
- Laboratory NCD Edit Software: Changes for January 2019 MLN Matters Article — New
- AWV, IPPE, and Routine Physical – Know the Differences Educational Tool — New
- Dementia Care Call: Audio Recording and Transcript — New
- Looking for Educational Materials?

###

CMS Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Open Door Forum

Date: Thursday, October 11, 2018 Start Time: 2:00 PM – 3:00 PM Eastern Time (ET);

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

Conference Leaders: Todd Smith & Jill Darling

This Agenda is Subject to Change

I. Opening Remarks

Chair – Todd Smith (Center for Medicare)

Moderator – Jill Darling (Office of Communications)

II. Announcements & Updates

- FY 2019 SNF PPS Correction Notice
- Release of Updated Hand in Hand: A Training Series for Nursing Homes

- Self-Paced Online Training: Hand in Hand: A Training Series for Nursing Homes Online

- Downloadable Materials for Instructor-Led Training: Hand in Hand: A Training Series for Nursing Homes Download

· SNF QRP Updates

- SNF QRP Outreach Available
- CORMAC sends informational messages to SNFs that are not meeting APU thresholds on a quarterly basis ahead of each submission deadlines. If you need to add or change the email addresses to which these messages are sent, please email QRPHelp@cormac-corp.com and be sure to include your facility name and CMS Certification Number (CCN) along with any requested email updates.
- PBJ Update
- For questions related to software or technical requirements, please email NursingHomePBJTechIssues@cms.hhs.gov
- For questions related to PBJ policies, please email NHstaffing@cms.hhs.gov

III. Open Q&A

DATE IS SUBJECT TO CHANGE

Next ODF: TBD

Mailbox: SNF_LTCODF-L@cms.hhs.gov

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

Open Door Participation Instructions:

This call will be Conference Call Only.

To participate by phone:

Dial: 1-800-837-1935 & Conference ID: 33973426

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

Encore: 1-855-859-2056; Conference ID: 33973426Encore is an audio recording of this call that can be accessed by dialing 1-855-859-2056 and entering the Conference ID beginning 2 hours after the call has ended. The recording expires after 3 business days.

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

**The Provider Ombudsman for the New Medicare Card serves as a CMS resource for the provider community. The Ombudsman will ensure that CMS hears, understands, and resolves any implementation

problems experienced by clinicians, hospitals, suppliers and other providers. Dr. Eugene Freund will be serving in this position. He will also communicate about the New Medicare Card to providers, and collaborate with CMS components to develop solutions to any implementation problems that arise. To reach the Ombudsman, contact: NMCProviderQuestions@cms.hhs.gov.

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

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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.