CMS Region 7 Updates – 8/24/2018

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New Medicare Card Updates

New Medicare Card, Same Old Scammers

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.

###

Important New Medicare Card Mailing Update – Wave 5 Begins, Wave 3 Ends

We've started mailing new Medicare cards to people with Medicare who live in **Wave 5** states: Alabama, Florida, Georgia, North Carolina, and South Carolina. We continue to mail new cards to people who live in Wave 4 states, as well as nationwide to people who are new to Medicare.

We're now finished mailing cards to people with Medicare who live in **Wave 1, 2 and 3*** states and territories. If someone with Medicare says they didn't get a card, you should instruct them to:

- Sign into MyMedicare.gov to see if we mailed their card. If so, they can print an official card. They'll need to create an account, if they don't already have one.
- Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

You can also print out and give them a copy of "Still Waiting for Your New Card?" or you can order copies to hand out.

To ensure that people with Medicare continue to get care, health care providers and suppliers can use either the former Social Security number-based HICN or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

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

***Wave 3 States include Region 7 states: Iowa, Kansas and Nebraska.**

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

###

New Medicare Card: 0 not O

The Medicare Beneficiary Identifier (MBI) uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers (e.g., between "0" and "O"). Read MLN Matters Article New MBI Get It, Use It for other helpful information, such as what to do if an MBI changes.

Save the Date: The next New Medicare Card Open Door Forum will be held Thursday, September 13, from 2-3 pm ET. Share your experiences transitioning to the MBI. Call in information will be provided in an upcoming edition.

###

ACA/Marketplace Updates

CMS Issues Proposed Additional Rule to Address Risk Adjustment Program for the 2018 Benefit Year

Proposed rule seeks to provide certainty and sustain consumer choices and affordability

The notice of proposed rulemaking, "Patient Protection and Affordable Care Act; Methodology for the HHS-operated Permanent Risk Adjustment Program for 2018 Proposed Rule," proposes to adopt the risk adjustment methodology that HHS previously established for the 2018 benefit year which uses the statewide average premium in the payment transfer formula.

"… proposed rule continues our effort to help stabilize the individual and small group markets," said CMS Administrator Seema Verma. "Our goal has been, and will continue to be, to stabilize the market and provide American consumers with more affordable health coverage options."

On February 28, 2018, the United States District Court for the District of New Mexico issued a decision vacating the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014 – 2018 benefit years. The government requested the court reconsider its decision and is currently awaiting the court's ruling.

This proposed rule further explains the justification for utilizing statewide average premium in the calculation of risk adjustment transfers, and expands on the reasoning behind operating the HHS-operated risk adjustment program in a budget-neutral manner. CMS seeks comment on the proposal to use statewide average premium in the risk adjustment methodology for the 2018 benefit year.

Previously, CMS issued a final rule which adopted the risk adjustment methodology that CMS formerly established for transfers related to the 2017 benefit year, so that HHS could continue operation of the program to maintain stability and predictability in the individual and small group health insurance markets. However, the rule only allows for the program to continue for the 2017 benefit year. The rule proposed today would allow the program to continue for the 2018 benefit year.

###

MACRA/Quality Payment Program (QPP) Updates

CMS Adopts the Methodology for the Permanent Risk Adjustment Program under the Patient Protection and Affordable Care Act for the 2017 Benefit Year

Final rule addresses the collection of risk adjustment charges and making of payments for the 2017 benefit year

The Centers for Medicare and Medicaid Services (CMS) posted a final rule that reissues, with additional explanation, the risk adjustment methodology that CMS previously established for transfers related to the 2017 benefit year. This important step fills a void created by a federal district court's vacating of the previously issued methodology, and enables the agency to resume the CMS-operated risk adjustment program in the individual and small group markets.

The Patient Protection and Affordable Care Act (PPACA) established a permanent risk adjustment program to provide payments to health insurance issuers that enroll higher-risk populations, such as those with chronic conditions, funded by payments from those that enroll lower-risk populations, thereby reducing incentives for issuers to avoid higher-risk enrollees.

"This rule will restore operation of the risk adjustment program, and mitigate some of the uncertainty caused by the New Mexico litigation," said CMS Administrator Seema Verma. "Issuers that had expressed concerns about having to withdraw from markets or becoming insolvent should be assured by our actions today. Alleviating concerns in the market helps to protect consumer choices."

CMS has determined that taking immediate action to allow for the continued operation of the risk adjustment program is imperative to maintain stability and predictability in the individual and small group health insurance markets. Quick resolution also helps to preserve the significant investment made by states, issuers, and the federal government to stand up the program. This final rule reissues the risk-adjustment methodology previously established for the 2017 benefit year.

Since its inception in 2014, the risk adjustment program has faced multiple federal court challenges. On February 28, 2018, the United States District Court for the District of New Mexico issued a decision finding CMS' use of statewide average premium in the risk adjustment transfer formula governing the 2014-2018 benefit years to be arbitrary and capricious. The court vacated the rule, and remanded it to the agency for further explanation of CMS' rationale for adopting the statewide average premium. Since this case was filed, CMS has vigorously defended its implementation of the risk adjustment program. CMS has sought relief from the court's February order, and filed a motion for reconsideration.

A hearing on the motion for reconsideration was held on June 21, 2018 in which the judge suggested a final ruling may not come until Labor Day. Following that hearing, it was clear that the case would not be resolved through the normal process in time to for the agency to make scheduled risk adjustment payments and collections in August.

This circumstance provided good cause for CMS to issue a final rule that dispenses with the typical notice and comment period. This final rule provides a fuller explanation supporting the 2017 risk adjustment methodology, consistent with the judge's request, and allows us to resume the risk adjustment program without delay.

Furthermore, today's final rule announces the agency's intention to issue a Notice of Proposed Rulemaking (NPRM) to propose and solicit comment on the CMS risk adjustment methodology that will apply to the 2018 benefit year, which was also vacated by the court. In the draft 2019 Payment Notice, we sought comment on our proposal to use the statewide average premium in the CMS risk adjustment methodology for the 2019 benefit year and beyond. We finalized that approach as proposed in the final 2019 Payment Notice published on April 17, 2018.

A copy of the final rule can be viewed: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9920-F-7-24-18-final.pdf. The final rule will be published at the federal register soon.

###

CMS Welcomes New Leadership Team, Makes Additional Staffing Announcement

The Centers for Medicare & Medicaid Services (CMS) announced several new additions to the agency's leadership team, as well as changes to the portfolios of senior staff in the Office of the Administrator. Since arriving in March 2017, Administrator Seema Verma has been committed to building an experienced and well-qualified team with a broad range of backgrounds and expertise. Today, Administrator Verma welcomes Paul Mango as CMS's Chief Principal Deputy Administrator and Chief of Staff and Chris Traylor as the agency's Deputy Administrator for Strategic Initiatives. In addition, the Administrator promoted Deputy Chief of Staff Brady Brookes to Deputy Administrator and Deputy Chief of Staff.

"President Trump and Secretary Azar have laid out an ambitious agenda to strengthen the Medicare and Medicaid programs for the millions of Americans they serve. This is a big responsibility and my team will have a critical role to play to help accomplish these goals," said Administrator Verma. "That is why I am pleased to welcome two distinguished and experienced leaders that not only have a wealth of knowledge managing complex healthcare issues, but also have hands-on experience at the local level in the practice and implementation of policy. These new additions will further strengthen our executive team and will help deliver on the promises made by the Trump Administration to better serve the American people."

Paul Mango joins the Office of the Administrator as the **Chief Principal Deputy Administrator and Chief of Staff**. Paul comes to CMS after a long and successful career at McKinsey & Company as a Senior Partner and also having filled additional leadership roles within their U.S. and global healthcare practices and as the head of McKinsey's U.S. Center for Health Reform. He is a veteran of the 82nd Airborne Division and a graduate of U.S. Army Ranger School; the United States Military Academy at West Point, where he was a Distinguished Cadet; and of Harvard Business School, where he was a Baker Scholar. He has been active in community and civic causes including a run for Governor of Pennsylvania in 2017, and as a board member of HM3 Partner Independence Fund, a foundation helping veterans, first responders and youth. Paul brings more than thirty years of experience in the healthcare industry that will prove invaluable in his role supporting Administrator Verma in the fulfillment of the agency's mission.

Chris Traylor joins the Office of the Administrator as the **Deputy Administrator for Strategic Initiatives**. Chris comes to CMS with over 26 years of public sector service in the area of healthcare and social services. His lengthy public service career in Texas concluded in 2016 when he retired as the Executive Commissioner of the Texas Health and Human Services Commission (HHSC) after previously serving as the commission's Chief Deputy Executive Commissioner. Earlier public service roles in Texas include a two-year term leading the Department of Aging and Disability Services (DADS) and as the state's Medicaid director for over three years. Under his leadership at Medicaid, Texas developed health passports for children in foster care and also expanded a managed model of care that integrated acute and long-term care services for Texans who are elderly or have disabilities. Since 2016, Chris has been leading a healthcare consulting firm serving clients in hospital operations and finance, long term services and supports, dental and oral health services, managed care and bio-health. His experience and expertise put him at the forefront of legislative innovation, reform, and regulation which will be instrumental to his new role at CMS.

"President Trump promised the American people a government that works for them with the efficiency of a successful business. Bringing highly qualified healthcare experts on board like Paul Mango will help deliver on that vision," said HHS Secretary Alex Azar. "The skills of top private sector innovators like Paul will complement the deep public sector experience and expertise of CMS staff like Administrator Verma and new Deputy Administrator Chris Traylor. The new additions to the team will help CMS build on its progress on HHS priorities, including value-based transformation and increasing consumer choice for healthcare coverage."

Administrator Verma also promoted Brady Brookes, CMS's current Deputy Chief of Staff to a concurrent role as Deputy Administrator. In this position, Brady will continue to oversee day-to-day operations and provide strategic counsel to the Office of the Administrator. Brady joined CMS in 2017 as Deputy Chief of Staff after serving as then-Governor Mike Pence's Legislative Director.

"I am excited to augment our already experienced executive team at CMS," said Administrator Verma. "I have known Paul for more than 10 years and look forward to having his support as we deliver on President Trump's agenda and execute on

our strategy on behalf of the American people. I believe CMS is headed into the future with an even greater ability to make positive change."

These new CMS staff additions build upon a leadership team at the agency that has made tremendous progress working to strengthen a non-sustainable healthcare system in need of major reform. This work includes:

- Launching Medicare's Blue Button 2.0, a new and secure way for Medicare beneficiaries to access and share their personal health data in a universal digital format.
- Creating the MyHealthEData initiative, designed to empower patients around a common aim - giving every American control of their medical data.
- Publishing for the first time state Medicaid and CHIP quality metrics, along with federally reported measures, in a Scorecard format to increase transparency and focus on outcomes.
- Releasing several new policies that improve federal and state program management, including improvements in the review, approval process, and monitoring of 1115 Demonstrations and Medicaid and CHIP state plan amendments (SPA) and 1915 waivers.

- Developing the Meaningful Measures initiative, focusing on high value measures that are outcome-oriented. CMS included proposals around Meaningful Measures in nearly every payment rule (FY and CY) in 2018 which would remove over 70 measures.
- Creating the Patients Over Paperwork initiative, a fundamental reform program to remove regulatory obstacles that get in the way of providers spending time with patients.
- Launching a new direction for the Innovation Center, issuing a Request for Information to solicit ideas for new payment models from innovators and experts on the front lines, because we know that the best ideas do not always come from Washington, DC.

- Issuing policies from the Center for Consumer Information and Insurance Oversight (CCIIO) that gave states flexibility and greater control of their health insurance markets to help consumers faced with rising costs.

- Providing relief every day from the rising costs of drugs, a top priority for President Trump.

- Utilizing Medicare Fee For Service payment rules to further the agency's priority of creating a patient-driven healthcare system by achieving greater price transparency, interoperability, and significant burden reduction.
- Organizing the mailing of New Medicare Cards to beneficiaries, removing Social Security numbers from cards in order to prevent fraud, fight identity theft and keep taxpayer dollars safe.
- Launching a nationwide program to better target medical review and put an emphasis on education and assistance in correcting claims errors.

###

CMS Empowers Patients and Ensures Site-Neutral Payment in Proposed Rule

Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) proposed rule advances CMS commitment to increasing transparency and lowering drug prices

The Centers for Medicare & Medicaid Services (CMS) took steps to strengthen the Medicare program with proposed changes to ensure that seniors can access the care they need at the site of care that they choose. In addition, as part of the agency's ongoing efforts to lower drug prices as outlined in the President's Blueprint, CMS included a Request for Information on how best to develop a model leveraging authority provided to the agency under the Competitive Acquisition Program (CAP) to strengthen negotiations for prescription drugs.

"Our healthcare system should always put patients first, and CMS today is taking important steps to empower patients and provide more affordable choices and options," said CMS Administrator Seema Verma. "In line with President Trump and Secretary Azar's priority to lower drug prices, today's proposed rule is also an important step towards expanding competition for drug payment in Medicare, in order to get the best deal for patients."

The proposed policies in the CY 2019 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule would help lay the foundation for a patient-driven healthcare system. To increase the sustainability of the Medicare program and improve quality of care for seniors, CMS is moving toward site neutral payments for clinic visits (which are essentially check-ups with a clinician). Clinic visits are the most common service

billed under the OPPS. Currently, CMS often pays more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting.

If finalized, this proposal is projected to save patients about $150 million in lower copayments for clinic visits provided at an off-campus hospital outpatient department. CMS is also proposing to close a potential loophole through which providers are billing patients more for visits in hospital outpatient departments when they create new service lines.

Additionally, CMS is giving patients more options on where to obtain care, in order to improve access and convenience and ensure that CMS policies are not favoring any particular provider type from the start. The proposed rule aims to address other payment differences between sites of service, so that patients can choose the setting that best meets their needs among safe and clinically appropriate options. For 2019, CMS is proposing to:

- Expand the number of procedures payable at ASCs to include additional procedures that can safely be performed in that setting;
- Ensure ASC payment for procedures involving certain high-cost devices parallels the payment amount provided to hospital outpatient departments for these devices; and
- Help ensure that ASCs remain competitive by stabilizing the differential between ASC payment rates and hospital outpatient department payment rates.

As part of active efforts to reduce the cost of prescription drugs, CMS is issuing a Request for Information to solicit public comment on how best to leverage the authority provided under the Competitive Acquisition Program (CAP) to get a better deal for beneficiaries as part of a CMS Innovation Center model. We believe a CAP-based model would allow CMS to introduce competition to Medicare Part B, the part of Medicare that pays for medicines that patients receive in a doctor's office. Currently, CMS pays the average sales price for these therapies plus an extra add-on payment. A CAP-based model would allow CMS to bring on vendors to negotiate payment amounts for Part B drugs, so that Medicare is no longer merely a price taker for these medicines. We are seeking public comment on how the vendors that CMS brings on could help the agency structure value-based payment arrangements with manufacturers, especially for high-cost products, so that seniors and taxpayers will know that medicines are working before they have to pay.

In 2018, CMS implemented a payment policy to help beneficiaries save on coinsurance on drugs that were administered at hospital outpatient departments and that were acquired through the 340B program—a program that allows hospitals to buy certain outpatient drugs at a lower cost. Due to CMS's policy change, Medicare beneficiaries are now benefiting from the discounts that 340B hospitals enjoy when they receive 340B-acquired drugs. In 2018 alone, beneficiaries are saving an estimated $320 million on out-of-pocket payments for these drugs. For 2019, CMS is expanding this policy by proposing to extend the 340B payment change to non-excepted off-campus departments of hospitals that are paid under the Physician Fee Schedule.

In response to recommendations from the President's Commission on Combatting Drug Addiction and the Opioid Crisis, CMS also is proposing to pay separately for certain non-opioid pain management drugs in ASCs; is seeking feedback on evidence to support that other non-opioid alternative treatments for acute or chronic pain warrant separate payment under the OPPS or ASC payment systems; and is proposing to eliminate questions regarding pain communication from the hospital patient experience survey.

As part of its commitment to price transparency, CMS is seeking comment through a Request for Information asking whether providers and suppliers can and should be required to inform patients about charge and payment information for healthcare services and out-of-pocket costs, what data elements would be most useful to promote price shopping, and what other changes are needed to empower healthcare consumers.

In the proposed rule, CMS is releasing a Request for Information to welcome continued feedback on the Medicare program and interoperability. CMS is gathering public feedback on revising the CMS patient health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers.

For a fact sheet on the CY 2019 OPPS and ASC Payment System proposed rule (CMS-1695-P), please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-25.html.

The proposed rule can be downloaded from the *Federal Register* at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-15958.pdf

Across all the Fiscal Year and CY proposed Medicare payment rules, we have proposed the elimination of reporting requirements for over 100 measures across the health care delivery system, saving providers more than $175 million over the next two years.

###

Quality Payment Program Performance Feedback and Targeted Review Video Demonstrations Now Available

View New Quality Payment Program Demo Videos on How to Access 2017 MIPS Performance Feedback and How to Request a Targeted Review

If you participated in the Merit-based Incentive Payment System (MIPS) in 2017, your MIPS final score and performance feedback are now available for review on the Quality Payment Program website.

If you believe that an error has been made in your 2019 MIPS payment adjustment calculation, you can request a targeted review until October 1, 2018 at 8:00 pm (ET).

To help you access your performance feedback for the 2017 performance year or request a targeted review, CMS has posted four new demonstration videos.

Video Details

1. How to Request a Targeted Review- demonstrates how MIPS eligible clinicians or groups can request a targeted review of their 2019 MIPS payment adjustment.
2. How to Access Performance Feedback for APM Entities- provides an overview of how to access 2017 MIPS performance feedback for Alternative Payment Model (APM) Entities.
3. How to Access Performance Feedback for Individuals- demonstrates how to access 2017 MIPS performance feedback for a clinician whose performance was scored separately from his or her group.
4. How to Access Performance Feedback for Voluntary Submitters- provides an overview of how to access 2017 performance feedback data for a clinician who voluntarily submitted data for 2017.

A fifth video on how groups can access their 2017 MIPS performance feedback will be posted later this week. We will notify you when it becomes available.

Please note: TIN/NPI information within these demonstration videos conveys mock data only.

Additional Resources

To learn more, visit qpp.cms.gov and review the following resources:

- Performance feedback user guide
- Enterprise Identity Data Management (EIDM) User Guide
- Enterprise Identity Data Management (EIDM) ACO User Guide
- Targeted review user guide

###

Updates to the 2018 CMS QRDA III Implementation Guide

The Centers for Medicare & Medicaid Services (CMS) has published an updated 2018 CMS Quality Reporting Document Architecture Category III (QRDA III) Implementation Guide (IG) for Eligible Clinicians and Eligible Professionals (EPs). This is an update to the 2018 CMS QRDA III IG for Eligible Clinicians and EPs originally published on 11/27/2017 and updated previously on 3/12/2018.

This latest update includes:

- Renaming of the Merit-based Incentive Payment System (MIPS) Advancing Care Information performance category to the Promoting Interoperability (PI) performance category.

- Changes to the MIPS performance period reporting which can be reported at either the individual measure level for the MIPS quality measures and at the individual activity level for the MIPS Improvement Activities, as defined by CMS; or the performance category level for the Quality and Improvement Activities performance categories, as previously specified in the 2018 CMS QRDA III IG.

- Performance period reporting for PI will remain at the performance category level only.
- Performance period reporting for Comprehensive Primary Care Plus (CPC+) for the Quality performance category remains at the category level only.

- The 2015 Edition (c)(4) filter certification criterion (45 CFR 170.315(c)(4)) is no longer a requirement for CPC+ reporting. However, practices must continue to report eCQM data at the CPC+ practice site level [practice site location, TIN(s)/NPI(s)].

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

- Eight new PI measure identifiers have been developed that indicate active engagement with more than one registries.

- The new measure identifiers consist of an existing measure identifier appended with "_MULTI". For example, the new measure identifier "PI_PHCDRR_1_MULTI" indicates immunization registry reporting for multiple registry engagement.

Additional QRDA-Related Resources:

- You can find additional QRDA related resources, as well as current and past IGs, on the Electronic Clinical Quality Improvement Resource Center.
- For questions related to the QRDA IGs and/or Schematrons, visit the ONC QRDA JIRA Issue Tracker.

For questions related to Quality Payment Program/MIPS data submissions, visit the Quality Payment Program website or contact by phone 1-866-288-8292, TTY: 1-877-715-6222 or email QPP@cms.hhs.gov.

###

CMS Finalizes Changes to Empower Patients and Reduce Administrative Burden

Changes in the Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule will advance price transparency and electronic health records

The Centers for Medicare & Medicaid Services (CMS) finalized a rule to empower patients and advance the White House MyHealthEData initiative and the CMS Patients Over Paperwork initiative. This final rule and others issued earlier this week will help improve access to hospital price information, give patients greater access to their health information and allow clinicians to spend more time with their patients.

Individually and collectively, these final rules put patients first, ease provider burden, and make significant strides in modernizing Medicare. The final rule issued today makes updates to Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) that will incentivize value-based, quality care at these facilities. CMS also issued final rules this week on fiscal year (FY) 2019 Medicare payments and policies for the Skilled Nursing Facility (SNF) PPS, Inpatient Psychiatric Facility (IPF) PPS, Inpatient Rehabilitation Facility (IRF) PPS, and the Hospice Wage Index and Payment Rate Update.

"We're excited to make these changes to ensure care will focus on the patient, not on needless paperwork," said CMS Administrator Seema Verma. "We've listened to patients and their doctors who urged us to remove the obstacles getting in the way of quality care and positive health outcomes. Today's final rule reflects public feedback on CMS proposals issued in April, and the agency's patient-driven priorities of improving the quality and safety of care, advancing health information exchange and usability, and removing outdated or redundant regulations on healthcare providers to make way for innovation and greater value."

Along with policy changes, the FY 2019 IPPS/LTCH PPS final rule provides acute care hospitals an average payment increase of approximately 3 percent, which reflects rate updates required by law and payments for new technologies and uncompensated care.

The IPPS/LTCH PPS final rule also updates geographic payment adjustments for IPPS hospitals. CMS looks forward to continuing to work on geographic payment disparities, particularly for rural hospitals, to the extent permitted under current

law and appreciates responses to our request for public input on this issue. By allowing the imputed wage index floor to expire for all-urban states, CMS has begun the process of making geographic payments more equitable for rural hospitals.

In addition, CMS is updating the LTCH PPS standard federal payment rate by 1.35 percent. Overall, under the changes included in the final rule, CMS projects that LTCH PPS payments will increase by approximately 0.9 percent, or $39 million in FY 2019. In addition, CMS is finalizing the proposal to eliminate the 25 percent threshold policy in a budget neutral manner.

MyHealthEData and Interoperability: The policies in the FY 2019 IPPS/LTCH PPS final rule will bring us closer to the agency's goal of creating a patient-centered healthcare system by increasing price transparency and fluid information exchange — essential components of value-based care — while also significantly lifting the administrative burden on hospitals so they can operate with greater flexibility and patients have the information they need to make decisions about their own care. CMS received stakeholder feedback on solutions for achieving interoperability, or the sharing of healthcare data between providers, through responses to a Request for Information (RFI) issued in April in the IPPS/LTCH PPS proposed rule.

While CMS previously required hospitals to make publicly available a list of their standard charges or their policies for allowing the public to view this list upon request, CMS has updated its guidelines to specifically require hospitals to post this information on the Internet in a machine-readable format. The agency is considering future actions based on the public feedback it received on ways hospitals can display price information that would be most useful to stakeholders and how to create patient-friendly interfaces that allow consumers to more easily access relevant healthcare data and compare providers.

The policies released today begin implementing core pieces of the White House-led MyHealthEData initiative through several steps to strengthen interoperability. In the IPPS/LTCH PPS final rule, CMS overhauls the Medicare and Medicaid Promoting Interoperability Programs (formerly known as the "Meaningful Use" program or Medicare and Medicaid Electronic Health Record Incentive Programs) to:

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

In addition, the final rule reiterates the requirement for providers to use the 2015 Edition of certified electronic health record technology in 2019 as part of demonstrating meaningful use to qualify for incentive payments and avoid reductions to Medicare payments. This updated technology includes the use of application programming interfaces (APIs), which have the potential to improve the flow of information between providers and patients. APIs can enable patients to collect their health information from multiple providers and incorporate it into a single portal, application, program or other software. This will support a patient's ability to share their information with another member of their care team or with a new doctor, which can reduce duplication and encourage continuity of care.

Meaningful Measures and Transparency: CMS's Meaningful Measures initiative is centered on patient safety, quality of care, transparency and ensuring that the measure sets providers are asked to report make the most sense. In the IPPS/LTCH PPS final rule, CMS is removing unnecessary, redundant and process-driven measures from several pay-for-reporting and pay-for-performance quality programs. The final rule eliminates a number of measures acute care hospitals are currently required to report across the four hospital pay-for-reporting and value-based purchasing quality programs. It also "de-duplicates" certain measures that are in multiple programs, keeping them in the program where they can best incentivize improvement and maintaining transparency through public reporting. In all, these changes will remove a total of 18 measures from the programs and de-duplicate another 25 measures while still ensuring meaningful measures of hospital quality and patient safety. In addition to the changes that apply to acute care hospitals, the final rule eliminates three measures in the LTCH Quality Reporting Program. Lastly, CMS is making a variety of other changes to reduce the hours providers spend on paperwork. This new flexibility will allow hospitals to spend more time providing care to their patients, thereby improving the quality of care their patients receive. Overall, changes in the hospital quality and value measures across the four programs will eliminate more than 2 million burden hours for hospitals impacted by the IPPS/LTCH PPS rule, saving them about $75 million annually after these changes are implemented.

Similarly, the Skilled Nursing Facilities (SNF) PPS, Inpatient Psychiatric Facility (IPF) PPS and Inpatient Rehabilitation Facility (IRF) PPS final rules establish policies that ensure the measures those providers must report are patient-centered and outcome-driven rather than process-oriented. Where applicable, these changes will allow providers to work with a smaller set of more meaningful healthcare measures and spend more time on patient care.

CMS is also advancing Meaningful Measures through the Hospice Wage Index and Payment Rate Update. This final rule will make Hospice Compare public data easier and more efficient to use.

Patients Over Paperwork: The SNF PPS final rule incorporates the agency's Patients Over Paperwork initiative through avenues that reduce unnecessary burden on providers by easing documentation requirements and offering more flexibility. As part of the agency's actions to modernize Medicare, the SNF PPS rule establishes an innovative new classification system, the Patient Driven Payment Model (PDPM), which ties skilled nursing facility payments to patients' conditions and care needs rather than volume of services provided. The new model will better incentivize treating the needs of the whole patient, rather than focusing on the amount of services for that patient, which requires substantial paperwork to track over time. The PDPM approach advances CMS's efforts to build a patient-driven healthcare system starting with innovation throughout Medicare's payment systems. Under this new SNF payment model, patients will have more opportunity to choose a skilled nursing facility that offers services tailored to their condition and preferences, as the payment to these facilities will be based more on the patient's condition rather than the specific services each skilled nursing facility provides.

Modernizing Medicare in additional ways to benefit patients, today's final IRF PPS rule adopts advances in telecommunications technology and removes obstacles that may prevent rehabilitation physicians from conducting certain meetings without being physically in the room. The rule also removes overly prescriptive documentation requirements for admission orders for these rehabilitation facilities.

For a fact sheet on the FY 2019 IPPS/LTCH PPS final rule (CMS-1694-F), please visit:

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-08-02.html

To view the FY 2019 IPPS/LTCH PPS final rule (CMS-1694-F), please visit:

https://www.federalregister.gov/public-inspection/

For a fact sheet on the FY 2019 SNF PPS final rule (CMS-1696-F), please visit:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-31-3.html

To view the FY 2019 SNF PPS final rule (CMS-1696-F), please visit: https://federalregister.gov/d/2018-16570

For a fact sheet on the FY 2019 IPF PPS final rule (CMS-1690-F), please visit:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-31.html

To view the FY 2019 IPF PPS final rule (CMS-1690-F), please visit: https://federalregister.gov/d/2018-16518

For a fact sheet on the FY 2019 IRF PPS final rule (CMS-1688-F), please visit:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-31-2.html

To view the FY 2019 IRF PPS final rule (CMS-1688-F), please visit: https://federalregister.gov/d/2018-16517

For a fact sheet on the FY 2019 Hospice Wage Index and Payment Rate Update final rule (CMS-1692-F), please visit:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-08-01-2.html

To view the FY 2019 Hospice Wage Index and Payment Rate Update final rule (CMS-1692-F), please visit:
https://federalregister.gov/d/2018-16539

###

Learn More About the FY 2019 Medicare IPPS and LTCH Final Rule

On August 2, the Centers for Medicare & Medicaid Services (CMS) issued updates to Fiscal Year (FY) 2019 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule.

The final rule changes the following aspects of the Promoting Interoperability (PI) Programs (formerly known as the EHR Incentive Programs):

- Sets a new performance-based scoring methodology for the Medicare Promoting Interoperability Program that has a smaller set of objectives that will provide a more flexible, less-burdensome structure.
- Requires the use of 2015 Edition CEHRT for eligible hospitals and critical access hospitals (CAHs) beginning in Calendar Year (CY) 2019.
- Finalizes an EHR reporting period of any consecutive 90-day period for new and returning CMS or State Medicaid agency participants in CYs 2019 and 2020.
- Finalizes changes to measures and removes certain measures that do not emphasize interoperability and the electronic exchange of health information beginning in CY 2020.
- Requires eligible hospitals and CAHs to select one quarter of CY 2019 data during the EHR reporting period and choose at least four self-selected electronic clinical quality measures (eCQMs) from a set of 16 for eCQM reporting.

For More Information

To learn more about these and other finalized changes, review the final rule, press release, and the fact sheet.

For more information on the PI Programs, visit the PI Programs landing page

###

Comments for QPP Year 3 NPRM due September 10

On July 12th, the Centers for Medicare & Medicaid Services (CMS) released proposed changes to its Physician Fee Schedule and Quality Payment Program (QPP). CMS is seeking comment on various QPP provisions in the NPRM. **Comments are due by 5:00 pm ET on September 10.**

You must officially submit your comments in one of the following ways:

- Electronically, through Regulations.gov
- Regular mail
- Express or overnight mail
- By hand or courier

More Information on the QPP Year 3 Notice of NPRM Draft Provisions

For Calendar Year 2019 (Year 3), proposed changes for QPP include:

- Expanding the definition of Merit-based Incentive Payment System (MIPS) eligible clinicians to include new clinician types (physical therapists, occupational therapists, clinical social workers, and clinical psychologists).
- Modifying the MIPS Promoting Interoperability (formerly Advancing Care Information) performance category to support greater electronic health record (EHR) interoperability and patient access while aligning with the proposed new Promoting Interoperability Program requirements for hospitals.
- Continuing the small practice bonus, but including it in the Quality performance category score of clinicians in small practices instead of as a standalone bonus.
- Updating the MIPS APM measure sets that apply for purposes of the APM scoring standard.
- Increasing flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program.

For More Information: To learn more, view the QPP Year 3 NPRM fact sheet and NPRM press release.
The Quality Payment Program may be reached at 1-866-288-8292 (TTY 1-877-715- 6222), Monday through Friday, 8:00 AM-8:00 PM ET or via email at QPP@cms.hhs.gov

###

The Deadline to Submit a MIPS Targeted Review Request

If you participated in the Merit-based Incentive Payment System (MIPS) in 2017, your MIPS final score and performance feedback are available now on the Quality Payment Program website. The payment adjustment you will receive in 2019 is based on this final 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 final score through a process called **targeted review**. The deadline to submit your request is **October 1, 2018 at 8:00 PM (EDT)** – which is just 40 days away.

When to Request a Targeted Review

If you believe an error has been made in your 2019 MIPS payment adjustment calculation, you can request a targeted review until **October 1, 2018 at 8:00 PM (EDT)**. 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 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 MIPS final 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 final score and associated payment adjustment (if applicable), as soon as technically feasible. CMS will determine the amount of the 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

- 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 final 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

###

Medicare and Medicaid Updates

CMS Releases Formal Approach to Ensure Medicaid Demonstrations Remain Budget Neutral

Agency reinforces commitment to transparency and controlling costs; provides new tool

The Centers for Medicare and Medicaid Services (CMS) released a letter to State Medicaid Directors that clearly describes CMS's current approach to calculating budget neutrality expenditure limits for Medicaid section 1115 demonstration projects. Medicaid demonstration projects allow states to design innovative ways to better serve the nation's more than 65 million Medicaid recipients. In response to longstanding concerns raised by the Government Accountability Office (GAO), this letter marks the first time that CMS has formally outlined how states must calculate budget neutrality for demonstration projects, in order to strengthen fiscal accountability. The guidance also comes a day after Administrator Seema Verma testified before the Senate Homeland Security and Government Accountability Committee on improper payments in the Medicaid program, which often result in higher federal spending.

The Social Security Act authorizes Medicaid demonstrations, if they are likely to promote the objectives of Medicaid. However, CMS will only approve them if federal Medicaid spending is estimated to be "budget neutral." The calculation of the budget neutrality spending limits—and how CMS monitors demonstration costs—is the subject of the letter.

"CMS welcomes smart new approaches to coverage and delivering care through Medicaid demonstration projects, but we won't approve them without a careful analysis of their impact on taxpayers. Federal spending on the program has increased, growing by over $100 billion between 2013 and 2016," said CMS Administrator Seema Verma. "Today's guidance is a comprehensive explanation of how CMS and our state partners can ensure that new demonstration projects can simultaneously promote Medicaid's objectives and keep federal spending under control."

Controlling Costs

Budget neutral demonstration projects will not result in federal Medicaid spending that exceeds what it would likely have been absent the demonstration. Currently, budget neutrality spending limits are one key component of CMS and state negotiations about proposed demonstration projects, and are listed in the special terms and conditions that govern each approved project. CMS currently subjects each demonstration to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration, based on projections of the amount the state would likely have received in the absence of the demonstration. The overarching goal of CMS's approach to budget neutrality is, therefore, to limit federal fiscal exposure resulting from the use of section 1115 authority in Medicaid.

New Tool for States

The State Medicaid Director letter also announces a new monitoring tool to support a more streamlined and standardized approach to expenditure reporting for Medicaid demonstrations.

The tool is a standardized budget neutrality reporting form that consolidates financial data for each demonstration into a unified report, to reduce redundancy—while, at the same time, strengthening and enhancing CMS reviews. States will upload the tool into the Performance Metrics Database & Analytics system as they currently do for their other monitoring and evaluation reports.

CMS intends to require states to use the tool as a condition of demonstration approval and will soon provide states with a schedule of training dates outlining completion and submission of the tool.

Transparency

In detailing how CMS determines budget neutrality and approves demonstrations, the Agency is reinforcing its commitment to transparency. Another notable effort to increase transparency—the Medicaid and Children's Health Insurance Program (CHIP) Scorecard—launched in June 2018.

The Scorecard offers taxpayers insights into how their dollars are being spent and the impact those dollars have on health outcomes.

The CMS agenda to transform Medicaid has three core tenets: state flexibility, accountability and program integrity. Today's guidance supports all of these tenets.

CMS continues to revise and improve its approach to budget neutrality for Medicaid demonstrations and will determine if additional guidance is needed as implementation continues.

###

Quality Payment Program Design Examples for CY 2019

For CY 2019, the Quality Payment Program has created a set of design examples that illustrate key concepts in the CY 2019 proposed rule. Listed here are wireframe drawings of key concepts in the CY 2019 proposed rule. To comment on any of these examples, go to the proposed rule at the Federal Register and leave your comments there.

###

CMS Streamlines Medicaid Review Process, Achieves Significant Reduction in Approval Times

The Centers for Medicare and Medicaid Services (CMS) announced significant improvements in managing the Medicaid program in partnership with states. Identified early as a priority for both the Trump Administration and the National Association of Medicaid Director's (NAMD), CMS has implemented changes resulting in faster processing of state requests to make program or benefit changes to their Medicaid program through the state plan amendment (SPA) and section 1915 waiver review process.

"With faster processing times and earlier communication, states now have much greater ability to manage their programs in an effective and predictable manner," said CMS Administrator Seema Verma. "We want to ease bureaucratic requirements for both states and our own staff so that we can focus those resources on improving health outcomes rather than pushing paperwork."

When states want to make changes to their Medicaid programs, they require approval from CMS. Typically these changes occur through a SPA or section 1915 waiver – even for simple updates, which sometimes require states to endure a months-long federal review process, thus creating a substantial burden for both states and CMS.

At the end of 2017, CMS issued a bulletin announcing an initiative to revamp these processes, highlighting four specific improvements: 1) a call with states within 15 days of receipt of each submission to review the state's request and any critical timelines to help expedite the review process; 2) launch of new tools available to states to facilitate the development of complete submissions; 3) implementation of a strategy to reduce a significant backlog of state requests and 4) expanding the use of MACPro, a web-based system for processing requests.

Today, CMS is following up with a new bulletin that highlights the successes of implementing the above strategies, outlines two additional long-term process improvements CMS is implementing, and highlights specific enhancements made to the review process for SPAs and 1915 waivers. Through extensive collaboration with states on this effort, CMS has achieved the following:

- Between calendar year 2016 and the first quarter of 2018, a 23 percent decrease in the median approval time for Medicaid SPAs.

- Eighty-four percent of Medicaid SPA were approved within the first 90-day review period in the first quarter of 2018, a 20 percent increase over calendar year 2016.
- Between calendar year 2016 and the first quarter of 2018, median approval times for HCBS waivers decreased by 7 percent. HCBS renewal approval times decreased by 38 percent and amendment approval times decreased by 44 percent for long-term care services.

To achieve this success, CMS undertook a significant effort to understand current processes and collaborated closely with states to understand where there was room for improvement and identify solutions. A work group was formed between

CMS and representatives from over a dozen states and representatives of their national associations. The combined focus by both CMS and states on SPA and 1915 waiver processing and implementation of improvement strategies is proving successful.

"We are appreciative of CMS for reaching out to state agencies for feedback on an improved process for 1915(c) HCBS Waiver applications and amendments and for responding so quickly to address issues identified through that engagement. States have reported that the new practice by CMS to call states within 15 days of a submission has been very beneficial, resulting in better applications and faster approvals" said Mary Lee Fay, Executive Director of the National Association of State Directors of Developmental Disabilities Services (NASDDDS).

###

CMS announces new model to address impact of the opioid crisis for children

Model to focus on children in Medicaid and CHIP who have physical and behavioral health needs, including substance use

The Centers for Medicare & Medicaid Services (CMS) announced a new Innovation Center payment and service delivery model as part of a multi-pronged strategy to combat the nation's opioid crisis. The Integrated Care for Kids (InCK) Model aims to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid and the Children's Health Insurance Program (CHIP) through prevention, early identification, and treatment of behavioral and physical health needs. The model will empower states and local providers to better address these needs through care integration across all types of healthcare providers.

The InCK Model will help state Medicaid agencies and their local health and community-based partners identify and address risk factors for behavioral health conditions, understanding that the earliest signs of a problem may present outside of clinical settings—such as in schools or at home—and may be known not to clinicians but rather to teachers and to child welfare and foster care programs. The interventions outlined in the InCK Model are designed to respond to this crisis by supporting state Medicaid agencies and local health and community-based partners to increase access to behavioral health for vulnerable children and build capacity in communities to provide more effective, efficient, and affordable care through home- and community-based services.

While the existing, required Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is comprehensive, variation remains among states in how and when children receive behavioral health screening, diagnostic and treatment services. In addition, despite the variety of federal, state, and local services that do exist to support children's health, limited information sharing and differing eligibility and enrollment processes have created barriers to putting children and families at the center of their care and coordinating across services.

InCK Model participants will benefit from systematic integration, coordination, and management of core child services, including clinical care, school-based health services, housing, and other health-related supports. The InCK Model aims to positively impact the health of the next generation through early identification and treatment of behavioral health risk factors of children up to age 21 covered by Medicaid and CHIP in selected states. Testing the use of a state-specific payment model to cover integrated care coordination and case management, the InCK Model will be tailored to the unique challenges faced by providers and patients at the local level, ultimately leading to long-term improvements in child health services and health outcomes.

The CMS Innovation Center anticipates releasing a detailed Notice of Funding Opportunity in Fall 2018 with additional details on how state Medicaid agencies and local health and community-based organizations can apply to participate in the model. CMS intends to award funding for up to 8 states at a maximum of $16 million each in as early as Spring of 2019 to implement the seven-year model.

The CMS Innovation Center was established by section 1115A of the Social Security Act to test innovative healthcare payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for those individuals who receive Medicare, Medicaid, or CHIP benefits.

For a fact sheet on the InCK Model, please visit: https://www.cms.gov/newsroom/fact-sheets/integrated-care-kids-inck-model.

For more information on the InCK Model, please visit: https://innovation.cms.gov/initiatives/integrated-care-for-kids-model/.

###

A More Modern Newsroom for You

August 8, 2018
By Seema Verma, Administrator, Centers for Medicare & Medicaid Services

America's journalists work hard every day to inform their audiences. At CMS, we recognize that the journalists who cover our agency—and our efforts to transform the healthcare system—need accurate, up-to-date information and they need it quickly.

Over the past year, we've been working hard to modernize our press operations. We have heard from you and we have listened. As part of this effort, starting today, you will see we've improved the usability and updated the look of our online Newsroom web page, which includes press releases, statements, speeches, blogs, and fact sheets put out by our media relations team. This update does not impact other areas of the CMS.gov website, or our other websites, such as HealthCare.gov. These changes will make it easier for you to find the information you're looking for and the background you need.

Many thanks to the journalists and others who provided us feedback, and especially those who participated in the usability testing of our site that led to this update. We greatly appreciate your help.

Improved usability

We heard from you that our Newsroom should be easier to use, and we agree. For a better experience, we've made CMS data and background, press contacts, and other information quickly accessible. We've also built a more robust search tool that will help serve your needs.

Give the new search functionality a try. You'll see autocomplete suggestions and other enhancements that will make it so much easier to find what you need. It'll also be clearer which search results page you're on.

We also wanted to assure you we're handling your questions. Now, when you send us a question through the Media Inquiry form, you'll get an email to let you know we received it.

New look

Beyond functionality, we heard the online Newsroom seemed dated, so we've refreshed the graphics and color to give the pages a more modern look and feel.

We've made many improvements, but nothing has been removed from the newsroom section. You'll still be able to get the same information that's always been available in our Newsroom—just more quickly and easily.

Innovation and customer service are core tenets of my Administration, and they will continue to be, so we'll keep improving CMS.gov over time. The updated newsroom section is just a first. . Thank you for your work to inform the public about our programs and initiatives.

###

Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Medicare pays Medicare Diabetes Prevention Program (MDPP) suppliers to furnish group-based intervention to at-risk Medicare beneficiaries:

- Centers for Disease Control and Prevention (CDC)-approved National Diabetes Prevention Program curriculum
- Up to 2 years of sessions delivered to groups of eligible beneficiaries

Find out how to become a Medicare enrolled MDPP supplier:

- Obtain CDC preliminary or full recognition: Takes at least 12 months to obtain preliminary recognition and up to 24 additional months to achieve full recognition; visit the CDC website for more information
- Prepare for Medicare enrollment; see the fact sheet and checklist
- After achieving preliminary recognition, apply to become a Medicare enrolled MDPP supplier (existing Medicare providers must re-enroll)
- Furnish MDPP services
- Submit claims to Medicare

For More Information:

- Materials from Medicare Learning Network call on June 20
- MDPP webpage
- CDC - CMS Roles Fact Sheet
- Contact the MDPP Help Desk at mdpp@cms.hhs.gov

###

Upcoming Webinars and Events and Other Updates

REGISTRATION OPEN – Upcoming IRF and LTCH QRP Webinars (August 29 and September 4, 2018) Related to Changes Associated with Coding Sections N and M of the LTCH CARE Data Set and the IRF-PAI

The Centers for Medicare & Medicaid Services (CMS) will be hosting two webinars for providers at Long-Term Care Hospitals and Inpatient Rehabilitation Facilities to present information about proper coding of Section M Skin Conditions (Pressure Ulcer/Injury) and Section N of the Continuity Assessment Record and Evaluation (CARE) Data Set Version 4.00 and the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Version 2.00. Updated reporting requirements for Sections M and N became effective on July 1, 2018, for LTCH providers and will become effective on October 1, 2018, for IRF providers. See the LTCH Quality Reporting Training and IRF Quality Reporting Training web pages for details.

###

In Case You Missed It - Recording of Panel Discussion on E/M Coding Reform

In case you missed it last week, see below for a link to the webcast of the panel discussion on Evaluation & Management Coding:

- **Title:** CMS Panel Discussion on E/M Coding Reform
- **Link:** https://youtu.be/W2QBTQNxfSY

###

Heartland Childhood Obesity Summit "Factors of Health: Addressing the Systems Influencing Childhood Obesity"

The Health Resources and Services administration, Weighing In, a program of Children's Mercy Kansas City, and the Region 7 Office of Assistant Secretary for Health, hosted the Heartland Childhood Obesity Summit "Factors of Health: Addressing the Systems Influencing Childhood Obesity" on June 27th and 28th, 2018. This summit brought together speakers to share how they are addressing the systems influencing childhood obesity. The purpose of the summit was to inspire, teach and foster collaboration for continuing progress in promoting healthy lifestyles in children and addressing the national epidemic of childhood obesity.

Recordings of day one of the summit can be found here and day two here. Our guest speaker's presentations and other valuable resources are located on our summit website.

Two internationally recognized key-note speakers featured at the Heartland Childhood Obesity Summit were Dr. Jim Sallis and Dr. Bill Kohl.

Dr. Jim Sallis is a Professor of Family and Preventive Medicine at the University of California, San Diego and has served as the director of Active Living Research. His interests in research are focused on promoting physical activity and understanding the policy and environmental influences on physical activity, nutrition and obesity.

Dr. Sallis 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 bases his research on addressing issues within this working hypothetical timeline, but more specifically, he focused on environment and policy research for his presentation at the summit.

Dr. Bill Kohl, III, Professor of Epidemiology and Kinesiology at the University of Texas Health Science Center, emphasized the importance of a systems-based approach to address physical inactivity. Various conditions interact to promote or hinder population levels of physical activity. Understanding and applying complex systems-thinking can allow for infrastructure changes that will give individuals and populations the opportunities to be more physically active and healthy. Physical activity is not only a health or public health sector issue, but one that involves city and community planners, transportation engineers, schools, parks and recreation, businesses, and the media.

If you have any questions, please feel free to contact us at HRSAORORegion7@hrsa.gov.

###

HHS Community Health News

SAMHSA's FAQ for the State Opioid Response Grants Affirms the Role of Faith-based Providers
The Substance Abuse and Mental Health Administration (SAMHSA) is currently accepting applications from states for $930 million to combat the opioid crisis through State Opioid Response Grants (Short Title: SOR), with a deadline of August 16th. A letter from Shannon Royce, Esq., Director, Center for Faith and Opportunity Initiatives at the U.S. Department of Health and Human Services (HHS) and SAMHSA's recently-released Frequently Asked Questions affirm that states may use the **State Opioid Response (SOR) grant funds to support the provision of substance use disorder services by faith-based organizations.** It also affirms that states are allowed to use a portion of their funds through indirect funding or voucher programs to enhance client choice and increase program participation by a variety of groups, including faith-based partners.

Faith-based providers of treatment, recovery support, and prevention efforts are reaching out to their state/commonwealth to discuss how their organization might participate in these grant funds as part of their state's comprehensive approach to the opioid crisis.

Honor National Immunization Awareness Month by Taking Your Best Shot
In this HHS.gov blog post by Adm. Brett P. Giroir, M.D., Assistant Secretary for Health says, "As a pediatrician, public health advocate, father, and grandfather of a young infant, it is one of my greatest sorrows to know that even one child died from a disease that is preventable." Read more here and learn how to support National Immunization Awareness Month (NIAM) throughout August.

Embrace Physical Literacy – Provide Children with the Foundation for Leading an Active Lifestyle
Health.gov Blog Post by Dr. Fran Cleland, SHAPE America Past President. Physical literacy has been defined as the ability to move with competence and confidence in a wide variety of physical activities in multiple environments that benefit the healthy development of the whole person. This post explains why physical literacy is important, the role of SHAPE America's 5 National Standards, and how Comprehensive School Physical Activity Programs can impact the physical activity behaviors of young Americans.

National Action Alliance for Suicide Prevention's/ September 7-9
National Action Alliance for Suicide Prevention's National Weekend of Prayer for Faith, Hope, & Life is an annual event around World Suicide Prevention Day in September. On this weekend, faith communities all around the country pledge to join in prayer for those who are struggling with suicidal thoughts and feelings, the people who love and care for them, and for those who feel close to someone who has died by suicide. Check out our **brief promotional video** and consider how you and your organization can participate during the weekend of September 7-9. To learn more, go to: **www.PrayFaithHopeLife.org**.

###

Medicare Learning Network

News & Announcements

- New Medicare Card: 0 not O
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- 2016 PQRS and 2018 Value Modifier Experience Reports
- Patients Over Paperwork: Medicare Physician Fee Schedule Proposed Rule Presentation
- 2019 MIPS Performance Year Virtual Groups Toolkit
- Hospice Compare Quarterly Refresh
- 2016 Inpatient Hospital Utilization and Payment Data
- Hospices: Second Quarter HQRP Update
- Help Your Medicare Patients Avoid and Report Scams
- SNF VBP FY 2019 Annual Performance Score Report: Submit Correction Requests by August 31
- Quality Payment Program Exception Applications Due by December 31
- Quality Payment Program: 2017 MIPS Performance Feedback and Payment Adjustment
- Quality Payment Program Performance Feedback and Targeted Review Videos
- Medicare Diabetes Prevention Program Suppliers: Separate Medicare Enrollment

- Vaccines are Not Just for Kids

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors — Reminder
- Reporting Changes in Ownership — Reminder

Claims, Pricers & Codes

- 2019 MS-DRG Definitions Manual and Software
- Hospice: NOE information in the HETS Transaction

Upcoming Events

- Quality Payment Program Virtual Groups Webinar — August 27
- Person-Centered Approaches to Support Dual Eligibles for Medicare & Medicaid- September 6
- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18
- Comparative Billing Report on Licensed Clinical Social Workers Webinar — September 12

Medicare Learning Network® Publications & Multimedia

- Additional Search Features on FISS Provider DDE Screen MLN Matters Article — New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — New
- Clarifying Language for Chapters 3 and 5 of the MSP Manual MLN Matters Article — New
- Medicare Coverage of Diabetes Supplies MLN Matters Article — New
- Improvements in Hospice Billing and Claims Processing MLN Matters Article — Revised
- Quarterly Influenza Virus Vaccine Code Update: January 2019 MLN Matters Article — New
- Update to Medicare Claims Processing Manual, Chapter 24 MLN Matters Article — New
- IRF Annual Update: PPS Pricer Changes for FY 2019 MLN Matters Article — New
- Implementing Epoetin Alfa Biosimilar, Retacrit for ESRD/AKI Claims MLN Matters Article — New
- Medicare Claims Processing Manual, Chapter 24 Update: Form Letters — New
- IPF PPS Updates for FY 2019 MLN Matters Article — New
- ASP Medicare Part B Drug Pricing Files and Revisions: October 2018 MLN Matters Article — New
- August 2018 Catalog — Revised
- Medicare Preventive Services Educational Tool — Revised
- Medicare Enrollment for Providers Who Solely Order, Certify, or Prescribe Booklet — Revised
- Quality Payment Program Year 2 Overview Web-Based Training Course — Revised
- Quality Payment Program: MIPS Promoting Interoperability Performance Category Year 2 Web-Based Training Course — Revised
- Quality Payment Program MIPS Quality Performance Category Year 2 Web-Based Training Course — Revised
- Safeguard Your Identity and Privacy Using PECOS Booklet — Reminder
- PECOS FAQs Booklet — Reminder
- PECOS for Provider and Supplier Organizations Booklet — Reminder

###

New AMA Accredited Web-Based Trainings Now Available

Now available on the Medicare Learning Network (MLN) Learning Management System (LMS) are three AMA accredited web-based training programs. All offer continuing education credit through the AMA. You'll need to log in to the MLN LMS and then search by title to access these new trainings.

###

Quality Payment Program Year 2 (2018) Overview Web-Based Training Course

Learn about:

- Quality Payment Program (QPP) in Year 2 (2018)
- Origin and objectives of the Quality Payment Program
- Four performance categories within the Merit-based Incentive Payment System (MIPS)
- Three criteria to be considered an Advanced Alternative Payment Model (Advanced APM)
- Available resources

###

Quality Payment Program Merit-based Incentive Payment System (MIPS): Promoting Interoperability Performance Category Year 2 (2018) Web-Based Training Course

Learn about:

Quality Payment Program's Merit-based Incentive Payment System (MIPS) Promoting Interoperability Performance Category in Year 2 (2018)

- Base, performance, and bonus score reporting requirements
- Performance category measure sets available in Year 2
- Scoring and reweighting methodology for the performance category
- Available resources and where to get help

###

Quality Payment Program: Merit-based Incentive Payment System (MIPS) Quality Performance Category Year 2 (2018) Web-Based Training Course

Learn about:

- Quality Payment Program's Merit-based Incentive Payment System (MIPS) Quality Performance Category in Year 2 (2018)
- Reporting requirements
- Data submission mechanisms
- Scoring and benchmark methodology
- Available resources

###

Publication Update: Opioid Overdose Prevention Toolkit Now Available in Spanish

SAMHSA announces the release of the Spanish translation of the updated Opioid Overdose Prevention Toolkit. This toolkit offers strategies to health care providers, communities, and local governments for developing practices and policies to help prevent opioid-related overdoses and deaths. Because interdisciplinary collaboration is critical to success, resources and information are specifically tailored for community members, prescribers, patients and families, and those recovering from opioid overdose.

View the Spanish Publication

View the English Publication

###

Virtual Groups Toolkit for 2019 MIPS Performance Year Now Available

If you're interested in forming a virtual group for the 2019 Merit-based Incentive Payment System (MIPS) performance year, you must follow an election process and submit your election to CMS via e-mail between **October 1 and December 31, 2018**.

CMS has posted the 2019 Virtual Groups Toolkit to help you understand the election process to participate in MIPS as a virtual group in 2019. The toolkit includes:

- **2019 Virtual Groups Overview Fact Sheet** – Provides an overview of what a virtual group is, who can participate in a virtual group, how virtual groups collect and submit data, and how virtual groups are scored.
- **2019 Virtual Groups Election Process** – Details the two-stage election process for forming a virtual group, and what needs to be included in a virtual group agreement.
- **Virtual Group Election Submission E-mail** – A sample e-mail that can be used for a virtual group election submission.
- **Virtual Agreement Template –** A template that can be used to develop a virtual group agreement.

Upcoming 2019 Virtual Groups Webinar

CMS is hosting a webinar on **Monday, August 27, 2018 at 2:00 PM ET** to provide information about how clinicians can participate in MIPS as a virtual group for the 2019 performance year. Register today to secure your spot.

Webinar Details

Title: Quality Payment Program Virtual Groups Webinar

Date: Monday, August 27, 2018

Time: 2:00 – 3:00 PM ET

Registration Link: https://engage.vevent.com/rt/cms/index.jsp?seid=1179

Learn More

- Quality Payment Program Website – Individual/Group Participation
- 019 Virtual Groups Toolkit

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CMS 2019 Medicare Physician Fee Schedule Proposed Rule Webinar: August 27, 2018

The Centers for Medicare & Medicaid Services will host a webinar on the 2019 Medicare Physician Fee Schedule Proposed Rule on Monday, August 27th, from 2:00 - 3:30 PM EDT. This webinar will be a fourth opportunity to get an overview of proposed rule, focusing on three main areas:

- Year 3 of the Quality Payment Program;
- Documentation requirements and payment for Evaluation & Management (E/M) visits; and
- Advancing virtual care

The information presented on this webinar will be similar to the CMS webinars held on August 9, August 14, and August 22.

To register for this webinar, please click on this link:

https://www.eventbrite.com/e/cms-2019-medicare-physician-fee-schedule-proposed-rule-webinar-registration-49088968426

Official comments are due by September 10, 2018 and can be submitted at this link: https://www.regulations.gov/document?D=CMS-2018-0076-0621

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CY 2019 Medicare Physician Fee Schedule Proposed Rule: E/M Documentation and Coding Webinar

Join the Centers for Medicare & Medicaid Services (CMS) Chicago Regional Office as we continue our webinar series with on the E/M Coding Proposed Rule This webinar will discuss E/M Coding Reform introduced in the CY 2019 Medicare Physician Fee Schedule and Quality Payment Program proposed rule.

To register go to: E/M Coding Webinar 2 Wed, September 5th 12:00 p.m. CT Dr. Patricia Meier *(Chief Medical Officer)*

Note: feedback received during this event will not be considered formal comments on the rule. See the proposed rule for information on submitting these comments by September 10, 2018. Once your registration is processed, you will receive a confirmation email with instructions for joining the session. We look forward to having you join us!

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